**UNIT 3: Conflicts of Interest**

Overview: This unit defines conflict of interest (COIs) and highlights multiple COI sources in healthcare. It reviews the mechanisms by which COIs influence decision making, noting that these may include unintentional biases in decision making. Next, I review common remedies to COIs (disclosure, oversight, removal, and incentive alignment) noting some important limitations of seemingly straightforward remedies such as disclosure.

Learning Objectives:

1. Understand the definition of COI
2. Recognize that COIs may operate non-consciously
3. Understand the pros and cons of the following remedies for COI: doing nothing, disclosure, third party oversight, removal, or better incentive alignment

Role in Course: Note that conflicts of interest are often a major impetus for the value-based payment models reviewed in Unit 4. Value-based payment models, in turn, must often be embedded within larger value-based initiatives to be successful. In some sense, then, Unit 3 illustrates the problem that value-based care initiatives often aim to solve.

**Healthcare Conflict of Interest: Definition**

A **conflict of interest** (COI) is a situation in which an individual has a duty to two (or more) distinct individuals or groups (including potentially him/herself), but cannot fully maximize the interests of both (or all) parties. Discussion of COIs is often complicated because the suggestion that someone has a conflict of interest is often conflated with the suggestion that the person is doing or will do something unethical or wrong. However, situations and incentives create conflicts. Individual advisors and advisees must respond to these conflicts.

As the individuals ultimately responsible for delivering high-quality, evidence-based care, physicians are often caught in the middle of multiple sets of conflicting objectives.

The major concern is that interests of clinician don’t always, fully align with interests of patients. Physicians have a primary ethical and professional duty to put forth patient interests, but those patient interests can be at odds with the physician’s own interests, for instance their own financial interests. More specifically, we would say a conflict of interest exists if physician income and patient health outcomes are not maximized by the same treatment mix. This could occur if a less clinically preferred path generated more fees to the physician or less expenses paid by the physician. This doesn’t mean that physicians respond to the financial incentives, much less that they respond knowingly and strategically.

Other conflicts also exist. The provider might be conflicted with respect to the payer, for instance if the provider believes that the best care for a patient won’t be covered under current payer rules. As another example, sometimes individual patient and general societal needs are at odds, for instance when scarce societal resources must be shared across individual patients. Finally, there are common concerns about incentives (including consulting fees, gifts, training, paid-for trips for training, etc) from for-profit pharmaceutical and device companies to physicians, including for-profit support for clinical research. These sorts of conflicts can be difficult to fully address, as for example we need providers to have input into clinical development and testing. While these other questions are interesting, our course will focus on physician payment for providing health services.

*Payment Models and COIs*

Many value-based care initiatives have as their genesis a concern with **fee for service** payments to providers. Fee for service is a payment model where services provided to patients are unbundled, that is accounted for as separate discrete activities, and each paid for separately. Under fee-for-service, physicians can increase income when they see more patients and when they shift the treatment mix to better-reimbursed services. If the amount and type of services that maximize reimbursement are not consistent with the highest-quality patient care, then fee for service models create a conflict of interest.

**Capitation** is often considered as a way to increase the value of care by empowering physicians to more directly balance benefits and costs. Capitation is a payment model where a fixed amount is paid to a provider per covered person for providing some defined scope of health services as needed for a specific time period, whether or not services are needed. In its purest form, capitation would cover all needed health services, but sometimes we see capitation for subsets of care, for instance for specific disease management such as diabetes care. Under capitation, physicians increase income when they cover more patients (for more revenue) and when they spend less on delivering care (for lower cost). With capitation, the motivation to spend less per patient actually creates rise to conflicts of interest. These conflicts are different from those related to fee for service but still conflicts nonetheless. There are two broad ways to spend less, and the second represents a conflict of interest, as discussed next

One way to spend less per patient is to provide more value, specifically more efficient care that is better at averting disease burden. For instance, providers, patients, and payers are all better off when complications are prevented or care is provided in a coordinated way. These kinds of outcomes are the goal of capitation, as everyone is better off.

However, the second way to spend less per patient is where one might have concerns about conflicts of interest. That is, another way to save money is to leave out care that would actually have medical benefits; this is often termed stinting on care or just stinting. Specifically, sometimes care that is valuable in the longer term can be avoided without much of a short-term negative impact on health. The problem is particularly pressing if there is some expectation that patients may churn in and out of a provider organization’s covered base, so that later health problems due to neglect would not be the provider organization’s financial responsibility. Consider, for instance, routine cancer screening. Even if early detection saves money on lifetime treatment costs (which may or may not be true), it may be counter to a provider’s specific financial incentives to encourage cancer screening. This could occur due to a combination of the following factors: 1) population screening is often expensive (because many people have to be tested for each illness found), 2) cancer treatment is also expensive even when cancers are caught early, and 3) some portion of the cancers expected to be found earlier with screening might be expected to be discovered (absent screening) only once the patient has moved to a different provider’s care. (This is a reason that some capitation models will also contain explicit requirements for coverage of screening.)

