

## 14. **Ethics, Professionalism and the “Trade”**

*Rajakumar MK. Ethics, professionalism and the “trade”. National Conference on Managed Care. Primary Care Doctors’ Organisation of Malaysia, 17-18 August 1996. Petaling Jaya, Malaysia.*

Our profession is facing a crisis. We can see this in the panic reaction of doctors responding to the threat of managed care. Serious division within the profession and tremendous animosity generated between friends have emerged over this matter of managed care.

For some time, there has been a deterioration in the ethical traditions of our profession. Community expectations of our profession is high, perhaps unreasonably high. They expect doctors will treat first and think of payment later. They do not expect this of other professions.

Remember that if we behave like ‘trades people’, the community will treat us as ‘trades people’. Conversely if the community treated us like ‘trades people’, we would tend to behave like ‘trades people’.

This is part of the challenges we face today: How do we preserve the values that have made our profession unique and special?

The community sees doctors in different ways. They expect us to practice as scientists – scientific medicine with modern technology. Some expect us to be the ‘saint’, but sometimes, they look at a doctor and say he behaves like a ‘shopkeeper’.

A correspondent in the *New England Journal of Medicine* (April 1996) says, “...*We forfeited the moral high ground long ago when we let our own desire for private enrichment displace our commitment to service... We sold out ... We cultivated the industry of money making. Under the old system, we over-used resources because it was to our financial advantage, we will underuse them now.*”

There have always been conflicts of interest, in dispensing, pressure on cost, pressure on referrals, pressure on sick leave, ownership of hospital, ownership of diagnostic facilities and now private hospital marketing. Private hospitals in primary care threaten destruction to the economic basis of the GP in this country.

The saving grace of our profession in this country is the Ministry of Health (MOH) hospitals – the ‘Crown Jewels’. These hospitals have to set the standards of excellence for the private sector. They provide health care to the vast majority of the country. This group of doctors, who have been insulated from commercial pressures, represents the practice of medicine at its best, with the spirit of good practice, long hours of work, not taking annual leave and ridiculous salary. It’s troubling that this country that can stand up to great power and fund big projects cannot pay government doctors enough to retain them so as to provide a decent level of services to the majority of the people of this country.

There are different methods whereby a doctor is remunerated: Salary (40-45% of our doctors are salaried), capitation (the British National Health Service works on this method), fee-for-service (private hospitals work on this with discounts for certain clients) and profit-sharing (hospitals take part of the profit of the specialist). Let not someone in one mode of compensation claim to be ‘holier’ than others.

I believe there has been a serious misunderstanding by investors in Malaysia regarding prospects in managed care. Great fortunes have been made by managers or investors in the USA. They think great money could be made here in Malaysian health care. But primary health care in this country is poorly paid; whilst hospitals are well-organised and specialists are in short supply. These managers or investors are misled if they think that there are great fortunes to be made. The overheads of private health care are very high – 20-30% (profits, salaries and cost of running; non-profit plans use less than half the amount: US non-profit plan – 6%; Medicare – 2.1%; Canada – 0.9%).

In the US, managed care has been irresistible. Three out of four doctors have converted at least part of their private practice and are involved in some types of HMO activities. 40 million people are in HMOs but 40 million people in US have no insurance cover.

The 'Medical-loss ratio' is the proportion of premium money spent on health care services. They consider this as the loss. So, to make more profit, reduce the loss. 'Risk management' is management to reduce medical loss (Total medical costs = utilisation x service cost). So, one way to reduce 'loss' is to get physicians to share risk. Certain HMO-type organisations offer incentives to physicians to share risk and also have various forms of utilisation and to punish those who over-utilise.

The strategies of risk management of a for-profit company are to advertise to the rich, recruit from the young and fit, share risk with the providers and give incentives to the physician to reduce utilisation of services. As a result, states in the US have passed laws stating that not more than 25% of doctors' income can come from incentive payments.

There are restraints in managed care: Allocation of time, referral for second opinion, use of investigation, choice of drugs, admission to hospital, discharge from hospital, release of information and confidentiality.

## **Two extreme examples of Managed Care**

### *For-profit Managed Care (in US)*

A month-old girl with ALL was referred for bone marrow transplantation to a 'preferred provider' in another state although the physician preferred a local university centre. The mother had to give up her job to accompany the child. Since they could not afford health insurance, they gave it up and applied for Medicaid. The father could not see the child because the treatment for ALL was 6 - 18 months. The elder sister had to be sent to relatives to be looked after. When the time came for second course of treatment, the provider had been changed again to another provider. The end result was the family exhausted all their savings and had to sell their house to make ends meet.

*Not for-profit Managed Care (in UK)*

A six-month-old girl with motor and sensory neuropathy was in intensive care on a ventilator for one year with no possible treatment for her condition (they discovered this after they had put her on a ventilator while investigating). The regional health funding authority decided she deserved the experience of home life before she died. They set up intensive care in the home and she remained on a ventilator for 18 months before she died. The cost of home care was £160,000. The health authority met it because they are not for-profit.

Here, we can see the huge difference in the attitudes that are brought to bear on decision making in health-care depending on what your starting position is. The not for-profit managed care in UK was a civilised decision but no society can afford such an expensive choice. My point is that it is better to err in this way.

The general practitioner under managed care has increased responsibility and diminished autonomy. In UK, they are under ‘fund holders’ – they have increased autonomy and they can negotiate with hospitals and get better service for the patient. In US, there is the ‘gate keeper’ system (because there is no family doctor system) and in New Zealand, the ‘coordinated care’ system (a variation of fund holding).

## **The role of Managed Care Managers**

*Quality: Desirable, acceptable demands*

If the community is going to pay, they have the right to demand certain standards of excellence: equity, accessibility, patient satisfaction, cost-efficiency, rational management, justified outcomes. By rational management, I mean care that reflect guidelines or consensus that is evidence based.

*Patient's right*

- choice of personal family doctor
- choice between competing health plans
- referral to most appropriate specialist or institution
- confidentiality

### *Doctor's right*

- professional autonomy
- professional quality assurance and audit
- professional credentialing
- fair remuneration

### **Legislation on for-profit Managed Care**

There is need for legislation to control all elements in health care. I would like the following:

- independent quality assurance and standards organisation (let QAP remain professional and not let businessman come in to set standards)
- separation of ownership of primary and tertiary care facilities
- confidentiality

### **What to do**

1. Organise - every health district needs an organisation (an independent practitioner association, a charitable trust) to receive funding from the National Health Authority to look after the welfare of the people in the district. We will need new types of organisations and new skills to meet these new challenges.
2. Cooperate - cooperate with National Medical Association, Ministry of Health, community (unions, consumers or elected representatives of the people) and with other sections of the profession.
3. Negotiate - This requires expertise that we do not now have. Professional managers will be needed.

The delivery of health care will change in response to changes in health financing. Medical practice will be seriously affected as cost accountability or cost containment become determinants between alternative treatments. We have to respond positively and proactively in the interests of our patients, the community and the profession.