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THE BATTLE FOR
CONTROL OF
HEALTH CARE

by Victor R. Fuchs

Prologue:
As Victor Fuchs pointed out in his well-known little book Who Shall Live?, the economic point of view is rooted in three fundamental observations. One, that resources are scarce in relation to human wants. Two, that resources have alternative uses. And three, that people have different wants and there is significant variation in the relative importance that they attach to these wants. Given these three conditions, the basic economic problem is how to allocate scarce resources so as to best satisfy human wants. The burgeoning health care industry has demonstrated a capacity in times of prosperity or recession to grow at a rate faster than the Gross National Product. Put another way, or as economist Fuchs might note, the more resources health care absorbs, the less that is available for other pressing societal needs. It is this phenomenon and the certainty that it cannot continue indefinitely that brings Fuchs to write about several of the battles that lie ahead for the control of health care.

One battle that Fuchs pays particular attention to is the emerging conflicts that inevitably will pit practicing physicians against management, a clash “between a fiercely independent profession and a management structure that seeks to gain firmer control over what doctors do.” Some medical care organizations have been in the vanguard of resolving, or at least learning to live with, these conflicts. Fuchs, a highly respected economist and a leading figure at the National Bureau of Economic Research and at Stanford University, never has chosen to spend much time seeking to influence federal policy through a presence in Washington, but he is a voice listened to by decision makers. Fuchs points out that two of the emerging battles he identified do not involve government as a chief contestant, even though “the battle for control of health care is often depicted as one of medicine against government.”
Recent years have witnessed numerous battles for control within and between health care institutions and professions. These battles are likely to intensify in the years ahead because of mounting economic pressures as well as changes in the social and technologic framework within which physicians, hospital administrators, and other health professionals must function.

The economic pressures will be felt first by physicians because there is likely to be a drastic slowdown in the rate of growth of real health care expenditures per physician. These expenditures grew at 3.6 percent per annum between 1950 and 1980, but during the 1980s the rate of increase will probably be under 2.6 percent per annum and may be as low as 1.6 percent per annum. The principal reasons for the slowdown are: (1) slow growth of the economy as a whole; (2) rapid growth in the number of physicians; and (3) a slowdown in the rate at which the health care sector increases its share of the Gross National Product.

The economy is likely to grow more slowly because of lagging productivity and because the labor force will not expand as rapidly as it did during the decades when female labor force participation was zooming and the baby boom of the 1950s was reaching working age. With respect to the number of physicians, there has been some discussion recently about reducing the size of medical school classes, but in most instances this is still just talk. It is no easier to turn off the education pipeline of physicians than it is to turn it on; thus a rapid increase in the number of practicing physicians by 1990 seems almost inevitable.

To be sure, even if the economy as a whole slows down and the number of physicians increases, health care expenditures per physician could still grow rapidly if the health care sector acquires more and more resources from the rest of the economy. This could happen—if some highly effective, highly expensive new technologies appear—but it seems to me unlikely that it will. Resistance to rapid expansion of government spending for health care is already very great, both in the form of the public’s reluctance to pay higher taxes and also in the increased competition within government from other agencies fighting for their share of public funds. Private health care spending is also being watched more carefully, with growing numbers of business firms becoming more conscious of health care costs and other groups in the community asking, “What can we do to hold down the rate of growth of health expenditures?”

Suppose health care expenditures per physician do increase more slowly. Why should that matter? It will matter critically for physicians because it is these expenditures that determine what they can do for their patients in terms of hospitalization, tests, drugs, and other elements of care. Equally important, these expenditures determine the physician’s own income. Once this becomes apparent I believe that physicians, in their own self-interest, will give more thought to how they can influence
the overall rate of growth of health care expenditures and, in particular, how they can hold down the nonphysician portion of these expenditures. Given a limit on total health care spending, physicians’ incomes will depend heavily on their success in slowing the rate of growth of spending for hospitals, drugs, and similar items.

Thus, not out of ideology, not as a consequence of exhortations from economists or politicians, but rather in pursuit of their own self-interest, physicians will be attracted to modes of medical practice that are conducive to holding down the growth of expenditures. Many physicians are already practicing in such modes—prepaid group practices, independent practice associations, primary care networks—and many others will join in the future. Furthermore, new kinds of organizations and new modes of practice will develop to compete with those that are already in place.

