

Virtual Mentor

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CONLEY CONTEST WINNING ESSAY

First, Do Not Punish: Individual Incentives in Health Policy

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Scenario

Dr. Montgomery has been caring for Mr. Carson for almost 5 years, helping him manage his non-insulin-dependent diabetes and weight. Mr. Carson also has hypertension and high cholesterol. At Mr. Carson's 3-month check-up, Dr. Montgomery was surprised to see his patient's blood pressure at an uncharacteristically high 165/90. When asked what he thought was responsible for the jump, Mr. Carson said that he had only been taking his blood pressure medicine sporadically in the last few months.

"Why is that?" asked Dr. Montgomery.

"Well, we've had this new wellness program at the job," said Mr. Carson. "Started almost a year ago, now. We had to fill out a 'lifestyle profile'—did we wear seat belts? How much alcohol did we drink? Did we smoke? How much did we weigh? A whole bunch of stuff like that."

"That doesn't sound like an altogether bad idea. What does it have to do with your blood pressure medication?" Dr. Montgomery asked.

"Well, whoever looks over these things at the insurance company decided that I should lose weight, at least 10 pounds over 6 months. I couldn't do it, doc. You know how hard I've tried and all the plans we've worked out for exercise and the like. I tried, but I ended up actually gaining a few. So now I have to pay \$50 more for my health insurance every month until I get my weight down. I can't pay for that and buy all this medicine, too. My wife and I talked it over and we figured out that it's more important to take those two kinds of diabetes pills. That's right, isn't it, doc? I don't get feeling bad from the blood pressure like I do when my sugar's out of whack."

Response

As the soaring price of health care consumes national political campaigns, bankrupts families, and further destabilizes a fragile U.S. economy, it's no wonder that insurers and employers are turning to creative new ways to control costs. Personal health incentives, a prominent example of such efforts, seek to rein in cost by offering individuals positive or negative motivators for maintaining and improving their health. In vogue for years at top global firms, such policies are now finding traction even in state Medicaid plans.

In the heated rhetoric of a political season bent on systemic reform, several calls have been made to increase the role of the consumer in the management of health care in America. And while this trend may seem warranted in a country built on the power of the individual, such policies, especially those that employ penalties and negative incentives, raise larger questions about the determinants of health and stir ethical concerns about the principles of justice and respect for autonomy. Indeed, as in the case of Dr. Montgomery and Mr. Carson, the patient may become a victim of the very policy that was ostensibly implemented to promote his health. Penalties like these may lead to worse outcomes for the patient, and in the end may compromise the physician's ability to provide effective care.

Having subdued much of the infectious disease that once plagued humanity through immunization, sanitation, and medication, and having mastered the management of acute illness and emergency care, biomedicine in the developed world finds itself confronting the growing burden of chronic disease. Downstream manifestations of maladies like hypertension, diabetes, and obesity now overwhelm hospital wards and state budgets. Since the middle of the last century, such insidious illnesses have been recognized as “lifestyle” diseases because factors such as diet, exercise, smoking, weight control, and adherence to prescribed treatment have predictable effects on their progression and outcomes. Once we tie these diseases to personal behaviors and choices, it seems natural to approach their management through policies directed toward the individual making the choices.

After all, as heirs to Mill and Locke, Americans understand that personal responsibility and individual choice form the foundation of our free society. Why shouldn't such responsibility extend to the arena of health? This logic, combined with a context of limited health resources, has led to the recent boom of such approaches in the corporate world and government health programs alike [1]. And while most of those programs, unlike the case study at hand, employ positive rather than negative incentives, surveys show that more than 50 percent of Americans support the implementation of higher insurance premiums and deductibles for patients with unhealthy lifestyles [2].

Incorporating lifestyle incentives into health policy thus seems to be a sensible and appealing idea, and one that accords with American ideology of individual responsibility. What physician has not struggled to enlist patients to take charge of their own health—lose those extra pounds, keep that blood sugar in check, get those 30 minutes of exercise? One could argue that a policy encouraging this type of behavior, or discouraging damaging behaviors, is actually a means of empowerment, giving patients ownership over the progress of their disease. The problem, of course, is that even in the so-called lifestyle diseases, forces larger than individual control are at play.

Situating health at the level of the individual, as controlled by a free agent's choice, fails to acknowledge the wide spectrum of causality that leads to human health and

human disease. On the microscopic side, pointing out the effect of genetics seems almost too obvious; knowing that a strong family history of essential hypertension can predispose someone toward high blood pressure should undercut the notion that disease can be viewed solely, or even primarily, through a lens of individual behavior. And at the macroscopic level, studies correlating rates of chronic disease mortality to socioeconomic class speak for themselves. The fact that members of a certain class, social stratum, or race are more vulnerable to certain chronic diseases undermines any policy that attempts to manipulate disease at the level of individual behavior [3]. By restricting causal analysis to individual responsibility, we fail to follow “health” to its etymological root in “wholeness.” When we do recognize the tangled web of health determinants, from genes to neighborhoods to race, it seems inappropriate to hold patients responsible for deficiencies.

