To Subscribe:  https://fulfillment.healthaffairs.org

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution.
The Vital Role Of Professionalism In Health Care Reform

by David Blumenthal

In this Commentary I wish to move beyond the topics covered at length by the economists in this volume of Health Affairs to a different but equally compelling set of issues. In doing so, I am motivated by a disturbing sense that much of the discussion is diverting us from the concerns and problems that are truly troubling the American people and that must be addressed if health care reform is to succeed. In particular, I want to draw attention to the critical importance of designing a reform initiative that promotes professionalism among physicians and other health care providers.

The topic of professionalism is one that until recently I never found appealing. My distaste for the issue had a lot to do with the company it has kept. In most national health care debates the topic has been raised principally by opponents of reform—often organized medicine—and has been used for the explicit purpose of obstructing progress and protecting the self-interested prerogatives of the medical profession. Whatever the reform proposal, it is decried as a threat to medical professionalism and implicitly, therefore, a threat to the quality of care and the satisfaction of patients. This use of the professionalism issue is a great misfortune whose dimensions become apparent if one examines the true role and significance of professionalism in health care reform. The simple fact is that health care reform cannot succeed politically or substantively—unless it preserves and bolsters the professionalism of physicians and other health care providers.

Why is this the case? The answer lies in the following simple and, to my mind, almost incontrovertible assertions. First, no amount of external quality monitoring or regulatory intervention will fully correct what economists so delicately call the “asymmetries in information” that exist between health care providers and their patients. In their hour of real or fantasized need, patients rely on the knowledge of their providers to protect and/or maximize their health. No matter how many “report cards” are mandated, or how many colorful consumer guides are printed and distributed, the

David Blumenthal is chief of the Health Policy Research and Development Unit and associate professor of medicine and health care policy at Massachusetts General Hospital, Harvard Medical School, in Boston.
health care market cannot be rendered a level playing field.

Second, with the possible exception of a small intellectual elite in this country, consumers and voters understand, expect, and even value this asymmetry in information. What, after all, did those doctors and nurses do with all those years of schooling? Of course they know a lot more than the average person about health and medicine. The more health professionals know, the better!

Third, and consequently, consumers and voters want to believe that the health care providers they rely on will use their superior knowledge to promote the best interests of their patients. People want to trust their doctors. To put it another way, professionalism is an antidote to the inevitability of market failure in medicine, and it is an antidote that the public would dearly like to preserve. In this public desire lies the moral and ultimately political power of organized medicine.

It should be clear that I am defining professionalism somewhat differently than it is defined in much political discourse. Many doctors equate professionalism with autonomy—to be left alone to do what they want, not only medically but financially. Autonomy, however, is not a divine right of medical or other professionals. Rather, as Paul Starr and Paul Friedson have pointed out, it is a legal, institutional, and moral privilege that is granted by society and that must be earned by health care providers through observing certain standards of behavior, including at least the following.¹ (1) Altruism: Professionals are expected to resolve conflicts between their interests and their patients’ interests in favor of the patients. (2) A commitment to self Improvement: Professionals are expected to master new knowledge about their trade and to incorporate it continually into their practice. They also are expected to contribute individually to the knowledge base that informs their discipline. (3) Peer review: Because of their specialized knowledge, professionals are uniquely positioned to supervise the work of their peers, to protect consumers against failures of professionalism.

If health care reform is to succeed, it must consciously and energetically promote these qualities in the medical profession and among other health care providers. Any health care system that undermines these qualities will leave the public unhappy and rebellious and will fail to establish a stable, politically viable alternative to the present system. To paraphrase Bill Clinton’s campaign adviser, James Carville, “It’s the patients and the doctors, stupid!”

There is much in the Clinton plan that promotes true professionalism. The challenge facing Congress is to preserve those elements, fortify them, and expand upon them. Here I highlight some measures that can reinforce these factors of altruism, self-improvement, and peer review.

Altruism. The first and most important way in which health care reform
can promote altruism among medical professionals is by doing what the Clinton proposal so clearly does: provide financial health security to all Americans. This relieves physicians of the financial conflicts of interest that result in differential treatment of insured and uninsured patients.

But other conflicts of interest will continue to arise, with which physicians and other providers will continue to need assistance. One type of financial conflict arises from capitated health care arrangements and other systems of compensation that reward physicians for undertreating patients. Capitation has many desirable elements as a device for promoting cost control and encouraging providers to take an interest in maintaining the health of patients. But it is absolutely essential for the long-term health of health care reform that patients not perceive their caretakers to be skimping on care because of financial self-interest.

