

Provider-Patient Relations and Treatment Choice in the Era of Fiscal Incentives: The Case of the End-stage Renal Disease Program

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TO WHAT EXTENT SHOULD PATIENTS MAKE decisions about their medical treatment, and to what extent should they defer to their doctors? What role do financial concerns play in decisions about site and type of treatment, and what role should they play? More specifically, is it a good idea to motivate patients with end-stage renal disease (ESRD) to choose their kidney dialysis units on the basis of price as well as medical quality, personal convenience, and other important factors?

There is enormous professional resistance to increasing patients' financial leverage (and risk), but this article concludes that appropriately structured patient financial incentives could serve patient interests, medical as well as fiscal. This conclusion rests upon the authors' own policy analysis, drawing upon relevant literature, a two-day working seminar to thrash out the issues with known opponents of patient financial incentives and others, and numerous field interviews with renal providers and patients.

Background: Patient Interests and Professional Choices

Concerns about physician-patient relationships and who's in charge in medicine are especially important today—in their own right, in

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light of increasing patient rights and demands for different approaches to medicine, and because of the increased financial incentives entering medicine.

Patient Choice and Professional Ethics

Traditionally, physicians have seen themselves as preeminent in medical decision making, with patients as trusting dependents. What are the sources of this world view? One is clearly physicians' specialized technical knowledge of disease, diagnosis, and treatment. The very essence of professionalism is that professionals have unique, untransferable knowledge and should naturally make treatment choices for patients (Parsons 1951; Freidson 1970; Starr 1982).

A second source of paternalism is physicians' own self-confidence, even bordering on arrogance. A certain authoritarianism seems necessary to cope with the exigencies of medical practice, especially in cases of life-threatening illness (Cassell 1985, 140–44) and to live with medical uncertainties (Katz 1984, 165–75). Third, patients themselves can be fearful, dependent, and childlike, demanding that authoritative physicians bear the burden of choice (Cassell 1985, 25–26, 45–46; Katz 1984, 125–26).

Traditional medical ethics, of course, seek to protect patients by constraining physicians to act in the best interest of their patients (American Medical Association 1980). Medical professionals thus have to consult their consciences about patient interests but generally need not directly consult patients, certainly not about most technical aspects of medical practice (MacIntyre 1977).

This conception of paternalistic doctors and passive patients traditionally fits even very well-informed and educated patients—such as, for example, the late Dr. Franz Ingelfinger, editor of the *New England Journal of Medicine*. Faced with glandular cancer, he was bombarded with contradictory advice that left him feeling “confused and emotionally distraught” and was much relieved to accept advice of a “wise physician friend” who said, “What you need is a doctor.” That is, “a person who would dominate . . . who would in a paternalistic manner assume responsibility for care” (Ingelfinger 1980). At the extreme, professional paternalism extends even to the argument that

it is ethical to lie to a patient if the physician thinks deception is indeed in the patient's best interests (as discussed in Brody 1982).

Although this paternal ethic seems to dominate medical thinking, many thinkers apply to medicine John Stuart Mill's classic assertion that a competent adult has the absolute right to be in charge of his own body and mind (Mill 1859; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982b, appendix G [G. Dworkin. *Autonomy and Informed Consent*]). At its extreme, this view has been characterized as "patient sovereignty"—as contrasted with "medical paternalism" (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982a, 36).

In today's ever more common legal contests, the doctrine of patients' "informed consent" to treatment governs these matters. On the surface the doctrine seems to assert patient control, but its majority version holds that professional standards govern the legal duty, thus maintaining professional control, and both courts and legislatures have moved to bolster the majority view (Rosoff 1981; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982b, appendix L [The Law of Informed Consent]; Katz 1984). Even so, medical professionals tend to think the law interferes far too much with professional autonomy and doctor-patient trust (DeLee 1976; Laforet 1976).

One very closely reasoned book argues the reverse, that "patients' participation in decision making is an idea alien to the ethos of medicine" which the law of informed consent does little to change; more is needed to promote the unfamiliar value of physician-patient communication (Katz 1984). The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982a) has also called for more shared physician-patient decision making. Others have suggested that a "therapeutic alliance" between doctor and patient best serves both parties and reduces the likelihood of litigation (Gutheit, Bursztajn, and Brodsky 1984).

From a medical-philosophical perspective, the question of "who's in charge here?" is thus ever-present in medical care, as in all professional-client relationships (Burt 1981). Moreover, from practical and legal perspectives, the issue has become even more salient because of growing demands for more patient rights and more patient-oriented medical

practice (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982a).

Enter Fiscal Stringency

Money has finally reared its ugly head in insured doctor-patient relations, adding new reason for worry about who makes most therapeutic decisions—and thus determines medical spending. Under the old open-access, insured fee-for-service system, predominant at least as an ideal type until recently, payers would cover nearly any service a physician thought medically necessary, at nearly any provider-set rate. This generous financial regime, a golden age for providers and patients, allowed enormous professional autonomy without creating financial conflicts between doctors and patients. The cost for this freedom from conflict was, of course, rapidly escalating health care bills.