The key feature of all these modes is physician-centered control of, and responsibility for, the total health care bill. It is the total bill that really matters to the taxpayer, to the patient, and to the insurance carrier. And, in the end, it will be the total health care bill that is going to matter to physicians in terms of preserving and enhancing their earning power. I believe that it is inevitable that the American medical care delivery system is going to become more organized and more competitive as a consequence of these forces;

The intensification of competition has been forecast, hailed, and decried by many observers. Competition, of course, can take many different forms. One form has been outlined (and deplored) by Dr. Arnold S. Relman, editor of The New England Journal of Medicine, in a stimulating article entitled “The New Medical-Industrial Complex.” Relman discusses the rise of for-profit institutions in the health field, especially in hospitals, and particularly the large chains of hospitals. He also discusses nursing homes, clinical laboratories, kidney dialysis centers, and home health services—all of which operate under a for-profit structure.

Relman expresses great concern about this development. He charges the for-profit settings with overutilization of care, fragmentation of delivery, overemphasis on medical technology, and “cream skimming”—the practice of treating only the healthiest patients. Relman is also worried about what he terms the undue influence on health policy that might be exerted by these for-profit companies and about the ethical problems the profit motive presents to physicians.

Dr. Relman rendered a great service in publishing this article, but I believe that the facts of the case lead to a somewhat different set of inferences. It seems to me that the important distinctions are not between the for-profit and the nonprofit modes, but along other lines—lines that will shape the emerging battles for control of health care.
Physicians Versus Management

The most significant battleline emerging is between practicing physicians and management. By that I mean the inevitable clash between a fiercely independent profession and a management structure that seeks to gain firmer control over what doctors do. Traditionally, health care has been controlled by physicians—sociologist Elliot Friedson called it “professional dominance.” Any analyst who looks at health care from the outside is always in awe of the extent to which, until recently, physicians have controlled the medical enterprise.

That control rests on many things. It originated in the mystery and in the fears that are associated with illness and with dying. It is fed by technology. And it is supplemented by government regulation and by licensing, which is a grant of monopoly power that restricts the practice of medicine to physicians. This control is being eroded, however, by the development of large institutions that require vesting significant power in the hands of management if the institution is to function successfully.

The erosion occurs in nonprofit and for-profit institutions alike, but the latter are newer, larger, and seem more threatening to physicians. Consider the Hospital Corporation of America. It owns or manages some 350 hospitals throughout the United States and has its fingers in a large number of other health care enterprises. HCA reported the following results for the first quarter of 1982: revenues totaled $874 million, up 60 percent from the same period of 1981. Net income increased 55 percent to $48 million, and earnings per share increased 32 percent.

The national scope of HCA’s growth is impressive, too. The 1982 first quarter report said: “Growth through acquisitions continued during the first three months of 1982 with the addition of several general and one psychiatric hospital with a total of 900 beds. The newly acquired hospitals are located in Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee, and Texas. HCA’s management of hospitals owned by others also increased during the quarter, with new agreements signed in Arizona, Maine, Mississippi, New Mexico, Pennsylvania, South Carolina, and Texas.”

HCA is the largest of its kind, but it is not unique. There are many similar organizations that reflect the emergence of a new era in American medicine. Why does the power of management grow? Why do larger institutions become more important? Three main ingredients are involved. The first is the need for capital to finance growth. As medical technology grows more complex, capital requirements for practicing medicine, both in and out of the hospital, grow exponentially. Larger organizations have better, quicker access to capital markets and can finance the technologically intensive medical care of the 1980s on more favorable terms.
A second reason is the growth of government regulation and bureaucracy. Larger organizations have more effective mechanisms for dealing with bureaucratic phenomena. They have the contacts in government and they employ the counterparts to the reimbursement specialists and the regulators that staff the government agencies. A recent conversation with a physician who practices in a small town in Arizona illustrates this point. He told me that the hospital where he admits patients recently entered into a management contract with one of the large for-profit hospital corporations. I asked him, “What does this management corporation do for you?” He responded, “It’s very simple. When there’s a problem getting reimbursement from Medicare, when the reimbursements are coming in slowly or there are difficulties of one kind or another, they can deal with it. The management company has a team of experts, some of whom previously worked for the reimbursing agency. They know how to push the buttons, they know who to call, and they keep the process flowing. When problems of accreditation come up, they know how to get the approvals through, they know how to do the paperwork. In other words, they are good at things that do not have much to do with patient care or efficiency, but rather with the regulatory framework.”

