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Conflicting Interests: The Health Care Accountability Dilemma

By Kaveh Safavi and Finney Gilbert

When is the fiduciary duty a matter of life and death? For medical practitioners—unlike accountants, lawyers and other specialists with a fiduciary duty—the obligation to act solely in their customers' best interests carries the highest of stakes.

This responsibility dates back to the 5th century BC and the Hippocratic Oath, and the ''patient first'' ethos has been embedded within the soul—and the legal apparatus— of the medical profession in the U.S. since the inception of the American Medical Association in 1847.

Some 170 years later, physicians continue to enjoy significant levels of public trust and influence compared with other players within health care—primarily because of this expectation that they will place their patients' wellbeing above all other considerations.

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Tension between patient and purse

But now a competing notion of fiduciary duty is at play. With the advent of Managed Care Organizations (MCOs) and more recently Accountable Care Organizations (ACOs), physicians are expected to act as fiduciary toward risk-bearing institutions: employers, health plans and health systems.

This can lead to conflict. Perhaps a doctor must decide between optimal treatment for an individual patient and compliance with cost-containment pathways and protocols. Perhaps a patient needs an MRI scan but the cheapest one is two hours away. Medical professionals are increasingly savvy about financial realities, but they are bound to push back if they sense a direct threat to their ability to put patients first.

The U.S. Department of Health & Human Services' organ procurement and transplantation policies are an example of an explicit framework that enables the allocation of a scarce, lifesaving resource—organs—to a larger population of potential recipients. But it is the exception. The legal system has struggled with the fundamental conflict between medical professionals' fiduciary duty toward patients and their fiduciary responsibility toward risk-bearing entities: the legal and regulatory frameworks supporting MCOs and ACOs are

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not matched by frameworks to support the physicians' fiduciary obligations toward patients.

Calculating the conflict

To establish the potential economic magnitude of this conflict, Accenture divided total health care spend into three qualitative levels depending on the impact of the physician's fiduciary duty.

Level I: Trivial.

The health practitioner's fiduciary role is trivial for most low-acuity and/or low-spend items such as health and wellness services (gym membership, diet programs), dietary supplements, cold and allergy medication, and optometry. Typically, these products and services have a number of potential substitutes and there is more information for the consumer about cost, utility and quality. This category accounts for just 3 percent of total U.S. health care spend.

Level II: Material but not significant.

Here, the fiduciary role is material but not that significant. Examples might include pediatrician visits, primary care, dental services, ophthalmology, and antibiotics. These are specialized services, and products are typically more costly. There is some availability of substitutes and, increasingly, the consumer has access to information on the cost, utility and quality of these services. These types of products and services account for about one-third of total health care spend in the U.S.

Level III: Significant.

The fiduciary role is significant for most high-acuity care. Examples include cancer treatment, specialty medication, and most rare diseases. These are complex, high-stakes services and products that typically need to be tailored to each patient and account for nearly two-thirds (63 percent) of the total health care spend. The influence of patient/practitioner trust is most acute for Level III, and we expect the accountability dilemma for these treatments to become increasingly pronounced with the rising cost of new treatments (fiduciary duty to risk-bearing institutions) and increasing asymmetry of information (fiduciary duty to patients).

Ways to approach the accountability dilemma

So how can medical professionals, other industry participants, policy-makers and new entrants seek to deal with this conflict?

First, new governance models are needed that allow for a medical professional to navigate their dual conflicting fiduciary duties. This tension needs to be explicitly understood and incorporated because it cannot be eliminated. ''Either-or'' models will ultimately fail to meet any parties' interests.

Second, prices need to be made transparent to patients. Ensuring that the patient has a full understanding of the price of services involved in every option will reassure and empower them. Costs are a function of the price and use of services. Clinical judgment goes into the use of services. Price of services can and should be provided to patients in the interest of minimizing perceived conflict.

The third piece is full disclosure. Full disclosure of compensation arrangements are a necessary part of a patient-first framework. This is no different than expectations already placed on physicians with respect to drug or device promotion, financial advice providers or real estate broker professionals. The complex payment models increase the risk of fiduciary tension compared to a basic fee-for-service payment model and place a higher burden on disclosure. Redressing the balance on this front will ensure that the bond of trust between patients and full disclosure of health care institutions remains intact.

The bottom line is that patients usually make decisions about their health based on the advice of medical professionals, and this is especially true in significant, high acuity cases—where there is both a lack of information and greater imbalance between the knowledge and skills levels of patient and physician. So medical professionals wield a legitimate influence on market clearing for health care products and services: a necessary and important dynamic that needs the active participation and leadership of the medical community in resolving conflicting fiduciary obligations.

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