Since the mid-1970s for Medicaid (Bovbjerg and Holahan 1982) and the early 1980s for Medicare and the rest of the world (Califano 1986; Willis 1984), government, insurance, and business payers have begun insisting that either providers or patients take charge in a financial sense as well as a medical one. This profound shift in social expectations has been labelled a “buyer’s revolution” against the comfortable old regime (Califano 1986).

It may also be revolutionary for provider-patient relations. Payment reforms are either provider or patient oriented. Provider incentives generally involve prepayment for certain coverage, whether for a year’s care, as in health maintenance organizations (HMOs) or for a hospital stay, as under Medicare’s diagnosis-related groups (DRGs). Physicians may also receive financial penalties and rewards based on fiscal performance. This approach to reform deems providers far more important decision makers than patients; some proponents explicitly hold that patients cannot be expected to be held fiscally responsible at the time of care (Enthoven 1980).

The patient-oriented approach to reform is exemplified by greatly increased patient cost sharing, both under public plans (Feder et al. 1982) and private ones (Califano 1986). Newer ideas include rebates of unspent health insurance money (Califano 1986) and rewards to patients who use less expensive providers under preferred provider organizations (PPOs) (Boland 1985).

Either type of reform can introduce unpleasant financial pressures into physician-patient relationships, and raise questions of how well

patient interests are served. Reformist rhetoric assumes that cost-effective choices will be made in patients' best interests once payment mechanisms are correctly ordered, both because of competitive pressures and because of legal and professional-ethical constraints (Bovbjerg, Held, and Pauly 1982; Enthoven 1980). Congress was sufficiently concerned about physician incentives under DRGs or HMOs to ban payments to doctors that could motivate underservice (U.S. Congress 1986). (U.S. reforms are often part of a "procompetitive" framework, but financial constraints under wholly noncompetitive systems can pose similar issues for provider-patient relations, as, for example, the United Kingdom's fixed public budgets put providers firmly in charge of medical-fiscal choices [Halper 1985].)

ESRD as a Test Case

To evaluate the new incentives, one must go beyond theory and look at actual cases. Which cost-conscious approaches, in fact, best serve patients' interests? How do patient and provider incentives actually interact in the determination of treatment regimes? This article examines these issues in the very instructive context of ESRD payment reform.

ESRD offers a good place to examine the changing fiscal-medical state of the world because Medicare cost containment came first to ESRD. Unlike most of Medicare, ESRD coverage *began* with provider-oriented fiscal incentives. Medicare paid nephrologists largely by fixed capitation rather than provider-set fees for service, and independent dialysis units also essentially received fixed prepayment. Initially, the units' charges were limited by a national "screen" or maximum payment level; more recently, the so-called "composite rate" has applied an even lower fixed-payment level for all maintenance dialysis units in an area (U.S. Department of Health, Education, and Welfare 1973; Rettig 1982; U.S. Health Care Financing Administration 1983).

Moreover, ESRD patients comprise a "worst case" test of patient-choice issues because conventional wisdom holds that they are among the least autonomous of patients. ESRD patients are very sick, goes this view, and chronically dependent on medical technology for mere survival—which promotes exceptionally strong psychological dependence on doctors and passive patient behavior (Halper 1985, 67). Notably, ESRD patients have *financial* reasons for dependence as well. Most of them can no longer work and rely on public assistance for income as

well as medical coverage. Medicare's cost-sharing obligations (typically, 20 percent coinsurance) are often met by provider charity when not covered by Medicaid or private insurance, and nephrologists are required to take assignment. Because patients seldom pay providers themselves, they can seldom feel financially in charge of their own care and are not so perceived by providers.

Enter Patient Incentives

In 1983 a new idea burst forth on the kidney scene: to give ESRD patients financial incentives, but in a new way, through positive rewards rather than negative penalties. The U.S. Health Care Financing Administration (HCFA) (1984) proposed to give patients rebates for choosing less expensive dialysis units for their care. This proposal led to the so-called "competitive bidding" demonstration, which was tried in Denver and Riverside, California, for a brief period in 1985 (Held and Bovejerg 1985).

The basic idea was that HCFA would ask kidney dialysis units to "bid," that is, to say at what price they would provide dialysis. Where units bid a price below the prevailing composite rate, their patients would receive most of the difference in cash. Patients in nonbidding units, however, would not be penalized. For patients, the plan was all carrot and no stick. Physician payment rules were not to be changed in any way, but obviously one unit's physicians could lose fees if a patient chose to dialyze in another unit where they did not practice. All existing quality rules were maintained, and potential changes in quality were to be monitored.

An example may help clarify the model. Suppose Medicare's composite rate was \$130 per dialysis in a given area. One or more providers might bid a price of \$120 because they were already particularly efficient, could run a larger-scale unit, or could motivate patients to do more self-care or dispense with certain amenities. Bidders could then reward their patients with 70 percent of the \$10 difference for each dialysis (or about \$1,000 per year) and expect in turn to be rewarded by attracting more new patients.

