# Managed care: the takeover of medicine by commercial interest

**Robert F McCauley** and **Eugene D Robin** analyse the impact of managed care on patient outcome, physician status and medical ethics

The economic basis of health care is undergoing revolutionary change. The US is progressively converting from a system based on fee for service to a system based on so-called managed care. As is often true, changes in basic economic approaches usually result in changes in medical practice as well as changes elsewhere in society.

Though encompassing a large number of organisational formats, managed care for purposes of our discussion will consist solely of so-called Health Maintenance Organisations (HMOs), since these entities illustrate most clearly the concept of "management" of the delivery of medical care to patients by a health plan. The plan is paid, up front, a certain dollar amount by the patient (or employer) in return for complete coverage of outpatient and inpatient medical care plus specified benefits such as medications, optometry, psychological counselling and so forth.

The Plan, in turn, contracts with specific providers of health care beginning with physicians and hospitals for given amounts of compensation. Primary care physicians, for example, could receive, say, $34 per month to provide all inpatient and outpatient care for one patient covered by the government's Medicare programme for the elderly or disabled.

## Ethical challenges

Specialists and non-physician providers may be paid a certain amount per patient treated or, like the primary care physician, they may be paid monthly -- the latter system, a monthly payment for patients allocated for their care to the provider or specialist, is called "capitation."

Under this plan, doctors who see patients more often receive less income. The incentive, therefore, is to "work smart" and get the patient through the surgery and post-operative rehabilitation quickly and efficiently. Critics say that the incentive is to withhold therapy, particularly in questionable forms of treatment such as stroke rehabilitation, physical therapy for diagnoses like fibromyalgia, etc. Experimental or questionable therapies, particularly the more expensive ones like autologous bone marrow transplant following chemotherapy for metastatic breast malignancy, are difficult to obtain in the context of managed care.

The physician in managed care must overcome the built-in incentive to undertest and undertreat just as his fee-for-service counterpart must resist the incentive to overtest and overtreat.

## Status of physicians

If physicians were once held in high esteem in society, their fall in social status is demonstrable, whether coincidental, related to the movement into managed care. To illustrate: a recent publication listing patient rights replaces the word "physician" by the words "health care provider", and patients are identified as "customers." In programmes for advanced training for nurses, the students — soon to be practicing medicine independently — are instructed to refer to patients as "clients." These developments serve to illustrate if not enhance the decline of society's esteem for physicians.

Though not directly related to the emergence of managed care plans, increasing use of computers and the other public forums of medical education by patients may play a part in this decline. To the extent that patients are becoming more knowledgeable and more responsible for their own care, doctors are perceived as less god-like. The truly informed patient, one who has researched his own diagnosis through computers, may represent a genuine threat to the type of doctor who retains the idea that he occupies a truly lofty position in society. As patients become more informed doctors are more likely to be perceived as less all-knowing, in or out of managed care.

Meanwhile, the status of nurses is improving. Nurses play an increased role in the delivery of medical care in HMOs which employ, for example, nurse practitioners, obstetrical nurses and others. There are studies which support the conclusion that patient outcomes from nurse practitioners are at least as good as those of physicians. The rise in social stature of nurses at this time may be coincidental or may be causally related, at least in part, to their association with HMOs. It costs less to hire a nurse than a physician.

## Patient outcomes

Are patient outcomes superior in an HMO? The answer, for the present, is unknown. Some available data support the conclusion, for now, that patient outcomes are not worse in HMOs than in fee-for-service medicine. The potential for improved outcomes in HMOs is unquestionable. Under fee-for-service medicine, for example, it can hardly be disputed that hysterectomies were done unnecessarily. Some estimates, comparing delivery systems in the UK and the US, say as many as 70% of

*Robert F McCauley and Eugene D Robin, Tsurai Indian (native American) Health Clinic, Trinidad, CA 95570-1185, USA*

hysterectomies done between 1970 and 1990 were unnecessary. In HMOs, where the incentive is already to undertest and undertreat, one might guess that a surgical procedure of dubious benefit and of measurable risk will be less likely to occur. So also with lumbar laminectomies, a high percentage of which are of arguable benefit yet all with measurable risk. Thus an HMO may improve patient outcomes in many contexts.

