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Do Physicians Recognize Their Own Best Interests?

by Robert A. Berenson

As one of the few physicians on the White House Health Care Reform Task Force who came from private medical practice, I tried to identify the common interests practicing physicians share. Even physicians who are suspicious of my Democratic party allegiance and primary care orientation continue to thank me for representing them on the task force, apparently believing that doctors share a common interest in health reform and view health reform similarly; or, possibly, they are just being polite.

But the profession is splintered. Physician opinion varies by age, sex, geography, specialty, practice type, party affiliation, and many other characteristics. In an earlier draft of this paper I wrote that on a few issues there is physician consensus, particularly on the commitment to universal coverage. The December 1993 meeting of the American Medical Association (AMA) shattered even that illusion, with many members opposed to either an employer or an individual mandate.¹ (It turns out that many physicians do not even provide health insurance to their own employees.) There is physician consensus that the malpractice system does not serve the best interests of doctors or patients, but there is disagreement on preferred solutions. Similarly, physicians generally disdain third-party payers’ micro-management of clinical decisions and the administrative hassles resulting from too many payers with different policies and procedures, but they disagree strongly on how to reduce these problems.

Approaches To Cost Containment

Many doctors oppose systematic approaches to cost containment, arguing that any new benefits should be funded with new taxes. Some advocate Milton Friedman–type market reforms that would impose much higher cost sharing on patients to transform them into price-conscious shoppers. Yet I suspect that the very physicians who express support for this type of ap-

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proach would be repelled by their new role as salespersons, rather than physicians, required to participate in long discussions with consumers (no longer patients) about the cost/benefit trade-offs of every costly recommendation. In any case, except among the Republican right wing, there is no political support for cost containment based on requiring substantial patient cost sharing.

We are left with three other more likely approaches to systematic cost containment: a Canadian-style single-payer system; unmanaged competition among managed care companies; or managed competition among accountable health partnerships or plans.

As an advocate of managed competition, I never thought I was representing the perceived interests of certain physicians during my tenure on the task force. Indeed, as the political debate crystallizes around different versions of managed and unmanaged competition, I expect that a large segment of practicing physicians will realize that they would do better under a Canadian-style delivery system than under even a well-functioning, regulated market based around competing health plans. In general, physicians who would do better working in a market-based system than a Canadian-style system are primary care physicians, doctors in large group practices, doctors who practice more cost-effectively and with higher quality than their peers, and doctors willing to be entrepreneurial. Many physicians do not fit any of these categories.

Although many have expressed surprise that some in the American College of Surgeons supported the single-payer model, such a position is quite logical. A single payer would be aggressive at price negotiations but lacks other tools that managed care organizations can use to reduce excess utilization and lower costs. In particular, a government single payer could not easily engage in selective contracting—the major threat to specialties such as surgery, which are oversupplied in many areas.

Although, as I argue later, a system of managed competition would be better for most physicians than current unregulated, dysfunctional markets, the choice for physicians between a regulated, market-oriented approach and a Canadian-style system is less clear cut. Once political labels are put aside, physicians will realize that managed competition would be a more radical departure from the prevailing delivery system than a relatively unambitious, predominantly fee-for-service, single-payer system would be.

Professionalism

To a large extent, the different approaches to cost containment reflect different views of the role of professionalism in health care. The Canadian and many European systems reaffirm the dominance of the professional
paradigm, described by Duke Law Professor Clark-Havighurst as “a deep-seated belief . . . that medical care is not a commodity, that its characteristics are scientifically determined, and that decisions concerning it must be entrusted exclusively to professionals.” Many physicians who disagree on whether government should organize the health care system, nevertheless unite in their criticism of the “corporate practice of medicine” as exemplified by managed care, because it challenges a number of tenets of the professional paradigm. Summarizing Havighurst’s longer list, these tenets include the following. (1) Appropriate medical care should be evaluated only on the basis of scientific evidence and expert opinion and only on the basis of safety and efficacy, not cost considerations. (2) Consumers are generally incapable of making appropriate choices about their health care and should look to physicians to protect their interests. (3) Physicians, as professionals guided by science and ethical concern for patients’ interests, should enjoy autonomy in their professional work and be accountable only to other independent professionals, whose norms alone should set limits of professional judgment.

The problem with this paradigm is that it has become unaffordable. The profession has proved incapable of disciplining itself to hold down costs or respond to consumer preferences. Other countries’ governments, while deferring to professional control of clinical decision making, have attempted to contain the excesses that the professional paradigm produces, with reasonable success. In resisting functions that governments do elsewhere (for example, limiting diffusion of technology and allocating residency slots by specialty), organized medicine here, ironically, has fostered the development of corporate medicine. Managed care plans have sprung up precisely to fill the void created by the profession’s insensitivity to cost.

There remains a fundamental disagreement on the role of professionalism in the corporate practice environment. One view holds that physicians should be immunized from the commercial interests and many of the policies of managed care administrators, thereby ensuring that physicians continue to work for patients, not plans. The contrary view, which I endorse, holds that systems that pit managers against affiliated physicians are inherently dysfunctional, inhibit the full integration of financing and delivery, and will fail. Rather than pretending that the professional paradigm should reign supreme even in competitive markets, this view looks toward development of responsible corporate practice of medicine, with extensive disclosure and reporting as important protections against potential abuse. Instead of confronting the dictates of managers, physicians should become the managers.

