

# Balancing Cost And Quality In Fee-For-Service Versus Managed Care

Society has placed a totally unrealistic demand on the health care system to maximize quality while minimizing costs—without considering costs.

BY DAVID M. EDDY

AS THE NATION SHIFTS from fee-for-service toward managed care, few issues attract more attention than the tension between quality and cost. Advocates of fee-for-service accuse managed care of withholding effective treatments to save money or build profits. (I use *treatment* in a general sense to include all types of health care interventions.) In turn, advocates of managed care can claim that fee-for-service squanders money on treatments that generate fees but no quality.

To help to understand this tension better, this paper addresses three sets of questions: (1) How have quality and cost trade-offs been addressed under fee-for-service, and what ethical issues do these approaches raise? (2) How are quality and cost trade-offs addressed under managed care, and what ethical issues do these approaches raise? (3) What should health plans and public policy-makers do to improve both the quality and the affordability of health care, and to resolve the ethical issues? Before I address these three sets of questions, I offer a brief description of the social environment in which decisions involving quality and cost are made.

■ **The social environment.** The social environment in which health care providers have to make trade-offs between quality and cost could hardly be more hostile. Ever since the 1940s, when third-party payment cut the connection between demanding treatments and having to pay for them, people have latched on to the idea that costs should play no role in decisions about medical treatments. Today there is a strong taboo against explicitly taking costs into account when determining the appropriate use of a treatment. This taboo creates a huge limitation on how any type of system can trade

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off cost and quality.

Given the prominence of the cost taboo in determining how cost/quality trade-offs are made, it is useful to speculate on its origins and the prospects for change. Undoubtedly, the cost taboo is the result of many different factors, which are too numerous and complex to sort out clearly. Nonetheless, two seem especially important. First, health care deals with the ultimate issues of human existence: life, death, peace, suffering, function. The critical importance of these objectives of health care argue for sparing no effort—and no cost—in trying to achieve the best possible outcomes. Second, because of all the mechanisms our society has created for spreading the costs of health care (insurance, prepayment, taxes), many of those who are receiving the care are not paying the costs. Thus, it is easy for them to say that the care they receive should not be limited by any consideration of costs. This reality did not exist sixty years ago, when everyone was responsible for his or her own bills.

■ **Fee-for-service versus managed care.** Space precludes a full analysis of the differences between fee-for-service and managed care. For purposes of this paper, I outline the important characteristics of each that affect how trade-offs between quality and cost are made. For fee-for-service, these include the following: (1) There is no “defined population” for which the insurance company is responsible. (2) Contacts with the system are initiated by patients. (3) The main focus is on treating sick patients. Neither physicians nor insurance companies are responsible for providing care beyond what is indicated when patients seek care. (4) The responsibility of the insurance company is to pay the bills. Importantly, the insurance company is not responsible for the overall health of its subscribers or for the quality of care delivered by individual physicians. (5) Physicians are left alone to decide what care their patients should receive. (6) Where there is uncertainty about the appropriate level of care, physicians have a financial incentive to overuse care. (7) The insurance company has no managerial control over the providers, and there is no capacity for centralized decision making. (8) The locus of the conflict between quality and cost is split: Physicians have income incentives to maximize the services they deliver to patients, whereas administrators have market incentives to keep premiums low.

Characteristics of managed care that affect the cost/quality trade-off include the following: (1) The managed care organization (MCO) has responsibility for the health of a defined population: all of the people who paid dues. (2) For this “defined population,” the MCO is responsible for the entire spectrum of care, ranging from primary

prevention to screening, diagnosis, treatment, rehabilitation, and support care. Because the MCO's responsibility extends beyond just providing care when patients seek it, the contacts are initiated not only by the patients, but by the organization. (4) Physicians are not left alone to practice as they see fit. Rather, the MCO has a variety of clinical management systems for modifying (or "managing") the actions of physicians. (5) The MCO has a capacity for centralized decision making. (6) While the tension between quality and cost is felt differently in different parts of the organization, the conflict comes together at the level of the medical director, who simultaneously feels pressures both to improve quality and to reduce costs.

The reality of health care today, of course, is not nearly this well dichotomized, and it is difficult to find pure examples of either system. Furthermore, some of the variants have important implications for cost/quality trade-offs. This is especially true of different types of financial incentives, such as physician-based capitation and bonuses.