Conversely, the possibility for worse outcomes — delayed diagnosis of cancer, for example — is distinctly present in a system in which physicians perceive they are losing money by spending time with patients and in which the administrators perceive the plan is losing money with each laboratory test ordered and with each consultation obtained from a specialist. Inferior outcomes are not inevitable, perhaps, but it should be recognised which incentives operate in managed care.

## Physician income

What happens to physician income in the era of managed care? Those remaining in fee-for-service medicine in areas where managed care is competing for business nearly always experience a sizable drop in income. Physicians employed by or contracting with the Plan find their incomes "managed" as well. This control over physician income is facilitated by the relative excess of physicians in the US at this time. Physicians, the providers selling their services, are competing with each other and the more numerous they are the lower the price at which the seller will strike the bargain.

In this connection, it is interesting to note that US medical schools have more than doubled their output of physicians since 1965 and the influx of foreign medical graduates has skyrocketed in that same time period. Thus, in 1997, plan administrators in urban sites have no problem finding physicians to hire or work under contract.

The entry of nurse practitioners into the marketplace --employed by HMOs or practicing (competing) alongside physicians in fee-for-service-- further drives down physicians' incomes, both for those in fee-for-service and for those in the HMO. This upward movement of nurses' incomes and downward movement of physicians' income has not yet reached a state of equilibrium in the US.

## Costs of the system

Regarding overall costs of the system, HMOs began competing in earnest by offering the US government a deal it couldn't refuse. HMO administrators said they could care for the Medicare population (then in the fee-for-service system) for 95 per cent of what fee-for-service physicians charged the government. The government responded by encouraging senior citizens to enroll in HMOs. The campaign was successful: nearly 30 per cent of the Medicare population in California, the country's most populous state, gets their health care from an HMO.

However, within the last five years, several HMOs have gone bankrupt. The so-called "co-pay", the amount of cash they pay the provider for each office visit, increased from $5 to $10 in some plans; the co-pay for drugs has gone up. And costs in the fee-for-service sector have decreased so that now they are approaching those charged by HMOs.

Meantime, the income of administrators and the cost of non-medical administration (e.g., commercial advertising) has risen. The cost of administering the plan varies from one HMO to another with some plans showing administrative costs of over 30%. In the US, physicians account for 14% of the health care dollar, pharmacy expense 19%, hospitals 42%. As recently reported in *The Lancet*, the chiefs of seven large HMOs averaged $7 million each in cash and stock pay packages per year. The average plan, averaging 15% administrative overhead, therefore, uses much more of its income to pay administrators than to pay physicians.

Ethical challenges face these administrators as well as the physicians in the plan. The incentive in an HMO is to improve profits.The more care is required by patients, the less the profit. Thus, administrators have an incentive to ration care, to shape physician behavior along lines which encourage cost cutting, to tailor physician panels so that their "utilisation profile" is favorable to the plan. The end result of this culling process in which underutilisers are encouraged and rewarded while overutilisers are penalised or dropped from the panel is plainly evident. In its final form the physician panel of the most successful HMO will consist of the most underutilising primary care physicians to be found in the area's pool of physicians.

This natural evolution has occasionally been impeded by legislators. A good example emerged last year when the state government of California passed a provision keeping women and babies in hospital 48 hours after delivery. The statute came about when a newborn baby sent home eight hours after its birth developed a complication which would have been apparent within 36 hours had he been in the newborn nursery. There is infinite scope for legislators to tinker with the system of medical care delivery.

## What might the future hold?

Managed care is probably here to stay, in the US. If it does travel east to India, it would arrive with data behind it, derived from the American experience. Among the many unanswered questions, the most important is: does managed care result in either longer life or better quality of life, or both?

Regardless of the system in place for delivering medical care, physicians must keep our goal in sight: the proper goal of any system which delivers medical care is to improve the quantity of life or the quality of life, or both, for patients they perceive it.