Ethical Considerations for the Use of Patient Incentives to Promote Personal Responsibility for Health: West Virginia Medicaid and Beyond

American College of Physicians
Ethics, Professionalism and
Human Rights Committee
Position Paper 2010

Ethical Considerations for the Use of Patient Incentives to Promote Personal Responsibility for Health: West Virginia Medicaid and Beyond

Position Paper of the
American College of Physicians

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Abstract

Proponents and critics alike are passionate about the use of incentives to promote personal responsibility for health. Supporters maintain that individuals should be encouraged to take an active role in promoting their own health and choosing healthier lifestyles; this benefits the individual in improved health outcomes, and may also have a collective benefit in controlling health care costs. Opponents are concerned about introducing such strategies with limited evidence to support their use. They also caution that the linking of incentives to access to care may have a disproportionately negative effect on the disadvantaged and may lead to blaming individuals for health status without consideration of other health determinants.[1] Some health reform policymakers have proceeded with this approach in the design and implementation of new programs. This paper will explore the ethical issues raised by the use of incentives to promote personal responsibility for health, particularly those incentives found in the West Virginia Medicaid program.

The American College of Physicians (ACP) believes that programs that support the patient's role in promoting positive health outcomes should be evidence-based and should focus on increasing access to strategies for prevention and treatment of disease; respect for autonomy; consideration of variables influencing comprehension and learning; and understanding of cultural, religious and socioeconomic factors. Such programs should be grounded in the ethics principles of beneficence and nonmaleficence. ACP supports the use of positive incentives to motivate behavior change as part of a comprehensive strategy to improve patient care and offers recommendations for their development and implementation.

Position 1: Health care systems should promote high quality health care by following evidence-based models when implementing strategies such as the use of patient incentives to promote behavior change.

Position 2: Incentives to promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people. The incentive structure must not penalize individuals by withholding benefits for behaviors or actions that may be beyond their control. Incentives to encourage healthy behaviors should be appropriate for the target population. The American College of Physicians supports the use of positive incentives for patients such as programs and services that effectively and justly promote physical and mental health and well-being.

Position 3: Transparency and clarity are critical to effective implementation of innovative approaches to health care such as the use of incentives to motivate behavior change. Health plans should provide a clear explanation in lay terms of both the benefits and the operational details and should survey stakeholders such as patients and clinicians to ensure that the explanations are adequate.

Position 4: Incentives to promote behavior change should be consistent with the elements of patient-centered care. The incentive structure should support appropriate patient autonomy and participation in decision making, including the right to refuse treatment, without punitive consequences.

Position 5: Incentives to promote behavior change should be designed to recognize and support
responsibility to discuss all appropriate care options with the patient in a culturally nal obligation to make
recommendations on the basis of medical merit. Incentives should support honest, open and fair interactions among patients, health care professionals, health care entities and payors.

Background

What is personal responsibility for health?

Personal responsibility for health, the concept that illness can be prevented by behavior change, can be traced back through Greek and Roman history.[2] Galen, a disciple of Hippocrates, considered that "people who allowed themselves to harm their bodies when there existed the knowledge and the possibilities of life's action to prevent it were morally culpable." [3] During the Middle Ages and Renaissance, the personal obligation to care for oneself was seen as a responsibility to preserve one's body for God, [3] and is still an element of religious belief today for many. In the 1970s, as the United States paradigm for healthcare broadened to include health promotion and disease prevention, programs began to focus on personal responsibility and adopting health-promoting behavior.

Position 1: Health care systems should promote high quality health care by following evidence-based models when implementing strategies such as the use of patient incentives to promote behavior change.

The effectiveness of strategies such as the use of patient incentives to promote behavior change should be demonstrated through an evidence-based assessment process prior to implementation. Positive incentives, such as meaningful rewards, may successfully promote beneficial and sustained behavior change unlike negative incentives that are punitive and coercive. Evidence should demonstrate that the use of incentives

promote behavior change and acceptance of personal responsibility without penalizing or discriminating against individuals with increased health risks or other factors contributing to poor health status. The goal is not to punish, but to level the playing field for those who are in need of additional support to improve or maintain healthy behaviors. ACP has said that "Incentives to encourage personal responsibility for health (Australia, Belgium, Japan, New Zealand, Netherlands, Switzerland and Taiwan) can lead to healthy behaviors, improved health outcomes and responsible utilization of health care services. These countries restrain costs without punishing people who fail to adopt recommended behaviors or lifestyles." [20] We are mindful, however, that some critics have noted that offering enhanced benefits to patients who meet externally imposed metrics of personal responsibility is by definition denying those benefits to those who cannot meet those criteria and could be considered inherently unjust.

The American College of Physicians encourages physician support of health education and initiatives offered by community groups[21] and employer-sponsored cost-effective wellness programs. [22] The American Cancer Society Action Network (ACS CAN), the American Diabetes Association, and the American Heart Association support employer-sponsored evidence-based comprehensive wellness programs with appropriate regulation to protect against discrimination based on health status as well as the right to privacy. [23] These advocacy organizations do not believe that the use of financial incentives linked to health insurance premiums, deductibles or other patient costs are an appropriate way to motivate behavior change.[23]

It is important to consider society's role in health outcomes, particularly in the Medicaid population. Erika Blacksher argues that "health choices and the outcomes to which they

functioning." [30] Furthermore, it is the physician's responsibility to advocate particularly for the most vulnerable and disadvantaged populations. [29,31]

Position 3: Transparency and clarity are critical to effective implementation of innovative approaches to health care such as the use of incentives to motivate behavior change. Health plans should provide a clear explanation in lay terms of both the benefits and the operational details and should survey stakeholders such as patients and clinicians to ensure that the explanations are adequate.

Open and honest communication between the health plan administrators and its members is critical. Health plans should clearly communicate the benefits and the operational details of the plan in language patients can understand. As the ACP *Ethics Manual*

social and environmental causes of disease." [21] The Institute of Medicine (IOM) also expressed this view in a 1995 report on social and ethical impacts of biomedicine calling for health care professional associations to "recognize their special obligation to investigate the ethical implications of biomedical developments and advocate for the interests of the public and of patients, especially when those adversely affected by change are unable to advocate for themselves." [32]

Conclusion

Although there is a need for more evidence supporting such measures, personal responsibility for health has been embraced as a way of improving health outcomes and controlling healthcare costs. However, motivating behavior change is much more complex than can be accomplished with a single strategy and requires both an individual commitment to health as well as societal collaboration to eliminate barriers.[33] The IOM recommends that critical determinants of health including age, gender, race, ethnicity and socioeconomic status be carefully considered in designing, implementing and interpreting results of social and behavioral interventions. [34] In addition, programs must be designed to allocate benefits equitably; must not include penalties, should support the patient-physician relationship and the physician's ethical and professional obligations to care for patients; should not discriminate against a class or category of people; should facilitate patient-centered care; must respect patient autonomy; and should follow evidence-based models. Potential unintended consequences such as the promotion of negative behaviors in order to qualify for incentives or the shifting of resources from more effective interventions should be evaluated. A multi-faceted approach is required to improve health outcomes.[8] As Blacksher notes: "the call for personal responsibility should be accompanied by an awakening of our shared responsibility… directed at promoting health for all." [35] Promoting individual behavior change must be part of a larger comprehensive collaborative approach involving all stakeholders.

Acknowledgement

The ACP Ethics, Professionalism and Human Rights Committee would like to thank and acknowledge

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