

Managed Care and Medicine: The Search for Common Ground

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The rapid rise of managed care has sent shock waves through the American medical care system. Simply graphing the recent growth in managed care enrollment does not convey the acceleration in the trend. It took nearly 50 years for health maintenance organization (HMO) enrollment to reach 10 million, but only 14 more years to reach 50 million. With barriers to enroll Medicare and Medicaid recipients in managed care plans falling rapidly, it could take only five more years to reach 100 million.

Gross enrollment trends by themselves fail to convey the magnitude of the dislocation managed care growth has caused to the traditional pillars of the American health care system: hospitals and private medical practice. The rise in managed care represents a shifting of economic risk from those who pay for care to those who provide it, as well as a transfer of economic power from those who provide care to those who pay for it. The stress of these changes in economic risk and power has produced a full-blown panic among segments of the provider community.

However, the question begged by the rapid rise of managed care in medicine is: What is the proper role of insurance in the provision of professional services? The traditional theory of professionalism in a modern democratic society holds that society grants professionals the autonomy needed to bring their professional judgment to bear on solving its citizens' problems. In exchange, professionals agree to police themselves not only by setting performance standards, but by fostering ethical standards to protect the society from the moral hazard implicit in the potential use of that judgment to enrich the professional.

This classic framework does not reflect contemporary realities adequately because it fails to account for the influence of insurance. The impact of health insurance on the physician-patient relationship has been under-appreciated until relatively recently: Health insurance markedly increased the moral hazard associated with professional practice, and in doing so, helped create a clinical culture that is a rich medium for infection.

Health insurance has anesthetized the patient against the economic consequences of decisions to use health services. By injecting ample amounts of other peoples' money into the physician-patient relationship, health insurance has fostered a bias toward action. This bias has been amplified by a culture that idolizes technology, by lay publications like *Readers Digest* and now, by the Internet. The traditional restraints on professional behavior are no longer sufficient.

This problem is by no means unique to medicine. Physicians have experienced this same phenomenon in tort liability-but as victims, not as economic beneficiaries. Here too, there has been a lessening of risk (in this case, the risk of initiating legal action), a shielding of the client from economic risk (via contingent fees), a copious flow of other

peoples' money (malpractice and product-liability insurance pools), an insurance-funded bias toward action, and a huge income opportunity for the plaintiffs attorney.

Physicians are not the only victims of this activism. They share the consequences of this insurance-funded hunt for villains with all other service providers, park districts, good Samaritans, toy manufacturers, the makers of medical devices and a lot of others. The cost to society, both in dollars and in lost societal benefits, is considerable. The plaintiffs bar is now under sustained political attack for the same reasons that attacks have been focused on medicine.

Consider John Wennberg's work on area variation in medical practice. Several years ago, Wennberg and colleagues published a study in *The New England Journal of Medicine* which found a substantial age-adjusted variation in Medicare per capita physician spending (Part B) between major metropolitan areas¹. There was more than a two-fold variation from the lowest to the highest per capita physician expense between metropolitan areas. The relativist response to this variation usually is: Who really knows where overprovision stops and underprovision begins? The realist says, with Wennberg and others, that there is circumstantial evidence of significant overprovision of medical services in the high-expenditure markets, and competitive forces --e.g., more specialty practitioners in the physician mix--may influence the extent of overprovision.

The field observer who has worked in many "high-expense markets" would probably go further and say that the top-end represents an unfortunate triumph of the forces of moral hazard over professional restraint--a breakdown of ethical standards. In the highest expense markets, you will find hospitals with Caesarean section rates exceeding 40 percent of all births; normal findings for 30 percent or better of the catheterizations; and slick, physician-owned corporations which will send limousines to pick up cataract patients, and which perform a procedure some ophthalmologists have termed "kleptophakia."

Overprovision of medical services is a complex phenomenon in which patients and their expectations--as well as health insurers--are complicit. It is inappropriate for the practitioner to shoulder all of the blame in isolation from a patient's/society's expectations and the availability of insurance coverage. However, circumstantial evidence suggests a problem exists -- one that strikes to the heart of the conventional paradigm discussed above: Economic forces in medical practice combined with societal expectations have overwhelmed traditional, professional restraints on behavior. If so, how does one calibrate the societal response to encourage more conservative practice?