Policies with penalizing incentives thus threaten to violate a core principle of biomedical ethics: justice. Understanding that actual determinants of health and disease are deeper than individual choice, and that chronic diseases like diabetes and hypertension disproportionately afflict the disadvantaged and disempowered, individual incentive-based programs may be seen as discriminatory and destructive. In West Virginia, for instance, recent structural changes to Medicaid policy include a “Member Agreement” wherein prospective beneficiaries must agree to attend appointments, take prescribed medications, and strive for overall health. But as Bishop and Brodkey argue, the poverty-affected patients who must sign the agreement are those most influenced by forces beyond their control—be it access to food, transportation, or education. “This plan,” Bishop and Brodkey say, “asks the most vulnerable population to do more with less ability to accomplish what we ask of them” [4].

Programs based on individual choice are thus problematic in that “choice” is not equitably distributed across socioeconomic strata. As Harald Schmidt points out, “People in disadvantaged social positions are held responsible for factors that are largely beyond their control” [5]. Mr. Carson is a case in point. Economic penalties for those who fail to adhere may further diminish their ability to maintain health, punishing them when they are most in need. Such policies further widen the already gaping health disparities that define our broken system.

Incentive-based approaches also threaten another core principle of biomedical ethics: respect for autonomy. Cloaked in the language of empowerment, these plans actually operate paternalistically and authoritatively. As apparent in the West Virginia plan and the case of Mr. Carson, proscriptive policies demand compliance and punish deviation. And while compliance certainly has its place—no one denies the importance of following antihypertensive regimens or smoking cessation in slowing the progression of cardiovascular disease—enforcing obedience at the cost of reduced future access to care seems counterproductive.

A patient may not adhere to a treatment regimen for many reasons, from mental illness to simple disagreement with the prescribing physician. Enforcing adherence at

a policy level violates that patient's fundamental right to self-determination. Indeed, the irony is not missed when an intended emphasis on personal responsibility for health produces an environment of punitive enforcement that ultimately infringes upon personal autonomy.

This last point reveals a final disturbing effect of such plans: jeopardizing the patient-physician relationship. In our scenario, Dr. Montgomery finds his treatment options limited by the financial penalties imposed upon Mr. Carson by his employer-based health plan. The relational dynamic between physician and patient has been corrupted by the external pressures of the individual incentive program. Dr. Montgomery's professional interest in Mr. Carson's health has been confounded by the policy's interest in individual-focused cost control.

In West Virginia's plan, the physician is the "enforcer" and reporter of patient behavior, exacerbating the power disparity inherent in most clinical relationships. Here the patient is not only the obedient recipient of the powerful physician's sagacious instruction, but must obey such instruction in order to receive continued care. Such dominance undermines the physician's ability to build trust and work with the patient toward a sustainable long-term plan for health management. It prevents a more engaged cooperation, missing the greater forces at play and focusing instead on patients' failure to control their health.

As physicians, our duty is to serve as advocates who promote our patients' health by listening and collaborating with them to form integrative plans based on the realities of their situation. We best empower patients through partnership, not paternalism. Incentive plans that punish not only interrupt the physician's ability to treat the patient as needed; they threaten to erode the privileged regard granted the healer, and undermine that sacred role of physician as wise counselor, trusted friend, and partner in health.

It would be prudent to emphasize that encouraging healthy behavior through individual incentives is not an inherently bad or unethical idea. As we know, individuals are able to control considerable aspects of their health, and the use of positive incentives to promote healthy choices may serve as a valuable component of a more comprehensive health policy. After all, in the complex realm of human health and behavior, neither strict individualism nor structural determinism tells the whole story. When employed effectively, promotion programs encouraging ownership over one's health have been shown to help patients develop a sense of autonomy that can translate to other facets of life [6].

In the case of Mr. Carson, the use of positive incentives, coordinated through Dr. Montgomery, might lead to healthy choices in a responsible and empowering context. But as the case makes clear, giving undue emphasis to individual responsibility for health and imposing penalties on those who fail to comply with lifestyle modification programs only exacerbates the structural disempowerment of the underserved in American health care. While the long-term efficacy of such

programs remains to be proven [7], we might do well to tread lightly, given the significant threats to justice and autonomy and the potential conflicts that incentives could introduce into the physician-patient relationship. Rather, we should bear in mind the biological, social, and economic realities that contribute to each patient's health. To set aside such considerations in the pursuit of individual-centered cost control policies would be a grave breach of both physician's duty and bioethical principles.

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