No providers were to be excluded as a result of this so-called bidding; in contrast, under more normal bidding, losers lose completely—only the winner(s) can participate at all (Bovejerg, Held, and Pauly 1987). The HCFA proposal was in this way quite conservative;

all patients were protected from having to change by the ability to stay exactly where they were, without penalty (unlike PPOs, for example). The expectation was that new patients entering dialysis and existing home patients would be the ones most interested in bidding units, since such patients would not have to shift from an established location as would patients already dialyzing in a unit. Patients could use the rebates for any purpose; many expected drugs and transportation (uncovered by Medicare) to be leading candidates.

The model was termed “competitive bidding,” and bids were necessary to create price differences among which patients could choose, but the key was patient choice. Only the reward of attracting more patients gave providers any incentive to bid at all. The name “patient-choice model” would have been more appropriate—in truth the plan closely resembled a per dialysis voucher—but the name “competitive bidding” stuck.

Assessing HCFA's Model

Two of the authors were asked by HCFA to evaluate its model after plans for the demonstration were announced (Held and Bovbjerg 1985). We had previously cautioned against using conventional bidding for ESRD services (Bovbjerg, Held, and Pauly 1982, 152) and had no pride of authorship in HCFA's proposal (it was added to our pending grant application by special condition [Pemberton 1983]). But we had been more sympathetic to patient vouchers (Bovbjerg, Held, and Pauly 1982, 152–56), and in giving HCFA technical advice about demonstrating the model, we had come to appreciate its potential value for patients.

We nonetheless approached evaluation with some caution partly because the model differs so greatly from conventional, provider-oriented practice in ESRD, although not from patients' exposure to prices elsewhere. For the ESRD program, the patient incentive indeed proved radical. Its announcement was met with an unanticipated firestorm of resistance, particularly from Denver nephrologists. In light of this vehemence, we wanted to reconsider whether the HCFA proposal so threatened patients that we should not be involved at all—as some suggested. Assuming that it did not, we wanted to hear what potential pros and cons of the model we should investigate further. We decided to hold a conference—a working seminar—to discuss patient choice

and financial incentives, mainly in the demonstration model but also in the larger context of fiscal constraints generally.

Given this background, we were most concerned to hear from known opponents, but all of the affected interests were represented in our two-day discussions—including a dialysis social worker, an experienced head dialysis nurse, an activist patient, an economist who has studied the kidney program, a lawyer who has written about informed consent, and several well-known nephrologists. The full spectrum of nephrology practice was in attendance, practicing and academic, with and without any financial interest in any dialysis unit.

This article grows out of our preparations for these sessions in November 1984 and the points of view argued at this working seminar, often with some heat. It also draws on extensive subsequent interviewing of physicians, patients, and others in Denver and Riverside (Bobbjerg, Held, and Newmann 1986), as well as many less formal interactions. The balance of this article follows our seminar's division into three key sections: (1) patients' capacity for making choices, (2) the influence of provider fiscal interests, and (3) the influence of patient fiscal interests.

To What Extent Should and Can Patients Make Choices?

No one seems to object to the principle that "every human being of adult years and sound mind should have a right to determine what should be done with his own body" as expounded by Justice Cardozo,¹ echoing John Stuart Mill. But when discussion turns from abstract principle to the practical question of whether patients *can* make appropriate choices, the issues immediately become more complex, and qualifications or rationalizations begin to emerge about patients' (in)capacities.

The first facet of the question is whether patients are mentally or psychologically equipped to make choices among an inherently complex set of options of providers and of type and place of treatment. There seems substantial agreement that ESRD patients at first diagnosis are least likely to be in an adequate frame of mind to make good choices.

¹*Schloendorff v. The Society of the New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914).

Here, our conference participants agreed with conventional wisdom about patient confusion and passivity (Halper 1985, 67; Bovbjerg, Held, and Pauly 1982, 139), particularly when the diagnosis is made suddenly, in the context of a medical emergency, with no previous warning that kidney failure was a possibility. As for other life-threatening diseases, a diagnosis of ESRD can easily stimulate overwhelming anxiety, with its concomitants of denial and confusion. A complicating, if short-lived problem for ESRD patients is that after kidneys fail and before the patient's condition is stabilized through dialysis, elevated levels of blood toxins can physiologically reduce the ability to think clearly for a week or so. Given the ready availability of almost fully financed treatment, it seems particularly easy for ESRD patients simply to go with the first conveniently located provider(s) to whom they are referred.

Roughly half of ESRD patients have no advance warning of impending kidney failure and hence face these difficulties in their most acute form. According to our seminar participants and interviewees, stabilized patients in maintenance dialysis are much more capable of independent choice, but typically have already committed to one set of ESRD providers, notably a nephrologist and a dialysis unit, and have started one mode of treatment, typically in-unit hemodialysis. Other choices remain, notably of changing site or mode of treatment (for example, to home care or continuous ambulatory peritoneal dialysis), and, of course, patients can in theory always change providers, although in practice few patients do under the current system.