Physicians have reacted angrily to demands for economic accountability. Listening to physicians talk about the physician-patient relationship is not always easy, because they frequently use what one might term "Walden Pond" imagery, where doctor and patient float freely above the economic firmament that sustains their relationship. One sometimes hears the same thing from university faculty members about how the university has compromised the teacher-student relationship -- the ideal relationship had the student at one end of the log and Socrates at the other. The institution that both feeds

the scholar and buffers him or her from the rest of society is experienced as a massive bureaucratic nuisance.

But let us be real about this: Medicine is, among other things, an economic transaction. And the physician's economic transaction is no longer with the patient in the vast majority of cases, but with an agent of the society (either the government or an insurer). Why is this? Simply, the economic risk of illness is large enough that only the "3 standard deviations from the norm" wealthy can afford to self-insure for medical care. The moment the cost of medical treatment exceeded the capacity of most individual households to pay the cost, the "Walden Pond" stage of the physician-patient relationship ended, whether physicians realized it or not. That era was at least a generation ago.

Since then, those who pay the bill have participated, albeit in a civilized and generally unobtrusive way, in the physician-patient relationship. Insurers simply wrote the checks for what physicians did after the fact and physicians cashed them. After 20 years of hyperinflation in health costs, it is difficult to argue that those who pay the bill do not, at a minimum, have a legitimate seat at the table.

Now, however, health insurers are being asked-by Congress, by state legislatures, by employers and, it is important to add, by their subscribers (patients) to do more than pay the bill. They are being asked to ensure that the bill is reasonable. In fact, what is really going on with the shift in state and federal health care payment policy is getting state and federal governments out of the business of paying hospitals and doctors, and into the business of paying insurers a fixed contribution to cover their subscribers. In doing so, governments are delegating to market forces the messy task of mopping up the substantial excess capacity in both human and physical capital in health services -- a task that governments have been manifestly incapable of performing themselves.

What has not yet developed is a societal-let alone professional consensus about the appropriate limits on the insurer's role in the patient care process. Rethinking the physician-patient-payer relationship is essential. In an inevitably messy process, it will be necessary to renegotiate the societal contract which undergirds medicine, to civilize the insurance function, and to assure that it protects the physician-patient relationship. The "Reinventing Managed Care" initiative of the American Society of Internal Medicine (ASIM) in 1995 represents the beginnings of such an effort.

This is a difficult issue to discuss right now, as the air is filled with wishful thinking. There is much testosterone-fueled rhetoric in the provider community to the effect of- What do we need insurers for anyway? We do all the heavy lifting, and all they do is wrap cellophane around our product and pocket 20 percent of the premium for interfacing with the customer. Congressional budget-cutters have sensed a political opportunity, by proposing that thinly capitalized, provider-sponsored health networks can compete for Medicare enrollees free of state insurance regulation. I believe this is clever and cynical politics-offering providers some undefined potential for autonomy from managed care in exchange for large, tangible, federal payment reductions.

Insurers are not likely to be quaking in their boots about provider competition in managing medical risk. The recent history of providers functioning as health insurers is littered with mangled bodies, particularly those providers who were motivated primarily by economic protectionism or by visions of large amounts of unencumbered incremental revenue. We refer here to the first three generations of independent physician associations (IPAs) in the west, to the foundations for medical care, and to numerous hospital-sponsored HMOs.

Middlemen usually are present in economic arenas for a reason. They do not provide mere cellophane wrapping around what physicians and hospitals do. They pool premium dollars, and cushion both providers and patients against unmanageable variations in expense. The larger the pools, the greater the margin of safety. Unlike most provider groups, insurers remember (painfully) that their business is brutally cyclical. There are few provider organizations with a strong enough cash flow or deep-enough pockets to survive the loss that is part of the underwriting cycle. Provider network losses will strengthen the insurers' market leverage. By itself, this is why provider networks that accept risk should be regulated for reserve requirements, financial solvency, etc., just as the insurers are: to protect the consumer from insolvency-related interruption of coverage or service. For providers, it is important to remember that it is possible to drown in a river which is, on the average, a foot deep.

However, the central issue raised by the growing influence of managed care is: What are appropriate mechanisms for assuring professional accountability for high-quality, conservative, medical decision-making? We clearly have a long way to go. The initial stage of managed care-what we have termed "event-driven cost avoidance" represents the crude and irresponsible response to the cost-management challenge: using intrusive, case-by-case, external regulation of physician decision-making to reduce unnecessary hospital utilization. I agree with most physicians that this is not an acceptable societal response. However, it works, and there are many potential savings.