■ **Ethical principles.** I am not an ethicist, but I suppose that the ethical principles that apply to trade-offs between cost and quality include some concepts of fairness, equality, and optimality, tempered by the extent to which a provider has responsibility and control over a decision. By *fairness* I mean that if a group of people are all contributing equally to a pool of resources from which the costs of treatments will be paid, they should expect to receive equal consideration in terms of the treatments they will receive. *Equality* means that if two essentially identical patients seek treatment for the same health problem, they should get the same treatment. Anything else would imply that one of the patients was receiving second-rate care. By *optimality* I mean that treatments should be chosen to provide the best possible health outcomes, within whatever resource or other constraints the provider faces and consistent with the principle of fairness. Obviously, one of the main constraints that providers face is the size of the resource pool, which in turn is determined by whatever premiums or dues people are willing to pay.

When determining whether a particular policy or practice violates these principles, there has to be some concept of control. Someone cannot be held ethically responsible for an unfair or suboptimal use of a treatment if they have no control over the choice. The most obvious cause of lack of control is that the person in fact cannot control the decision (that is, someone else is making the decision). Another important cause of lack of control is intellectual: If no one knows the outcomes of the treatments, there is no way to determine which is best, and there is no ethical imperative to choose one over the other.

A physician, an insurance company, or an MCO cannot be held ethically responsible for something just because we do not like it or wish it did not occur. They can be held ethically responsible only if they have made some promise or have some contractual responsibility.

My listing of ethical principles does not include any idea that every patient must receive every treatment he or she might possibly want or that might possibly have some benefit, no matter how small. I take this position because I take seriously people's demands that costs be controlled and I respect their unwillingness to pour unlimited personal resources into the pool from which the bills will be paid. For the use of public resources, any ethical principles must accept whatever constraints people place on what they are willing to pay, and the obligation of providers is to be fair, equal, and optimal within those limits.

■ **Implications of the cost taboo.** Neither system, nor any of the variations (with very rare exceptions), approaches the trade-offs systematically or explicitly. To do so would violate the cost taboo and expose the party to charges of rationing. Thus, the superficial answer from fee-for-service and managed care plans on how they trade off cost and quality is, "We don't!" A search of mission statements, benefit language, instructions for designing guidelines, criteria for covering new treatments, or algorithms for developing care paths has not turned up any explicit policies about how costs should be incorporated in treatment decisions.

## **Cost/Quality Trade-Offs In Fee-For-Service**

The three best places to observe the trade-offs between cost and quality are in "standard and accepted" practices, practice variations, and inappropriate care.

■ **Implicit trade-offs in "standard and accepted" practices.** Although there is a general impression that costs should play no role in medical decision making, this is not and has never been the case, even in traditional fee-for-service medicine. There have always been trade-offs between cost and quality. They have just been implicit, rather than explicit. Instead of talking about "costs," we have talked about "practicality," "feasibility," and "prudence," but they are all the same thing. Traditional fee-for-service medicine has been rationing care all along, even for practices that are considered "standard and accepted." Here are two examples.

First, current national guidelines from the National Cholesterol Education Program (NCEP) call for treatment with drugs if, after a trial of diet, a person's low-density lipoprotein (LDL)-cholesterol exceeds 190 mg/dL.<sup>1</sup> There is reliable evidence that people who have lower LDL-cholesterol levels also would benefit. Why does the

NCEP not recommend treating everyone who would possibly benefit? Because that would grossly increase the number of persons to be treated, which would be impractical. That is, it would cost too much.

Second, published criteria for admitting patients with chest pain seen in emergency departments imply that patients whose probability of a myocardial infarction exceeds about 7 percent should be admitted.<sup>2</sup> But patients whose signs and symptoms imply a probability of a myocardial infarction of 6 percent or 5 percent also would benefit from admission. Why don't we lower the threshold down to, say, 3 percent? Because that would be impractical.

The fact is that wherever there is any threshold, any frequency, any set of indications or contraindications, or any other decision variable that determines who should receive a treatment and who should not, there is someone just on the other side of the line who would have benefited but who was "deprived" of that benefit. To extend the line to include everyone who could possibly benefit would be too expensive. These thresholds exist even for treatments that are known to be effective, as the two examples illustrate.

In short, traditional fee-for-service medicine is riddled with implicit trade-offs between quality and cost. If *rationing* is defined as withholding coverage, because of its cost, for a treatment that is known to be effective, then fee-for-service medicine has always rationed. As we will see, this is not a unique feature of fee-for-service, and the same types of trade-offs are made in managed care. But it is important to recognize that in fee-for-service, the standard practices that most people believe are free of any tainting by costs are, in fact, implicitly constrained by costs.