So, both fee for service and capitation models create conflicts between patient health and provider income. They are different specific types of conflict, but both models can create some conflicts. Note, then, that no payment mechanism is perfect.

**COI Mechanisms of Influence**

The conventional wisdom on conflicts of interest is often reflects concern that the conflicted individual will consciously decide to give in to a conflict and act unethically. However, there are also more insidious mechanism at play with conflicts of interests. An additional mechanism is that conflicts set up **self-serving biases** that are largely unconscious, hence unintentional. These are harder to identify and fix because the professional experiencing the conflict is not fully aware of exactly how their own cognitive processes are affected. Essentially, our own current incentives shape the questions we ask ourselves in judgment and therefore the sources of evidence that gain most of our attention and that we weight most heavily.

For instance, in a pure **fee-for-service** environment, the provider really doesn’t need to think about value as a balance between benefits and costs. This environment naturally leads an ethical provider to ask himself or herself simply whether a service is beneficial for the patient? The answer to this question naturally focuses the decision maker on evidence for the benefits of the service. It does not naturally focus the decision maker on the balance of costs and benefits of one service versus another. This environment will push towards overtreatment because the environment suggests taking any beneficial action at all.

In a pure **capitation** environment, the provider is incentivized to think about value, or the benefit / cost balance. This environment naturally leads an ethical provider to ask himself or herself whether a service is the worth the cost, given the entire range of potential actions and services? This is a more well-rounded perspective, a major goal for capitation. The issue is, however, that no professional’s judgment is perfect, particularly in a complex environment such as medical care. Capitation will create more balanced errors than fee for service will. Specifically, with capitation, the provider is more likely to sometimes over weight evidence that a procedure is not needed and therefore to sometimes under-treat.

Overall, then, instead of asking ourselves what payment models will remove all conflicts, we have to ask ourselves what conflicts are inevitable and how to identify and minimize them.

**Methods to Address COIs**

Approaches to mitigating the effects of conflicts of interest in healthcare range from doing nothing, to mandating disclosure of conflicts, to third party oversight such as by the Food and Drug Administration, to removing sources of conflict such as by prohibiting gifts to physicians, and finally to attempts to better align incentives.

*Do Nothing*

One way to approach a conflict of interest in healthcare is to do nothing to directly address the conflict itself. Even with no formal interventions addressing conflicts, there is reason to believe that many systemic factors keep in check the impact of conflicts on provider behavior. The vast majority of providers ascribe to standards of professionalism and professional ethics that emphasize patient care as the key goal. A sense of professional identity and responsibility may therefore constrain the impact of, say, financial goals even if these goals conflict with patient care. Further, providers may care about cultivating trust, positive reputations, and high-quality branding for themselves, their practices, hospital systems, etc. If there is even some risk of long-term reputational harm from subverting patient interests in the short term for financial or other gain, this risk will also limit acting in favor of financial conflicts. Finally, a provider’s own individual values such as morality or altruism will constrain reaction to financial conflicts.

These mechanisms are important because they have a pervasive, beneficial impact on patient care. They are also important because remedies for conflicts specifically, and value-based care initiatives generally, should strive to keep the above mechanisms in place. For instance, imagine a system for increasing value that constrains action so much that providers feel as if they are cogs in a controlling system rather than trusted, autonomous professionals. In that case, providers may be less likely to engage in thinking about what’s best for patients, their roles as professionals, etc.

*Disclosure*

Requirements for disclosure are an extremely common remedy for conflicts. Disclosure simply involves presenting information pertaining to an advisor’s incentives to advisees. An example is the “Sunshine Act” in the US for reporting payments or items of value received by physicians from drug, device, or biologics manufacturers.

Transparency of information is almost always a good thing. However, there is a good deal of research on disclosure and the general conclusion is that the positive effects of disclosure are rarely as strong or pervasive as we would hope or assume.

The normative view is that more correct information cannot reduce judgment quality. From that perspective, one would conclude that disclosure cannot hurt. However, a more descriptive view looking at the actual reactions to disclosure suggests perverse effects of disclosure are possible. Specifically, if disclosure is very salient, advisors may actually offer more biased advice. First, advisors may simply feel less of a need to check their own motives and view decisions from multiple directions if they feel that advisees will take care of any effects of conflicts by responding to disclosure. Second, advisors may actually respond to disclosure by strategically offering more extreme or biased advice, in an attempt to counteract any direct effects of disclosure.

Now, it’s possible that if they know about conflicts, advisees will adjust for the impact of more biased advice. However, the adjustments made are often minimal and insufficient. Even given caution on the advisee’s part, and an attempt to adjust for any impact of known conflicts on advice, we tend to see that the advisor’s initial recommendation is “sticky.” The patient anchors on the advice as given and then tends to insufficiently adjust for known conflicts.