The third reason for the growth of management is what I would call true skills of management—the ability to organize complex technology, bring together different people from different professions to deliver service as a team. Every large organization, for-profit or nonprofit, needs these skills. Physicians, on the whole, do not like this trend toward larger management-dominated enterprises. Most would prefer to maintain physician dominance over health care. But it simply will not be possible for physicians to dominate medicine in the future as they have in the past. I hope that physicians and management will work out compromises, will understand the legitimate functions and the legitimate concerns of each, and rather than engaging in bloody battle, will develop a unified and comprehensive approach that better meets the needs of patients and society.

Control of medicine, as far as I can see, will never again belong completely to physicians. If that is the case, physicians should decide what parts of the system are most important to them, what parts they would prefer to control in the future. They should look around to determine where doctors have been particularly successful in working out viable arrangements with management. A good example of successful accommodation—where physicians have remained in charge of what is important to them—is the Mayo Clinic in Rochester, Minnesota. A visitor to Mayo cannot help but be impressed by the extent to which the organization has worked out the necessary compromises between the practicing physicians and management. To an outsider, the organization seems to work smoothly. Significant power and authority is vested in
management, but it is shared with the practicing physicians. Perhaps the most interesting dimension is revealed by an exchange between one of my students and me. I was making the point in a lecture that Mayo had struck these compromises between its physicians and the management when a physician in my class, who had done a residency at Mayo, stopped me and said: “Professor Fuchs, you have that one all wrong. The physicians at Mayo perceive that they still have the power.” I smiled and responded, “Thank you. That’s just the point I am making.”

Mayo is a $250-million-a-year operation, and it runs smoothly, efficiently, and profitably. It is not possible for a $250-million-a-year operation to be run smoothly, efficiently, and profitably by practicing physicians. But if the physicians perceive that they still have the power, that is great. It is great because it demonstrates that Mayo physicians still believe they command what is important to them. They don’t feel that someone is trying to tell them how to practice medicine. I hope other organizations will be as successful in working out compromises and avoiding this battle.

There is another battle emerging that superficially seems to be related to the for-profit/nonprofit distinction, but really reflects a larger set of issues. This battle pits university physicians and hospitals against community physicians and hospitals. The university medical centers are facing very difficult times. Biomedical research funds are flat or falling; medical education support is dwindling and, increasingly, the university medical centers are looking to patient care to shore up their revenues. At the same time, these centers dread the notion of having to compete for patients in a tight economic environment. In many cases their concern is well justified. When it comes to delivering bread-and-butter care, the chances are that the community physicians and community hospitals can render this care less expensively.

On the other hand, the community hospitals and their affiliated physicians also feel threatened. They see these gleaming medical centers, big and powerful, and they see the famous specialists, and they wonder how the medical centers will use their power, and whether it will be at the expense of the community physicians and hospitals.

The conflict is exacerbated by the proliferation of tertiary types of medical care–activities at the frontier of medicine–that should be done primarily in medical centers but which increasingly are being undertaken in community settings. This proliferation frequently is bad economics and bad medicine. Eventually, this conflict is going to produce a need for better understanding, a need for compromise, a need to realize the legitimate concerns of each part of the health care enterprise.

I am particularly concerned, for example, about what will happen to medical research. Without research, without advancing the state of
knowledge, medicine will begin to run up against blank walls. There is only a limited amount of improvement in health that can be purchased by increasing the number of physicians or by adding hospital beds. The great advances have always come from figuring out better and newer ways of preventing or treating disease. Somehow there has to be enough funds generated in the medical centers to support research and to employ faculty who are actively engaged in research.