■ **Implicit trade-offs in practice variations.** Numerous studies have identified wide variations in many common practices. When two essentially identical patients can go to two different physicians and receive two different treatments, the effect is that two different cost/quality trade-offs have been made. Although some of the variations can be explained by differences in patient preferences and clinical details, not all of the variations can be explained by those types of factors, and whatever variations remain must represent implicit differences in cost/quality trade-offs.

■ **Implicit trade-offs in inappropriate care.** In many cases there is so much uncertainty about the treatment options that nobody is willing to start a public fight about which choice is better. In other cases people we would identify as experts are willing to make judgments and call certain choices "inappropriate" or "equivocal." *Inappropriate* means that the harms outweigh the benefits. *Equivocal* means that the benefits just equal the harms, without consideration

of costs. Unfortunately, when actual practices are compared with the judgments of the experts, a high proportion—ranging from 10 percent to 50 percent—are found to be inappropriate, and a high proportion—another 10 to 50 percent—are found to be equivocal. In those cases the implications for trade-offs between cost and quality are more stark. If a particular practice is truly inappropriate, then the effect on both cost and quality is clearly negative. And if the practice is truly equivocal, then the effect on cost is negative, with no complementary increase in quality. In both cases the implied trade-off between quality and cost is harmful.

If we were to search for the factors that influence these decisions, many would be personal and relatively independent of the financing system. These include physicians' perceptions of the benefits and costs of the alternative choices; their personal training, skills, and preferences for particular procedures; their financial incentives; the preferences of their specialties; and the pressures placed on them by patients. However, at least two features of fee-for-service tend to exacerbate the problems of wide variations and inappropriate care. These are the financial incentives to overuse service, and the lack of management, which allows physicians to practice in highly variable, sometimes inappropriate ways.

■ **Ethical implications.** I do not believe that the existence of cost/quality trade-offs that have been implicit in "standard and accepted" fee-for-service practices presents an ethical problem. Because we are now talking about standard practices, which by definition means that there is strong consensus and little variation in use of the treatment, most patients who are indicated for the treatment will receive it, and the principles of fairness and equality will have been met.

Some might argue that the existence of any trade-off between cost and quality is unethical, but I disagree. I have already argued that the implicit trade-offs in medical practices are inevitable. If that is so, it would be meaningless to declare such trade-offs to be unethical. If trade-offs between cost and quality in health care are unethical, then we would have to declare as unethical innumerable things we take for granted. Take airplane safety; we do not do absolutely everything possible to minimize airplane accidents, because to do so would cost too much.

With respect to the wide variations in practice patterns and the high proportions of inappropriate practices that have occurred in traditional fee-for-service settings, I do believe they pose important ethical problems. If fairness, equality, and optimality are important ethical principles, then wide variations and high proportions of inappropriate care imply both unequal quality and lack of optimality.

*“There is no way to determine an optimal allocation of resources without taking costs into account when making treatment decisions.”*

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### **Cost/Quality Trade-Offs In Managed Care**

The trade-offs in managed care are most easily described by comparisons with fee-for-service. In general, because physicians in managed care work in the same intellectual environment as fee-for-service physicians do, they tend to follow the same types of guidelines seen in fee-for-service. Thus, for standard and accepted practices, there are few differences between fee-for-service and managed care with respect to cost/quality trade-offs.

As for variations in practice patterns and inappropriate practices, to the extent that physicians in managed care are not managed but instead are allowed to follow their personal instincts, they can exhibit the same variations in practices and similar rates of inappropriate practices as seen in fee-for-service. But several features of managed care can influence the extent to which it mimics fee-for-service. Most notably, in the pure form of managed care the financial incentives seen in fee-for-service to overuse ineffective or harmful treatments are nullified; the financial incentives in managed care are to hold overall utilization within a fixed budget. In theory, at least, when the resource limits are being stretched, the first place to control utilization is in treatments that are ineffective or harmful. The extent to which this actually occurs is uncertain, and to the extent that physicians in managed care are from the same schools of thought as their fee-for-service colleagues, their actual practices may not differ by much. However, as time, competition, and differentiation progress, the economic requirement to stay within a fixed budget should have an increasingly beneficial effect on reducing variations and inappropriate practices in managed care.

Another important feature of managed care that affects the use of ineffective and inappropriate care is the ability to control physicians' practices. The essence of managed care is direct management of physicians' practices, which in theory gives managed care the capability of reducing variations and inappropriate care. However, the extent to which MCOs actually do this is highly variable. Some plans apply their control aggressively, while others apply it not at all. Furthermore, even plans that try to control practices may apply those controls only to selected treatments, and with varying success.