One potential reason for this is that the patient’s heart really isn’t in adjusting. Patients tend to think that other physicians are more biased than their physicians. That is, they understand that conflicts of interest might be a problem in general, but they have a hard time believing conflicts would be a problem for their own trusted providers. In fact, trust may even increase with disclosure because disclosure makes an individual seem more credible. There is also a difficult to address effect called insinuation anxiety. Even if disclosure does decrease trust, patients may be less likely to act because they don’t want to reveal that distrust.

While it’s effects are limited, disclosure is usually a good idea, as there are a lot of reasons to conclude information transparency is better than deception. Some patients may respond very appropriately to disclosure, acting in their own best interest. We should not block their ability to do so. Disclosure may also change the behavior of the advisor in a positive way, particularly in situations where advisors can choose to avoid conflicts such as gifts from for-profit entities. Disclosure requirements can focus the provider’s attention, resulting in voluntary attempts to correct for any effects of conflicts.

*Third-Party Oversight*

In part because disclosure is often not judged to be completely sufficient, there are many aspects of healthcare subject to oversight (review and authorization) by third parties. A major role of regulatory bodies is often oversight to minimize the negative impact of COIs. Un-conflicted second opinions, that is opinions from providers who only offer advice about treatment plans and do not financially benefit from executing those treatment plans, can also address conflicts.

The benefits of review are pretty obvious; we can mitigate concerns about conflicts if we separate decision making power from the conflicts. Like disclosure, third-party review often tends to seem more powerful in concept than it is in reality. First, decision making power itself may generate additional conflicts. For example, providers offering second opinions might feel beholden to clinicians providing care as referral sources.

More insidious is the effect that regulators might actually have incentives to over-restrict action. This is a specific form of the omission bias. Regulatory bodies are much more likely to be criticized for what they do than for what they don’t do. For the FDA specifically, they are more likely to be criticized for harm resulting from a drug that’s approved than for missed benefits from a drug that is stalled or not approved.

Finally, review is very costly and it is impossible to review every potential action.

*Removal*

Another remedy often on the table with policy discussions is removal of the conflict. This is the action being advocated when groups talk about initiatives such as banning the pens, or other gifts, offered to providers from pharmaceutical sales representatives.

It is generally not feasible to get all secondary incentives out of a professional domain such as clinical care. Providers must be compensated somehow. And other incentives matter as well. For instance, providers might want the prestige of being associated with a clinical breakthrough or being known as the leading referral source; these auxiliary incentives usually line up with care quality but don’t have to do so.

*Alignment*

Often, what we are left with is attempting to align incentives, for instance by striving for clinical compensation models where better care is also more financially rewarding. These actions are often closely related to removal of conflicts in that perfectly aligned incentives won’t conflict with one another. I break it out here mostly to note that most of the time the best we can do is keep moving in the direction of alignment of incentives such as financial compensation with patient care.

For instance, one advantage emphasized by some health systems such as Kaiser, Mayo, and Cleveland is that some or all physicians are evaluated in terms of quality of care and compensated by salary. This removes the core fee for service conflict for a physician because she doesn’t influence her own income directly by performing procedures. However, these overall health systems must generate sufficient resources to function, often at least partly through fee for service. Individual providers would quite reasonably feel they have a stake in the financial outcomes of their hospitals or provider groups.

Better aligning incentives is a major promise of value-based care and an impetus for some of the different payment models we’ll discuss in unit 4.

**Summary**

This unit reviews conflicts of interest in healthcare, noting that the environment for healthcare typically determines that some conflicts exist. In general:

* Healthcare conflicts are difficult to address, in part because their effects on judgment can be **unconscious and unintentional**.
* **Payment models** shape the potential for specific, COI-relevant problems, e.g., fee-for-service encourages over-treatment while capitation encourages under-treatment.

Possible remedies for COIs have pros and cons that may not be immediately obvious, as follows:

* **Do nothing**: Factors such as provider professionalism naturally constrain the impact of COIs on delivered care, and ideally other remedies will not significantly erode these naturally-existing controls on COIs
* **Disclosure**: Very common and defensible. However, disclosure can have unintended consequences, for instance if it gives advisors motivation or license to exaggerate advice. Advisees may be limited in their motivation and ability to respond to disclosure by adjusting for advice in their own decisions.
* **Third-Party Oversight**: Useful because it separates decision-making from COIs. Downsides include creating new COIs, generally resulting in biases towards inaction / omission, and is very costly hence infeasible for every possible decision.
* **Removal**: Often infeasible in healthcare settings where professionals must be compensated.
* **Alignment**: Related to removal (in that perfect goal alignment means the COI is removed). The goal of most value-based payment systems. Realistically, we can often move towards better alignment but we cannot create perfect alignment.

In raising limitations with COI remedies, I hope to help ensure you are calibrated in terms of the need for careful consideration in setting up provider incentive models and in addressing conflicts more generally.