One way to preserve the benefits of paying for health care on a prospective, per capita basis while avoiding some of the potential hazards of this approach is to compensate organizations on a capitated basis but pay individual providers within those organizations on a different basis. As Alan Hillman has noted, the managed care organizations that constitute prototypes for so-called accountable health plans (AHPs) use a wide variety of mechanisms for compensating their providers. These include traditional fee-for-service mechanisms, fee-for-service with various supplementary incentives, partial capitation, complete capitation, and salary. Salaried compensation is most likely to create the financial neutrality that is ideal for eliminating financial conflicts of interest between patients and providers, but it may not be feasible or appropriate in all situations. One function of state authorities and alliances may be to scrutinize the compensation systems of competing AHPs and to highlight the incentives that result. When AHPs choose to create strong financial conflicts of interest between patients and providers—for example, by capitating individual physicians and placing them directly at risk for the health care costs of their patients—alliances should at a minimum bring this to consumers’ attention and subject those AHPs to additional and more intense monitoring. Some states may choose to forbid this approach to paying providers altogether.

Self-improvement. Of the numerous mechanisms through which health care reform can promote self-improvement in the medical profession, the most important is research. New knowledge empowers the profession, increases its self-confidence and sense of mission, and adds to its hope that untreatable illness will be manageable in the future. Public awareness of research and its products also increases public confidence in medical professionals and the health care system. It is therefore absolutely essential that research for the improvement of health care—biomedical research, research on medical effectiveness, and health services research—be sup-
ported as fully as possible under health care reform.

The ideal way to promote needed research would be to create a trust fund that sets aside a fixed proportion of the health care dollar for this purpose. The annual congressional appropriation process has not provided a secure or adequate source of research support in the past and is unlikely to do so in the future, since the on-budget costs of delivering health care services are almost certain to exceed projections under almost any reform proposal. This will add to the pressures on domestic budgets that have constrained research expenditures in the past, leading to underfunding of outcomes and medical effectiveness research and health services research. Unfortunately, the Clinton proposal continues to rely on the current authorization and appropriation process for future funding of essential evaluative and biomedical research.

The Clinton plan, however, does contain several innovative and promising devices for promoting self-improvement within the profession. Under Title V, Subtitle A, Sections 5008 and 5009, the Health Security Act provides for the creation of regional professional foundations and a National Quality Consortium. Foundations would be organized around academic health centers and would have the duty to develop “programs in lifetime learning” for health professionals; “foster collaboration among health plans and health providers” for quality improvement; and disseminate information about successful quality improvement programs, guidelines, research findings, and patient education systems. A national consortium would oversee the development of regional foundations and would advise the Agency for Health Care Policy and Research (AHCPR) and the proposed National Health Board on a variety of quality improvement matters. As important as are the specific provisions of these programs is the commitment to enhancing professionalism that they demonstrate. Congress should preserve and build upon them.

**Peer supervision.** Health care reform should support and reward effective peer supervision, education, and discipline. The promotion of altruism and self-improvement through the devices discussed above are important to effective peer regulation, but policymakers need to think carefully about how other facets of health care reform proposals could assist as well.

Among the conditions necessary to support effective peer supervision are (1) a collective sense of responsibility and accountability among medical professionals for the conduct of peers and colleagues; (2) a sense of local autonomy and empowerment among medical professionals, so that they believe that their efforts in supervising peers are valued, appropriate, and efficacious; and (3) institutional, legal, and financial support for peer supervision at the local level.

It is easier to identify these conditions than to specify how to create them.
within the context of a complicated overhaul of the health care system. To begin with, federal and state authorities should be careful to avoid the reality or appearance of removing the power of professionals through counterproductive efforts to limit professional autonomy. This is a particular danger where guidelines are concerned. The Clinton proposal relies heavily on the formulation of guidelines as a mechanism for improving the quality and reducing the cost of health care services. As heuristic devices for communicating information in a concise and usable form, guidelines are very useful. However, in most important clinical situations the knowledge base is insufficient to dictate proper treatment, and, in any case, local conditions vary so much that national guidelines must be tailored to patients’ wishes and institutions’ capabilities. If peers are to hold themselves accountable, they must have the freedom to develop guidelines that take into account these uncertainties and local variations. Nationally formulated guidelines should be the starting point for the development of local practice standards, not an end in themselves.

The development of such local practice standards and other necessary tools and conditions for peer review will require funding and technical assistance. It also will require research specifically directed at enhancing the peer review process. Whether centers of lifetime learning and regional foundations will have the needed resources and competencies remains to be seen. If not, other mechanisms to support this process should be developed.

The promotion of peer supervision specifically, and professionalism generally, may seem hopelessly abstract and idealistic to hard-nosed practitioners of the economics and politics of health care reform. However, it bears repeating that for the average voter the issue could hardly be more central. At its heart is the question of whether patients will be able in the future to enter their physician’s office with confidence and trust in the good will, integrity, and competence of that provider.

NOTES