There is one feature of managed care that is not present in fee-for-service and that has great implications for trade-offs between qual-

ity and cost: managed care's responsibility to maximize the overall health of its members within the limits of the available resources. Fulfilling this responsibility requires very explicit analyses of the benefits and costs of treatments and very explicit comparisons to ensure that the values or cost-effectiveness provided by different treatments are consistent.

At present, very few MCOs have taken active steps to implement this responsibility, and those that have are proceeding tentatively. The reason is the cost taboo. There is no way to determine an optimal allocation of resources without taking costs into account when making treatment decisions. But that is precisely what is forbidden by the cost taboo. Thus, managed care's responsibility to maximize the health of its members is at present unrealized. To the extent that it is eventually implemented, it will have huge implications for trade-offs between cost and quality.

■ **Ethical implications.** With respect to the trade-offs that are buried in standard and accepted practices, the similarity of standard practices in managed care and fee-for-service raises no new ethical issues. With regard to the trade-offs that are implicit in practice variations, the ethical implications for managed care depend on the extent to which the incentives and management capabilities of managed care actually change practice patterns. Specifically, if the incentives and capabilities lead to decreases in variations and inappropriate care, then equality and fairness will be improved. However, to the extent that the budget limitations of managed care cause underuse of high-value treatments, the quality of care will suffer, and ethical problems will exist. This becomes most problematic in variants of managed care that include direct financial incentives to underuse care.

The most complex ethical issue for managed care revolves around its responsibility to maximize the overall health of its members. Whether this raises an ethical problem depends on the extent to which managed care can control the mechanisms needed to fulfill this responsibility. And there is the rub. It is absolutely impossible to determine how to allocate resources efficiently to maximize the health of a population within a limited budget without analyzing the costs of different treatments and without incorporating that information in determinations of what constitutes appropriate care. But that is precisely what is forbidden by the cost taboo. Thus, the ethical implications of managed care's failure to meet this responsibility are dampened. Nonetheless, we need to recognize that there is a very important conflict between its responsibility and promises versus its abilities. Sooner or later, that conflict will have to be resolved.

The most important variants of managed care that affect cost/quality trade-offs involve financial incentives. In fee-for-service, loosely speaking, a physician receives \$10 for a \$10 procedure. This one-to-one correspondence creates the fee-for-service incentive to overuse treatments. The ethical implications of that have already been discussed. In the pure form of managed care, physicians are salaried and have no direct financial incentives to either overuse or underuse care. Their only financial incentive is actually an obligation—to do their part to keep total costs within a fixed budget. However, there are many variants of managed care that do create financial incentives for physicians to underuse care. The variants vary in their strengths. At the extreme is individual physician-based capitation, where a physician who withholds ordering a \$10 laboratory test gets to keep \$10. A wide variety of bonuses and distribution plans provide softer incentives, many of which have little more than symbolic value. For an example at the other extreme, with a uniform redistribution of profits a physician who withholds a \$10 laboratory test might pocket 0.0001 cent. The ethical implication of these types of financial incentives obviously depends on the strength of the incentive. The most glaring case is direct individual physician-based capitation, where the incentive to withhold care creates ethical problems that are as serious as the fee-for-service incentives to overuse care.

### **Cost/Quality Trade-Offs In Investigational Treatments**

The topic of investigational treatments, judging from press reports, is commonly thought to represent one of the most important ways in which fee-for-service differs from managed care with respect to cost/quality trade-offs. The perception is that managed care is stingier than fee-for-service when it comes to covering promising new treatments. Ideally, to determine if this is true, we need systematic surveys of coverage practices in the two systems. I know of no such studies and can only draw on my own experience, which includes working extensively with both types of organizations. While I have seen wide variations in how individual insurers and individual MCOs make decisions about investigational treatments, I have not seen any systematic or important differences in how those decisions are made in the two systems. The contract language of fee-for-service insurers is practically identical to that of MCOs; both restrict the coverage of investigational treatments. Furthermore, while the actual criteria used to determine whether a treatment is investigational vary widely, the gist and intent of the criteria are, for all

practical purposes, the same in both systems. Currently, despite the popular conception, the coverage criteria for investigational treatments in both systems exclude cost.

A symbol of the similarity of approaches is that one of the most visible national programs for assessments to support decisions about investigational treatments is a joint program between the oldest insurance association, the Blue Cross and Blue Shield Association, and one of the oldest MCOs, Kaiser Permanente of Southern California. Furthermore, the technology assessments produced by that program are used by both fee-for-service insurers and MCOs.