Participants differed in whether they thought many patients' choice of dialysis location might be changed by small per dialysis incentive payments and in how well informed they expected such choices to be. The physicians generally saw the typical ESRD patient as incapable of understanding all the issues involved in care and likely to suffer from "information overload" when showered with information. Physicians generally felt that information and choice often tended to paralyze rather than facilitate decision making.

Nonphysicians with direct ESRD experience—either as patient or as nonphysician health care professional—felt that at least some patients can be helped to participate in most decisions regarding their care. The timing and manner in which needed information is imparted was held to be critical, however, as well as its content. Patients whose renal failure is progressive rather than sudden can and should be

educated before final failure, held this line of thinking; all discussion should feature a neutral site and atmosphere, nondirective presentation, considerable repetition, and some written descriptions for reference.

No one disputed that the full range of treatment choice is very complex. Most of the physicians consequently felt strongly that only nephrologists can be counted on to understand the implications of treatment and the particular patient's medical condition. Nonphysicians felt equally strongly that the patient's physician should not decide alone. Any nephrologist is expert in a particular type of treatment and, therefore, tends to overemphasize its advantages relative to other methods. It was noted, for example, that a nephrologist's specialty interest correlates with the type of treatment his patients receive (on this point see Friedman and Lundin 1984).

This implication of physician bias stimulated the rejoinder that all sources are biased and that physicians are at least experts who, having put any bias on the table, remain the most competent source. Others responded that, however expert, the person who stood to gain from delivering certain forms of care could be expected to have a particularly strong reason for bias and possibly also for concealing it—making an independent source of advice especially valuable. This led to the suggestion that the government might usefully create an information bank addressing different therapeutic alternatives; patient associations could play a similar role.

How Do Provider Financial Incentives Affect Patient Choice?

One of the main financial incentives of ESRD physicians is the flat Medicare payment per patient they receive for supervising maintenance dialysis. Most nephrologists, however, also have a financial interest in one or more dialysis units where they practice, whether in for-profit or not-for-profit units. Some have an ownership interest, some have profit-sharing arrangements, and some receive benefits tied to the number of patients contributed. Moreover, doctors clearly can earn fees only from patients of units where they practice. How do physicians respond to these financial inducements?

All participants agreed that physicians definitely care about how many patients they and their units have, not only because of the

income generated but also because the size of a nephrologist's practice influences professional standing. Physicians frankly admitted that the influence of financial incentives to acquire and retain patients was a disturbing issue for them. Conference participants—physicians and nonphysicians alike—nonetheless felt that the majority of physicians do “the best job of taking care of patients” that they possibly can, regardless of financial incentives. Some physicians could not be relied on to put patient interest before financial reward, however, and mention was even made of some nephrologists' thinking of patients as “property” that generated income for them. How many? Some physicians thought the proportion of self-serving nephrologists was very small (less than 5 percent), others that it might be substantial (30 or 40 percent). Most of the nonphysicians agreed with the higher estimate.

All participants could also cite instances of physicians putting inappropriate pressure on patients. Some described what they considered immoral “patient stealing”; for example, a doctor leaving one unit might falsely imply to patients that they would have to follow the physician in order to continue their accustomed treatment regimen. Others characterized such behavior more legalistically, as a violation of the physician's contract with a particular unit (not with patients). Less extreme pressure was also mentioned, that doctors and other professionals often give subtle but hostile psychological signals to patients who express any desire for change.

Compared with other specialties, nephrologists perceive greater need to hold on to their patients, it was argued. Other specialists tend to get a relatively constant flow of referrals; moreover, because of the nature of episodic disease, one patient constitutes a far smaller share of their practice than does a chronic, ESRD patient for a nephrologist, and there are not a lot of extra patients to go around. (A national survey of dialysis units in 1984–1985 indicated that fully 83 percent of their medical directors wanted to attract more patients and could comfortably handle an average of 50 percent more [Urban Institute 1985].) Also, it was asserted that most specialists do not normally lose a patient because of the latter's preference for a particular mode of therapy. With ESRD, however, a patient who chooses a kidney transplant is a significant and permanent loss not readily replaced. (So is a patient's move to a different unit, perhaps one more committed to home care, for example.) Most nephrologists' financial security is thus more tied to a single therapeutic modality than is that of other

doctors. One participant even voiced the opinion that current financial incentives actually impede the progress of nephrology research, by leading physicians to become wedded to dialysis rather than pursuing the search for better forms of treatment.

The financial incentives involved in unit ownership or profit-sharing provisions came in for more self-criticism among the physicians than those involved in the per patient capitation payment. At least one physician said that he avoided such interests as a personal decision because of the potential conflict of interest between serving the patient's interest and the firm's. Others countered that physician-owned facilities ensure that the person in charge knows the business. For-profit units' fiscal incentives are also clear and overt, unlike the arrangements at many not-for-profit facilities that also reward nephrologists for their contributions to patient census. Everyone agreed that disclosure lessened the potential for conflict or abuse of discretion.

How Do Patient Financial Incentives Affect Patient Choice?

