Topic Description and Agenda

Health care leaders are held accountable to achieve the triple aims of: 1) improving the patient experience of care (including quality and satisfaction), 2) improving the health of populations within their regional or national catchment area, and 3) reducing the per capita cost of health care. These aspirations and goals were created by The Institute for Healthcare Improvement (IHI) in recognition that there are increasing demands "to derive greater value for the resources devoted to their health care systems. Aging populations and increased longevity, coupled with chronic health problems, have become a global challenge, putting new demands on medical and social services."

In the United States and other high income economies we operate health care in so-called "mixed" approaches: public and private sector participation. With private sector involvement there is the co-mingling of business models with health care practice. The ethics of business and the ethics of health care frequently don't align. In fact they frequently create conflicts where profit-maximizing ethics of corporations and the needs of patients and providers pull in opposing directions. For example, it has become increasingly difficult to use business models of volume based discounts or cost controls (e.g. capitation) without patients or their physicians objecting with concerns that the "business model" encourages over- or under-utilization of

care. And as these business practices, applied to healthcare, have come into greater question we have a concomitant rise in the use of incentives.

In the past half century, attempts to shape patient, provider and institutional performance to meet the triple aim goals have increasingly centered on incentives which reward desired behavioral changes. These new incentives have taken the form of programs such as “pay for performance”, value-based insurance premiums, rewards and prizes awarded to individuals and institutions, etc. As the trend has increased it is useful to look more carefully and skeptically at incentives as a model for behavioral change. What unintended consequences follow from the transformation of patient or physician into remunerative exchanges? In exchanges, increasingly laced with remuneration, how is the core patient/provider relationship modified? Are we inadvertently changing a “moral” or professional code to do “what is right for the patient” to “do what is compensated”?

From a management theory perspective, it is important to note that W. Edward Deming, a notable innovator in “continuous improvement”, warned about incentive-based strategies. He counseled that incentives are “meddling”: money should not be the primary motivator to drive out unnecessary steps and costs; to improve quality. The job itself, not an added incentive, should assure that continuous quality improvement does and will continue as part of the work. Making “quality” separate or additionally incentivized may undermine the work motivation of a job. “Pay for performance” could unwittingly undermine rather than add quality.

> How can health care leaders act wisely in wielding the power of incentive-based performance goals? When can they be used effectively and without creating unintended and counter-productive consequences?

There are many examples where a health care provider has secondary, often financial, interests that conflict with his/her primary ethical obligations to the patient. Many suggestions have been made to specific situations to manage conflicts of interest. But many of these remedies fall short and insert into the patient/provider relationship the spectre of mistrust. A number of questions are raised by these conflicts of interest.

- How do medical institutions manage the “revenue minus expenses equation” while committing to high standards of care for patients, particularly when some of those care needs may not be reimbursed by traditional insurance mechanisms?
- For example, what are the requirements of a physician inventor to disclose royalty payments, require second opinions or other steps to reduce frank conflicts of interest as she discusses a recommended procedure with a patient?
- How does the physician protect the trust in the patient/physician relationship, follow the ethical injunction to “do no harm” as well as “do well by the patient” and work to maintain the patient’s autonomy to make an independent decision?
- Beyond financial rewards, how does personal recognition and prestige drive behavior and create the fact or appearance of conflict?
- How has financial support for research by private industry influenced the publication, or more perversely, the lack of publication, of important information so that physicians, patients and payers can make informed decisions?

- In the complex environment of health care, how does the ethical and effective health care leader focus on the myriad of conflicting interests at play in any given circumstance?

Leadership theory and best practice argues that the solution to these ethical, conflict of interest and incentive challenges in the health care business falls to individual leadership; meeting regulatory and legal requirements alone is usually inadequate. While regulatory and statutory compliance are important considerations, it is ultimately up to the physician leader and the firm or institutional leader to set high ethical standards, and decide how individuals affiliated with the institution will manage complex and ethically "murky" responses to secondary interests. And by establishing these practices these leaders move themselves and their institutions to standards of what they determine is "best" that are frequently beyond what is legal or required by regulation.

Our ultimate question for the Fall 2012 HSAC meeting is: What are the responsibilities of leaders to understand and use incentives and manage conflicts of interest that meet the triple aim: more meaningful and satisfying patient experiences, better outcomes and lower costs in the health care system?

As is our practice in HSAC, the meeting will be exploratory, case based and highly interactive. There is no simple solution to matters with this level of complexity. But there are important practices and guide posts to gauge our practice. We will benefit from our usual high caliber of thought leading presenters for this discussion topic.

Wednesday, November 14, 2012
Kirby Reading Room, Fuqua School of Business, Duke University

7:00p	Social Featured Speaker: Andrew Murray, MD, MBA "Managing and Operating Ethically in Emerging Markets"
8:00	Dinner
9:30	Adjourn

Thursday, November 15, 2012

7:30 am	Continental breakfast Location: Kirby Reading Room, R David Thomas Center, Duke University
8:00	Agenda review and introductions *Jeffrey Moe, Executive in Residence, Fuqua School of Business*
8:15	"Issue Spotting" introduction and 4 Cases [Note: different cases from the previous CHAPI meeting on Nov 14] Each short case describes ethical and conflict of interest problem situations

Participants choose one group to join to read for 5 minutes and then discuss: "What are the key issues that must be considered in choosing an appropriate response to the situation"

8:35	Team Report Outs; Facilitator Identifies Key Issues
9:00	BREAK
9:20	"Up To Code" and Introduction to Business Ethics and Conflicts of Interest *Rick Larrick, Fuqua School of Business*
10:20	The Patient Perspective: Business Ethics in Health Care *Wendy Lynch, Altarum Institute*
11:20	The Ethical Challenge of Incentives Redux: Key Points on Incentives and Reflections from the Nov. 14 CHAPI discussion *Ruth Grant, Duke University (author, "Strings Attached: Untangling the Ethics of Incentives")*
12:00	Lunch
1:00	Can "Business as Usual" continue in Health Care? *Richard Payne, Kevin Schulman, Millie Solomon*
2:00	Stakeholders, Business Models and Involvement Processes: An Approach to Ethics in the Health Care Business? *Jeffrey Moe, Rich Payne*
3:00	Adjourn