As managed care matures as a business, and as it increasingly saturates health insurance markets, event-driven cost avoidance is no longer proving an effective strategy. As managed care organizations achieve easy savings from reduced hospitalizations, they are shifting their focus to controlling the resource intensity of clinical services, given a patient's condition, and setting empirically verifiable performance standards to govern clinical decision-making. We have referred to this stage of evolution as "value improvement." This stage becomes vital as the premium differences among health plans narrow, in order to provide a national basis for employers and patients to select a particular health plan².

In the value improvement stage, managed care emphasizes an appropriate, conservative diagnostic process and highlights the calibration of the therapeutic response more closely to documented clinical need. To do this effectively, an evidence-based framework is required to integrate information about clinical risk and the appropriate professional response. Physicians should seize this opportunity to regain some measure of control over their professional lives.

There are significant philosophical divisions among health insurers about the proper relationship to clinicians in this process. There is the "command and control" school, typified by so-called managed indemnity plans and a few large HMOs. This philosophy holds that the insurer can minutely manage clinical decision-making through centrally imposed clinical protocols. This approach relies upon an asymmetrical relationship between insurers and providers in highly fragmented networks, where the individual physician is a virtual prisoner. The sole leverage point for the practitioner is the decision whether to join the network.

There is another school, which might be called the "partnership" school, which holds that if the insurer shares risk and premium (and in some cases, health plan equity) with participating clinicians, it is freed from the cost and hassle of case-by-case verification of medical need. In this model, which I believe eventually will prevail, a passive clinical network will not get the job done. What is required is a thinking network with lively feedback loops, which focuses on defining and redefining appropriate standards of clinical decision-making.

As practitioners and as contractors, physicians have significant influence over the outcome of this debate, since physicians' decisions to participate in networks ultimately will determine if they survive. Collective actions such as organized boycotts of particular health plans are appropriately constrained by antitrust laws.

But if physicians make decisions about how they organize their professional lives based on blind panic or narrow economic calculation, they will not be able to maximize their leverage to achieve a balance of power in protecting the patient. Unfortunately, many physicians, panicked by voices yelling "Fire!" in the proverbial crowded theater, have literally sold out in the face of massive uncertainty. This may represent a short-term, rational response to economic or professional uncertainty: shift risk and uncertainty to large, temporarily cash-rich organizations, and let them worry about all this.

I have several observations about the physician's organizational relationship to the rest of the health care system. Much of the recent and abrupt movement of physicians toward some form of salaried employment has been driven by a nearly unanimous belief that the typical, future metropolitan health care market will comprise a handful of closed systems, with proprietary, closed-panels of employed primary care- and ultimately, specialty-physicians.

What is so surreal about these expectations is their marked divergence from what managed care organizations are hearing from their employer-customers, and what employers are hearing from their employees about what they want from their health coverage. The customer does not appear to want closed-panel systems, but rather disciplined, open-panels with broad geographic coverage and maximum flexibility of consumer choice. The pressure toward inclusive, open-panel provider networks has been so intense as to force historically closed-systems, such as Kaiser Permanente or the

Group Health Cooperatives, to organize point-of-service networks of noncaptive providers for their subscribers. The same atmosphere of panic has enabled health plans to achieve significant economic concessions from physicians who want to assure current patients maximum access to their services. There is scant evidence that there is an economic advantage to the health plan, employer or consumer when opting for closed-panel systems.

If this proves accurate over the longer term, a bubble is building in compensation for primary care physicians. Many closed-panel plans and systems that have been aggressive purchasers of primary care physician practices during the past few years will be writing large checks to fund their 60 percent utilized primary care networks. It is not yet clear whether there is a primary care physician shortage, or whether the upward pressure on salaries is a function of a bubble created by the simultaneous construction of redundant, closed-panel primary care systems.

The recent analysis of physician coverage in the United States and Great Britain -- which found that the ratios of primary care physicians to population in the two countries are virtually identical -- is sobering³. The differences in physician staffing relate to the superabundance of specialists in the American system. Fuchs and Hahn found something similar in their comparative analysis of United States and Canadian health spending: While Americans spent only 16 percent more than the Canadians on "evaluation and management" physician care, we spent 278 percent more per capita on "procedure-oriented" physician care⁴. More importantly, since the analysis used 1985 data, these results fail to reflect the clinical reality of American ambulatory surgical and diagnostic expansion. The disparity surely is greater now.