The effects of patient financial incentives stimulated the most intense debate both in our seminar and in almost all other discussions or interviews. The main concerns were that the doctor-patient relationship could be disrupted to the patients' detriment, that patients could make bad choices (to accept lower quality dialysis care in order to receive cash payments), and that it is inherently immoral for a government health care program to make cash payments to patients. These concerns were mainly but not exclusively raised by physicians.

Harm to Patient Trust

A good doctor-patient relationship, including mutual trust, is universally perceived as extremely important to good treatment. Most agree that the requisite thorough knowledge of the individual patient's medical history, family circumstances, overall health, physical condition, and psychological vulnerabilities is best obtained through a continuing physician-patient relationship, particularly for long-term, chronic patients. Physicians exposed to the bidding-patient choice model almost universally object that the payment incentive interferes with good

relations and trust, a conclusion typically presented as self-evident. To change providers obviously severs any existing relationship, and a decision to change providers may cause a psychological rift with current providers before a move is made. Some seminar participants felt that such choices could stimulate bad feelings and a tendency to disruption that might lead to an occasional accident and conceivably even some deaths. Of course, new patients' initial choice of their first unit interferes with no existing relationship.

A contrary viewpoint notes the previously made points that the typical patient is extremely dependent and that in some cases doctors or others inappropriately pressure patients who consider alternative treatment modes or dialysis units. Such dependence and pressure seem incompatible with mutuality and trust. Might not a financial incentive such as the rebate-like payment proposed by HCFA actually help a patient to make a more informed decision about his or her own well-being, rather than continue in a dependent or pressured relationship? So went the rhetorical question. The issue did not seem resolvable in the abstract; whether choosing one relationship over another is harmful mainly depends on how good the two are.

Bad Choices

Again here, physicians and some others expressed doubts about whether a patient can be informed enough about the merits of various units, their staff physicians, and treatment patterns to make a responsible decision. The main concern, however, was that the chance to get money would cloud patients' judgment, causing them to move away from high-quality providers (units and physicians). Interestingly, such arguments assume that high cost alone adequately shows quality, although participants were actually in substantial agreement that the correlation between cost and quality for maintenance dialysis is not necessarily high.

In light of the typical patient inertia and the pressures against change, financial incentives were seen as most likely to influence three subsets of patients—already independent patients, dissatisfied patients, and many of the poor. The first group includes those patients who naturally place a high premium on finding out about alternatives and on making an informed choice, i.e., very autonomous people who feel at least potentially confident of their ability to maximize their

own well-being. The second group includes those who are already unhappy or not doing well medically under their current regimen, and who at least arguably could expect to benefit from a change. The third group (mostly poor persons) includes those who are less concerned about their existing provider relationship (including the continuity of their care and potentially its quality as well) than in the alternatives that ready cash could bring (including payment for drugs or transportation). For the first two of these groups, there was little disagreement with the proposition that such patients stood to benefit, or at least not be harmed, by a change in their doctor or dialysis unit.

With respect to the third group—patients felt to be most interested in ready cash—the argument about bad choices was made with more force. Some participants saw any choice as one between cash and the best treatment; they seemed to feel that to choose money over care was frivolous. But others, mainly the nonphysicians, felt equally strongly that patients could have good reasons to prefer money to the very best treatment in medical terms—even assuming that lower price necessarily implies lower quality, which it does not. Moreover, it was at least arguable, some asserted, that any short-run detrimental consequences of promoting patient choice might be outweighed by the longer-term benefits to patients from being encouraged to weigh their own treatment options and to participate more in decisions affecting them.

Only relatively modest cash payments seemed likely to emerge from the proposed bidding, so they would have strong appeal only for poor patients. It can be troubling to influence the poor more than others, but they are also the persons most susceptible to legitimately competing demands of their households for other material needs. Forgoing color TV and a box lunch during dialysis to save for food for the baby at home was given as an overdrawn example of the point. It was clearly difficult for the clinically oriented participants to think about legitimate nontreatment-spending alternatives—although most (not all) acknowledged the point in principle.

One more practical objection deserves mention, that per dialysis cash payments might inappropriately motivate some patients to dialyze more frequently than was medically desirable. (This could be accomplished, it was pointed out, by being careless with diet and medication, causing symptoms that would require more frequent dialysis.) The general sense of the meeting seemed to be, however, that the time

and transportation costs and the generally unpleasant nature of dialysis for the patient would render this a minor problem at most. It was also pointed out that paying a monthly incentive rather than per dialysis could eliminate the overtreatment incentive altogether.

Illicit Lucre

Most opponents of the model much preferred to focus on the normative argument that it is inherently immoral for government medical programs to make cash payments to patients. This contention took two forms. The first was the familiar paternalistic argument that, since one cannot trust public beneficiaries to spend cash wisely, any benefits should be in-kind benefits. Many supported the idea of giving not cash but vouchers for ESRD-related medications, of which the typical patient needs several hundred dollars worth a year. Others proposed that any cash payments be earmarked to pay Medicare's Part B deductible. It was pointed out, however, that the deductible is rarely paid out of pocket, so that using the incentive payment toward the deductible would be equivalent to making an extra payment to the unit (i.e., a provider incentive, contrary to the demonstration's patient-centered design).