## **Recommendations For Health Plans And Public Policymakers**

In the following recommendations, my objective is fairness and optimality within whatever budget people want to pay for their health care, and within whatever responsibilities and capabilities are possessed by the particular system they choose.

■ **Trade-offs in standard care.** Although there is uniformity of agreement across both fee-for-service and managed care about the benefits of “standard” treatments, there also are wide discrepancies in the actual values provided by different treatments. These discrepancies can be reduced and eventually eliminated only by explicitly analyzing the evidence for the treatments; estimating the magnitudes of their benefits, harms, and costs; making explicit trade-offs between the benefits and costs; and giving priority to those treatments that have the highest value.

■ **Variations.** The wide variations and high proportions of inappropriate care that occur in fee-for-service and that spill over into managed care because of the common intellectual environment should be stopped. These variations arise not only out of poor evidence but out of the incentives and physician autonomy of fee-for-service. In addition to requiring more research about the effectiveness of different treatments, solving these problems will require a removal of financial incentives to either overuse or underuse treatments and more active management of physician behavior.

■ **Maximizing the health of a population.** For managed care to fulfill its commitment to maximize the overall health of its members within the available resources, it will have to do two things: formally incorporate costs in decisions about treatments, and actively manage practices to line them up with the priorities based on the values of different treatments.

■ **Underutilization.** In managed care, underutilization can occur because of financial incentives to stay within the budget created by

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the members' dues. In some cases, as with full capitation of physicians, any losses or savings will be directly absorbed by physicians, making the incentives stronger. Two ways to prevent underutilization are (1) active management of physicians to ensure adherence to guidelines, and (2) creation of performance measures to reward high use of treatments that otherwise might be underused.

■ **The cost taboo.** There is an overall theme for these proposals. We will never be able to achieve our ethical goals regarding the trade-offs between cost and quality until we get past the cost taboo and incorporate costs formally and explicitly in decisions about treatments. The fact is that health care is being practiced in an environment in which many if not most people are not willing to pay an unlimited amount of money to receive a benefit that may be small. They have placed severe cost constraints on both fee-for-service insurance and managed care in terms of the premiums and dues they are willing to pay. In both systems administrators and physicians are under an implicit if not explicit obligation to use those limited resources in the optimal way to provide the best health care possible to the people for whom they are responsible. There is absolutely no way to do this without taking into account the costs of treatments. Thus, by far the biggest threat to both cost and quality in health care today is not to be found in the systems of fee-for-service or managed care; it is to be found in the cost taboo itself—the totally unrealistic demand that society has placed on the health care system as a whole, to maximize quality while minimizing costs, without considering costs.

Unfortunately, the prospects for changing the cost taboo are poor. Given that the ultimate nature of health and the use of mechanisms to share the costs of care will not change, the only way to break the cost taboo is to change people's expectations. People must somehow be helped to understand that when they are participating in a system that shares resources, they cannot expect to receive everything they might want or that squeezes out the last bit of benefit. This will be a very hard message to sell, for several obvious reasons. First, it represents a rollback from what people now perceive as their right to maximal care. Second, there is a lobby—fee-for-service medicine—that has a strong financial incentive to hold them to that view. Third, all physicians, in both fee-for-service and managed care, have a long tradition of serving as their patients'

advocates—providing each of their patients with maximal care.

Getting beyond these barriers will require courageous and consistent leadership. The question is where it will come from. No single MCO can take action by itself because the public relations effects of counteracting the cost taboo are so dire. As for having MCOs act in concert, that is prevented by a variety of problems ranging from antitrust to lack of credibility. Nor has the political process shown the strength to lead the way.

If there is any hope, the best I can think of is that it must come from those who have the most credibility on this topic and who have a national scope: the professional societies. If we are to make headway against the cost taboo, professional societies will have to take the lead in making a sharp distinction between fee-for-service insurance and managed care. Those who want unlimited care, and are willing to pay unlimited amounts of money to get it, should join fee-for-service insurance. Those who want their costs controlled, and are willing to accept the limits on care that accompany limits on budgets, should join managed care. In that setting, specialty societies should make it clear to physicians, patients, the press, and the courts that cost/quality trade-offs are not only appropriate, but necessary and ethical.

Whether or not specialty societies are the ones to act, until the cost taboo is broken, the tension between cost and quality—and the high cost, variable quality, confusion, and ethical problems that result—will continue to plague the practice of medicine.

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## NOTES

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