Society would benefit from the evolution of a medical care system where academic centers concentrated on research, teaching, and tertiary care, and did only as much primary and secondary care as is necessary for them to carry out their principal missions. At the same time, complex tertiary care should be limited primarily to regional medical centers because such centers can provide the specialized services more efficiently, offer higher quality care, and carry out the research that should accompany all innovations in medicine.

In the preceding discussion of two emerging battles for control of health care, government has not been one of the chief contestants. This may come as a surprise because the battle for control of health care is often depicted as one of medicine against government. However, that simply is not the case, at least in these two battles. Currently, medicine has a little respite from the hot and heavy breath of government. Unfortunately, the medical profession is not using this breathing space as creatively and as constructively as it might.

For a time in the late 1970s, physicians were running scared, largely in fear of a government takeover of medical care. When the proregulation forces were in power, organized medicine was more willing to talk about competition, more willing to consider major changes in the system. After the 1980 election, the reaction among medical leaders was “Let’s go back to business as usual.” This is a shame because, while the regulatory threat went away for a time, medicine should not think that it has disappeared forever. It could come back quickly and heavily. Indeed, a case could be made that it already has, in the form of Medicare and Medicaid budget cuts. Medical leaders should use this breathing space to demonstrate real leadership, to make unnecessary the imposition of centralized controls and tighter regulation later in this decade.

**Physician Versus Physician**

There is one other battle that may emerge in the years ahead. The likelihood of struggle on this issue is less certain than for the two already discussed, but there is enough of a possibility to merit some consideration. This battle will pit physicians against physicians, and the basis for it was nicely delineated by Dr. Benson Roe in an article entitled, “The UCR Boondoggle: A Death Knell for Private Practice?”


Roe, an experienced California surgeon, made one central point that every physician knows: there is a serious imbalance in the fees physicians receive for different types of work. When a new medical procedure comes along, it is usually reimbursed at a high relative fee. According to Roe, the high fee is justified at first because there is a tremendous amount of cost and effort and risk involved in the early stages of developing a new procedure. Roe, a cardiac surgeon, describes what was involved in doing those early operations. A high relative fee was justified. But then what happens? The procedure becomes routine, or certainly more routine than it was. The volume grows enormously, unit costs decline, but unlike almost any other industry with this pattern of development, the fee remains relatively high. At some point any physician doing that procedure on a reasonably full-time basis earns a fortune. Of course, not all do because the high fees attract more physicians than are needed to perform the procedure and they all cannot maintain full workloads.

Sometimes these specialists do not even have half workloads or one-third workloads, so they don’t derive huge incomes, but the cost to the patient and to the taxpayer and, indeed, to society from these disproportionately high fees remains. A few words should be added to complete the picture. Many physicians work hard practicing high quality care that is not procedure oriented and that does not generate high relative fees. They put in long hours in return for moderate incomes. At some point, the competitive squeeze I discussed earlier could result in confrontations between the different kinds of physicians. That is, there may be a battle within medicine itself between specialists who command large fees for the technology-driven medicine they practice and generalists who render high quality care that is not procedure oriented. Again, government would be largely a bystander in this battle, unless it uses the battle among physicians to strengthen its own control over all of them.

In other countries that have had major changes in health legislation, such as the United Kingdom and Canada, one of the techniques that the politicians employed was to turn physicians against each other. The government can create splits within the medical community, play off one type of physician against another, and give one a better deal than the other. It will, therefore, be important for physicians to be attentive to this potential battle within the profession and try to deal constructively with it before it destroys them.

In conclusion, physicians face the likelihood of several unpleasant, unrewarding battles for control of health care. No matter how they are resolved, the next ten years are not likely to be as pleasant as the last thirty. Things are going to be different. A realistic approach for physicians, one that they often recommend to patients, is to “Learn to live with it.”
Once physicians and other health care specialists understand the reasons for conflict and change, their best hope is to work out appropriate compromises. Let practicing physicians concentrate on treating patients and let management concentrate on managing. Let academic physicians in medical centers concentrate on teaching, research, and tertiary care with only as much primary and secondary patient care as is necessary to perform these functions well, and let community physicians concentrate on less intensive forms of care. Unless the necessary compromises are struck, American medicine will be consumed by conflict in the years to come, and patients and society will be the major sufferers.

NOTES

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