In connection with the cash versus in-kind argument, participants were asked to consider why this bidding's payment incentive was so different from that of the earlier HCFA demonstration of paid aides for ESRD patients dialyzing at home. Those patients were given money to pay a relative or other support person to help them dialyze at home, whereas Medicare normally provides no such assistance. (The idea was to promote home care, thought to be medically and fiscally superior.) Although some participants agreed that the two models were similar, others rejected the comparison because payments for home aides were tied to actual medical spending (even if the work was done by a family member), whereas the cash payment could be used for anything. The fact that home patients under the bidding-patient choice demonstration *could* choose to use their payments to help cover a home aide was not perceived by these participants as making any real difference, nor was the fact that families in which a spouse was paid also ended up with more disposable family income.

The second form of the normative argument, emphasized by a few physicians at the seminar and in interviews, saw the proposed cash

payments as an illegitimate bribe to patients for going to a particular unit, as well as an inappropriate payment simply for being sick—a kind of undeserved windfall profit (on bribery, see also Freeman 1984). It is different from allowing private patients to save on cost sharing or giving them a rebate because in the latter case the money involved is the patients' own. That is, it is legitimate to return a proportion of money that patients themselves had already paid but not to reward someone financially who had no assets at financial risk in the first place.

This argument came in for lively rebuttal from both physicians and nonphysicians. The first point made in rebuttal was that patients may not have financial assets at risk, but they certainly have their comfort, health, and ultimately their life on the line—all likely to make them think carefully about their choices. This point was considered true but irrelevant by opponents. The second rebuttal was that standard economic theory holds that people react essentially in the same way to positive as to negative payment incentives as long as the money involved is small relative to overall wealth. (That is, a small, certain cash reward like this incentive has the same impact as a cut in cost sharing.) Noneconomist participants remained skeptical. (As an anonymous reviewer noted, some social psychology suggests that where risks of loss and rewards are *uncertain*, unlike the known incentive here, people may feel worse about losing money once possessed than “losing” only a promised incentive never obtained [Tversky and Kahnemann 1981].)

The third rebuttal was made as a hypothetical question: Is the proposed patient-choice payment morally different from other proposals to offer general Medicare beneficiaries vouchers that would allow them to buy the insurance coverage of their choice and use the difference, if any, for any purpose they like? This analogy seemed to be the most telling counterargument. It caused substantial pause, although the opponents of cash payments remained adamant, citing quality grounds.

A final argument against cash payment was not made by any participant or interviewee: In-kind medical programs are politically more popular than cash assistance programs (“welfare”), and allowing patients even to seem to reduce “medical” spending in exchange for money may compromise political support (Havighurst and Blumstein 1975).

Hostility to HCFA

One important nonsubstantive reaction to HCFA's proposed demonstration was not foreseen by the seminar agenda: Throughout the discussion there ran a strong undercurrent of hostility and cynicism on the part of the physician participants. At first, anger and frustration were specifically directed at the proposed demonstration, but later came to include HCFA and cost containment more generally. (Subsequent interviewees were also often hostile, typically less so the further removed from the actual demonstration.)

HCFA was accused of interfering with health care with no regard for the quality of care. It was seen as uninterested in patient choice, really, but only in budget cutting. In so doing HCFA was ignoring its statutory responsibility to solicit the advice of the relevant experts on health care, namely physicians. HCFA had convened a group of nephrologists to brief them about the impending demonstration and to get their reactions, but was thought not really to take their concerns seriously. Although the overwhelming physician reaction expressed at that meeting was negative, HCFA went ahead without even significant modification of its plans. Of course, nephrologists as a group, many dialysis unit owners, and some patients had been adamantly opposed to the 1983 price reductions of the "composite rate" (U.S. Health Care Financing Administration 1983), predicting dire consequences; they even sued, unsuccessfully, to block the cuts. Although the full effects of changes brought by this rate reduction are not yet documented, obvious disasters have not occurred. This line of thinking did not change the vehemence with which opponents felt that *further* changes would indeed pose grave problems.

When asked whether cutting payments to some unit(s) in a bidding process was any worse than a gradual ratcheting down of the composite rate for all units, most seminar physicians felt that there was essentially no difference. Those who saw a difference felt that bidding was worse, as did many interviewees in the demonstration sites. Their reasoning was not always clear, but a central element seemed to be that it is destructive to stimulate patients even to consider a move, and to make units compete for them directly on the basis of price. Gradual whittling down of everyone's price seemed greatly less threatening.