Regardless of the economic impact of the trend toward health system employment of physicians, the relevant issue is how employment ultimately will affect the physician-patient relationship. How can physicians realistically hope to be honest brokers of medical need on the patient's behalf as direct employees of the insurer? What role will caregivers; play in the setting of clinical standards, let alone in governance and policy-making? My sense is, very little.

Absent real leverage to influence institutional policy, physician-employees of health plans sometimes revert, in my colleague Mike Goran's sad image, to the role of social workers in New York City's vast welfare bureaucracy: fighting a kind of guerrilla warfare to game the system, to extract maximum benefits for their clients. This failure to align professional and organizational incentives eventually will doom most staff-model health plans. Some of these problems are generic to any large system which salaries its physicians: the Department of Veterans Affairs, the armed forces, Kaiser Permanente, and teaching hospitals all share them in varying degrees. But in most of these other systems, physicians' role in governance and clinical policy-setting is far larger.

Hospital employment of primary care physicians is almost as unfortunate a trend. For at least the next decade, whether they wish to or not, hospitals and the systems that own them are going to be consumed in the task of protecting their assets, as well as the

franchises of their most powerful clinical actors-the procedure-oriented specialists and hospital-based physicians, who generated most of the hospitals' operating profits under fee-for-service medicine.

Some hospital leaders understand that this is a recipe for slow death under at-risk payment. Yet, regrettably, the majority of hospital and system strategies remain biased toward assuring full employment of existing capital and technology. Shifting market share and filling beds, operating rooms and imaging suites at the expense of others remains at the center of most systems' strategies. Most hospitals and systems that purchase primary care physician practices are not doing so to improve patient care, but rather to attempt, at great expense and risk, to purchase the utilization of clinical services and market share wholesale, while anticipating the "closed-panel" environment discussed above.

As they contemplate their future, physicians considering hospital employment should be asking some strategic questions. In how many hospital or so-called integrated health systems is there an effective balance of power between primary care physicians and specialists-the type of balance that good managed care will demand? In how many large, integrated health care enterprises in the United States do primary care physicians have decisive political influence?

The unfortunate reality is that the employed primary care physician will be working for the system's radiologists and surgeons, whose influence on policy is filtered through and masked by the hospital's or system's governance and political hierarchy. Some hospital and system leaders recognize that these political realities must change if they are to function effectively under at-risk payment. However, many system leaders lack the political strength to shift the balance of power and institutional priorities toward a primary care-based, preventive system.

Until hospitals can assure that transition, the salaried employment of primary care physicians is a pernicious trend, not to mention a bad investment. For primary care physicians, employment by hospitals or health plans represents the road to serfdom.

As long as we are staking out contrarian positions, we might as well dispose of the other prevailing myth-the inevitability of the primary care physician functioning as a gatekeeper for the rest of the health system. While the gatekeeper model may work for the relatively young and healthy-for whom use of the health care system is atypical-it is genuinely questionable for the chronically ill, elderly person or the high-risk Medicaid patient, who will represent 70 percent or better of the growth in managed care enrollment in the next 10 years. Care for these populations will be team-based and multidisciplinary. Spreading the risk broadly across clinical teams and the contracting provider panel is going to be essential-particularly given the large variation in cost risk.

The financial perils to an individual primary care physician for high-risk or chronically ill patients seem unmanageably and inappropriately large. The primary care physician-as-gatekeeper model may survive for a segment of the enrolled population, but

does not seem robust enough to function as a template for health care delivery to the broader community.

The issue of how physicians are paid continues to cloud the discussion about managed care and is still an unresolved issue. There is a critical need for a "Manhattan Project" on how to pay physicians, because all three current methods have definable problems.

- With fee-for-service, one has the problem of potential abuse (and its intrusive remedies), excessive cost and iatrogenic complications from overly aggressive or poorly coordinated treatment.
- With salaried employment, one has the problem of poor physician productivity and commitment.
- With capitation, one runs the risk of systematic undertreatment and potentially poor bonding with the patient.