Most participants and subsequent interviewees assumed, interestingly,

that regular maintenance dialysis in freestanding facilities could indeed be adequately performed for less than the going rate; clearly one fear was that the bidding demonstration would reveal just that and would prompt HCFA to cut payment rates nationwide. We were not privy to HCFA's motives in developing this model, but we can note that the patient-incentive model as proposed—unlike most bidding—was not well calculated to induce the lowest feasible bid or to be generalizable nationwide. Subsequently, HCFA did indeed cut dialysis rates nationally, but used accounting findings—not bidding—as the justification (U.S. Health Care Financing Administration 1986). The cuts were retroactively “rolled back” to nominal levels by Congress (U.S. Congress 1986).

Another perceived danger was that higher-cost units that serve the hard-to-treat patient and emergencies—typically units attached to hospitals—would “go under” as a longer-term result of continued price squeezes. This, in turn, would mean leaving such patients with nowhere to go. This point was pressed in spite of frank acknowledgment that not only high-risk patients but also accounting rules and other factors make hospital-based facilities more costly. Those concerned about the hospitals' fate were unimpressed by a reminder that payment “exceptions” are available for high-cost units to receive a higher rate both under the current system and under the demonstration.

Somewhat paradoxically, given objections to the extent of HCFA interference in ESRD, the bidding demonstration was also criticized as too narrow—that it was arbitrary in the extreme for HCFA to make “guinea pigs” out of the nephrologists, patients, and dialysis units in two particular sites. Some trial run was deemed better than immediate large-scale implementation, but this was seen as very cold comfort for Denver and Riverside.

Concluding Thoughts

Three interrelated central themes emerge from considerable reading, thinking, and discussions about giving ESRD patients positive financial incentives. First, quality of care is the main reason for public concern, and physicians are its natural advocates. Second, the overt focus on price and competition is the main reason for physician concern, only in part because of potential effects on quality. Third, the key determinant

of anyone's reaction to HCFA's model is whether they trust patient choices, particularly when money is involved.

Quality

Paying less often means getting less, certainly in normal competitive markets. But not always. Economies of scale can yield savings, as can enhanced competition among providers or greater self-help by patients—all possible outcomes of HCFA's voucher-like incentive model for kidney dialysis. Almost all physicians, either at our conference or otherwise, however, have found it almost impossible to accept that a low bidder could actually provide equal or better care. For them, a lower bid necessarily meant either worse care or "cream skimming" of inexpensive patients, leaving sicker, high-cost patients to nonbidders. They also assumed that at least some patients would act against medical advice (their physician's) in choosing a unit. (That bid units might accept lower profit margins with the same level of quality also did not seem to be a plausible alternative.)

Moreover, accepting the hypothesis that costs and quality go hand in hand, very similar dangers surround *all* economizing incentives, not just HCFA's demonstration proposal for outpatient dialysis. For example, one may object that hospitals that are paid fixed amounts per DRG—or dialysis units paid the composite rate—may make inappropriate cutbacks in care to save themselves money. It is not obvious that patient welfare will suffer more when providers must economize so as to attract patients, as in the demonstration, than when prepaid providers economize for their own reasons. The golden-age option of having no one economize no longer exists.

Finally, there are reasons to believe that increased competition would tend to *improve* quality—certainly as perceived by patients. And patients may have somewhat different goals from their providers. Many dialysis markets have been relatively uncompetitive in the sense that a few providers have a large market share and entry of new dialysis units has been barred by regulation (Bovbjerg, Held, and Pauly 1982, 143–48). Moreover, patients have no financial stake that encourages them to seek the best value. Traditionally, medical competition has focused on quality (Bovbjerg 1981, 980–83; Joscow 1983), and in the special case of dialysis, there is empirical evidence that greater competition means lower returns for providers and hence higher value

given to patients (Held and Pauly 1983; Joscow 1983). The availability of a financial reward could prompt patients to be more demanding whether they move or not, forcing more provider attention.

Money

There are certainly grounds for concern that over-economizing will hurt patients, whether medical-fiscal choices are mainly made by patients, physicians, or, for that matter, bureaucrats. Why are ESRD providers so hostile to enhanced patient choice as an adjunct to provider-oriented economizing? This article has covered several altruistic explanations, mainly that HCFA cuts and bad patient choices will in fact hurt patients and quality of care. Opponents were quite sincerely passionate about these points.

Much less altruistic motives, however, also exist, most notably financial self-interest. Strikingly, the numerous nephrologists and other physicians we talked to were quite comfortable with “traditional” ESRD payment practice—putting providers in charge of economizing—at least at historical payment levels. It comes as no surprise that providers oppose administrative price cuts on the ground that patients will suffer. It is more surprising that they oppose allowing volunteer economizers (the bidders) to give almost all of the savings to patients rather than to HCFA. We cannot directly assess physicians’ or dialysis unit operators’ motives any more than HCFA’s. Yet, it is hard to escape the conclusion that providers fear price competition, under which nonbidding units and their nephrologists might lose some patients and might have to improve service to the rest. In contrast, noncompetitive price cuts to all could more readily be met, at least in part, by ratcheting down services or amenities to nonmobile patients.

Patient Capacity for Choice

The arguments about patients’ (in)capacity to make therapeutic choices have been thoroughly discussed elsewhere (President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982a), although with little attention to the relevance of financial incentives. We conclude here that ESRD patients would probably benefit by participating more in choices about their care, including the choice of where to receive treatment.

ESRD patients are now theoretically entitled under Medicare rules (U.S. Health Care Financing Administration 1985) and the law of informed consent (Katz 1984) to participate in treatment choices, but the law does not work well as a matter of substantive rights (Katz 1984) or practical enforcement (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983, appendix 2 [R.E. Rosenblatt. Rationing "Normal" Health Care]). Ultimately, to achieve more participation, patients must be assertive about wanting more participation. HCFA's patient-incentive model offered new financial leverage for patients to command providers' attention in this regard. And it did so in a way that protected patients: patients could only gain financially, existing quality protections were maintained, enhanced competition was meant to help quality, and patients were free to stay with nonbidding units at the old payment rate.

To us, these structured choices about where to dialyze seem within patients' capacity to make. Even more consequential decisions are, at least in theory, left to patients (with professional advice, of course), including the ultimate decision to terminate treatment altogether (Neu and Kjellstrand 1986) or the major changes of seeking a transplant—both of which have financial as well as medical and personal consequences. Being put more in charge financially (without threat of financial loss) could well boost patient autonomy, with potential personal and medical benefits, much as being more in charge medically through self-care at home is often said to do (on patients' fiscal involvement, see generally Bovbjerg and Held 1986). Properly understood, the incentive could make patients feel that program payments were for *them*, not for their nephrologists or dialysis units. Even patients choosing a nonbidding unit could well benefit psychologically from making a choice—and they might find their providers more attentive to their wishes as a result.

Moreover, more patient control might well promote "quality" more broadly than the technical medical quality beloved of physicians (or the morbidity/mortality outcomes beloved of researchers and policy analysts). After all, ESRD patients are not so totally dependent and despondent as some might believe; their sense of well being and satisfaction is not dissimilar to that of others, and they express certain clear interests (Evans et al. 1985). Thus, giving patients a larger say might indeed shift some dialysis resources away from physicians' preferred

uses toward what patients want. Not all patients have to be shoppers or assertive of their rights to make providers responsive. Even a small proportion of assertive patients can be economically important to providers where patients can move; and providers' responses generally have to apply to all patients, both shoppers and nonshoppers.

Of course, if patients participated more actively—and financially—in decisions on their treatment, including its location, some “mistakes” would surely occur, certainly from the perspective of nephrologists. But from this perspective, mistakes already occur without financial incentives. Almost all nephrologists candidly admit in private that they know of one or more dialysis units in their region to which they would refuse to send a dependent or spouse for care.

It remains an open question how many ESRD patients truly want the increased control that would likely come with exercising greater financial power. The rather atypical patient at our conference clearly came to believe that enhanced patient responsibility was desirable. So have others in private conversations and in interviews. The attitudes of patients in general remain unclear, even after the actual demonstration was tried (see postscript below). Many patients might reject financial inducements for all the reasons already discussed; this is a reason for not forcing patients but for accepting the results of each patient's choice in consultation with his physician in a fair test of alternatives. It is very different, however, to object that patients should not have the opportunity to choose, as have most opponents of even demonstrating this new patient incentive.

Quite independent of new patient financial incentives, we strongly suspect that any policy initiative that promotes greater patient autonomy and choice constitutes a threat to traditional professional prerogatives and will be resisted by the medical profession, certainly in ESRD. The history of disputes over informed consent lends support to this suspicion. Even without economic pressure, all professionals seem to resist increases in clients' assertiveness. Nephrologists are quick to emphasize the importance of patients having trust in physicians; few seem willing to trust in patients.

Postscript

After this seminar was held and despite provider resistance, in 1985 HCFA pressed ahead with its demonstration of a somewhat altered

bidding-patient choice model. (The largest change, made elsewhere from the original model, was to make Supplemental Security Income (SSI) recipients ineligible for rebates.) Much to the surprise of the ESRD community and especially of Denver nephrologists, one dialysis unit there made a bid for care beginning in April 1985—and for a strikingly low amount, creating a rebate of over \$8 per treatment for eligible patients. No bid was made in Riverside, and apparently no new patients came to the bidding Denver unit as a result of the rebate. As was the bidder's right, the bid was withdrawn after six months, and HCFA has evidently decided not to continue this or other bidding demonstrations in ESRD.

Our assessment showed that the model had not really received a fair trial (Bovbjerg, Held, and Newmann 1986). Riverside had been an inappropriate site for patient choice because its huge geographic area and the wide distances between its dialysis units precluded any significant patient movement. In Denver, patients had virtually no understanding of their options. Problems included the final model's making many patients ineligible to receive a rebate and the failure of both HCFA and the bidding unit adequately to explain patients' options to them. The biggest reason for lack of patient movement, however, seemed to be active resistance within the nephrology community. The bidding unit lacked even the wholehearted support of its own staff nephrologists. No one played the key role of entrepreneur in promoting a very unfamiliar and oft-vilified innovation. So patients' attitudes remain unclear.

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