Do we yet know how to pay physicians to optimize clinical effectiveness or to improve the health status of enrolled populations? The answer should be, "No, not yet."

While many physicians -- who have invested how they are paid with additional symbolism -- may find this hard to accept, how they are paid is not the most important issue. The professional responsibility for safeguarding the quality of clinical medicine has appropriately devolved onto those who are taking the real risks--the risk of a patient not surviving a procedure, or a course of therapy not alleviating suffering or improving a patient's life. The challenge physicians face is how to foster professional values and maximize the value of clinical intervention within the resource limits imposed by managed care.

The most effective managed care plans will be the ones that give physicians who are delivering the care the responsibility for setting and enforcing professional standards (defined as adhering to "best professional practices" given defined clinical uncertainty). They will contain lively feedback loops which continuously evolve into a working definition of "best professional practices." They will have a collegial medical directorate, as well as a commitment to long-term strategic partnerships between insurers and their provider panels--a commitment that transcends economic cycles.

From the insurer's standpoint, sharing premiums with physicians renders the case-by-case second-guessing of clinical decisions unnecessary. True risk-sharing means delegating professional responsibility as well as risk. To those health plans that refuse to devolve professional responsibility for setting and enforcing clinical standards, physicians must say, even at the short-term cost of lost practice income, "Sorry, I don't want to participate in your plan."

But saying "No" to exploitative or asymmetrical relationships is not enough. Physicians must be ready to explain to their patients their affiliation decisions, and in *noneconomic* terms, tell them why they should switch health plans to those ready to empower their physicians to act in the patient's clinical as well as economic best interests. If patients perceive that physicians are acting solely to preserve their existing economic interests, and not in the patient's welfare, physicians eventually will lose much more than income. They will lose their legitimacy as professionals in our society.

Physicians in the managed care arena must organize their practices into viable economic units to exert their influence.* Complex antitrust issues related to the scope of organization represent important constraints on the scope of these units. However, the economic units need not be so large as to trigger antitrust concerns. Further, they need not be based upon the merger of practices into fully integrated groups. Other forms of organization such as the IPA have proven resilient in highly competitive managed care markets. However, whatever type of organization physicians choose must have strong enough governance to enforce economic discipline and maintain quality standards.

In the coming managed care era, physician-governed enterprises will exert the greatest leverage for practitioners: primary care-driven, multi-specialty group practice, multi-site primary care groups, balanced IPAs, or physician-driven management entities such as managed service organizations. Insurers, hospitals and even management firms may be involved as equity partners; however, they should be minority equity holders, and have limited involvement in clinical standard-setting and the care-review process. The successful physician enterprise under managed care will be one where risk and responsibility for clinical decision-making is spread over a professional cadre which collectively takes responsibility for setting and enforcing clinical standards.

Physicians have the power to protect the patient's interests and preserve professional values and autonomy. Still, they must fight to use that power constructively. Physicians should embrace the risk inherent in population-based payment and the responsibility that goes with it. Physicians should not accept the risk unless it is manageable and unless responsibility for setting and enforcing clinical standards is devolved onto the risk-bearing physician enterprise. To accept the risk while the insurer retains the power to micromanage clinical decisions is an unacceptable proposition for both physician and patient.

The rise of evidence-based medicine, and the movement of managed care enterprises toward empirically demonstrable value as the basis for selecting a health plan, represents a major opportunity to strike a balance between economic accountability and professional responsibility in medicine. Physicians should seize that opportunity. Managed care is still

* Of course, the agency of definition of "appropriate" organizational expressions of physician economic interests is the U.S. Congress, which is, at this writing, considering modifying federal antitrust laws to account for the need for physicians to organize into viable economic units. The shape of the actual modifications is unclear as this article is being written.

young enough as a movement, and still fluid and plastic enough to allow physicians to strategically reshape it by how they participate in it. Physicians have instinctively rebelled against society's demand for economic accountability. It is time to re-examine those reflexes, and to re-instill in professional values the skepticism about therapeutic capacity that has informed professional training in the past 60 years.

Physicians have the moral imperative to create a more robust framework for protecting the patient's and society's interests,- not only against the moral hazard implicit in health insurance, but also against the moral hazard implicit in professional practice. Finding that balance is the best defense against unreasonable intrusion into the physician-patient relationship, and achieving this balance in practice will be good medicine.

References

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