Thus, physician autonomy should be promoted not because it adheres to the professional paradigm, but rather because patients generally prefer an
unencumbered relationship with a caring and skilled physician. Where the physician is neither caring nor skilled, autonomy should be restricted.

Understandably, physicians feel threatened by the paradigm shift from professional practice to corporate practice. It was not surprising, therefore, that organized medicine rejected a “good deal:” the White House task force’s proposed shift of liability from the individual professional to the enterprise responsible for financing the injured patient’s care.

Overall, the Clinton administration acts schizophrenic on its support of market competition and its view of the professional paradigm. Even though its proposal was built on managed competition principles, it has often endorsed the professional paradigm by criticizing managed care interference with physician decision making. The Health Security Act itself seeks to reduce costs through competition but, at the same time, is very concerned about protecting potential losers. As with most protectionist policies, each one makes some sense, but the sum total of exceptions to protect vulnerable parties can distort markets and reduce competition too much.

Organized Medicine’s Response

The AMA has developed a clever but disingenuous position on the Clinton proposal. The AMA would have supported a proposal calling for a “true, competitive market.” However, because the administration’s proposal calls for centralized regulation of the new market, the AMA, unhappily, found itself forced to oppose many components of the president’s plan.

What makes this position disingenuous is that on issue after issue the AMA itself has long sought to restrict the workings of a pure market. Instead, its policy positions understandably support the paradigm of professional dominance over the health care system. The AMA leads the opposition to loosening barriers to market entry of nonphysician professionals, such as nurse practitioners and chiropractors. It would impose “any-willing-provider” requirements that would restrict the ability of health plans to contract with the providers they want. It would strengthen state and/or federal restrictions on what it labels the “abuses” in managed care. It would preserve state-imposed “corporate practice of medicine” laws that limit the organizational structures that integrated provider groups can take. Most ominously, the AMA would seek a broad antitrust exemption to permit unaffiliated physicians to collectively negotiate with health plans over fees.

In short, the AMA does not support a true competitive market, but rather seeks broad protections for physicians from competition. However, by limiting the ability of plans to contract selectively, physicians inadvertently would have plans rely instead on the intrusive micromanagement
that physicians decry to hold down costs. Furthermore, recommended protections would interfere mainly with managed care organizations that contract with private physicians and not with staff- and group-model health maintenance organizations (HMOs) that have exclusive relationships with physicians. In the long run, anti-managed care laws and antitrust exemptions could have the unintended effect of hastening the demise of independent private practice because managed care organizations could avoid these imposed contracting restrictions only by employing physicians.

Assuming that the country does not go the single-payer route, the choice for physicians essentially is between unregulated managed care markets that are increasing throughout the country and regulated markets that are envisioned under the Clinton proposal and, with significant variations, under the Cooper and Chafee approaches. Physicians have not understood that much of the Health Security Act’s proposed regulatory authority they complain about would in fact help many physicians both financially and professionally. In the remainder of this paper I detail how regulated markets are better for physicians than open markets are.

Regulated Markets Versus Open Markets

**Plan incentives.** Today an unfortunate emphasis in unmanaged competition is risk selection. Physicians who treat patients with special health problems or care for an underserved population are disadvantaged in their ability to contract with HMOs, which are worried that physicians who treat high-cost patients will bring these patients with them. If, under managed competition, plans are not permitted to “redline” geographic areas, and if, by risk adjustment, plans receive more appropriate payment for the population that enrolls, physicians who now are disadvantaged in their ability to contract with managed care organizations will be in demand.

In addition, the incentive changes brought about by risk adjustment naturally will shift the orientation within plans from the marketing and actuarial functions to the medical director and provider relations functions. Managed care organizations should become oriented more to helping physicians provide care, rather than simply regulating their behavior.

**Patient choice.** A key component of the health alliance structure is the shift in plan selection from the employer to the individual. In today’s markets patients are forced to switch personal physicians whenever employers choose plans with different provider networks. This compulsory switch may sever a good doctor/patient relationship and exact new transaction costs as patients establish themselves with new physicians.

In an alliance system that provides individual choice of plans, physicians would obtain much more appropriate bargaining power in their negotia-
tions with plans than would be brought by the anticompetitive antitrust exemptions the AMA seeks. Patients would be free to follow physicians to the plans in which they participate. That alone would give physicians with patient allegiance more negotiating leverage. Physicians without such allegiance would not get new negotiating leverage, but why should they?13

**Consumer information about plan operations and quality.** Today the policies and procedures under which managed care organizations function are a black box. Health plan brochures and informational materials are skimpy or overtly misleading. For example, plans commonly list tertiary care hospitals in their network but do not explain the referral mechanism that restricts access to those facilities.

Plans in reformed markets would disclose a lot more information, not only about their performance as captured in “report cards,” but about how they are structured and how they function. For example, most consumers today are not aware of the financial incentives applied to plan physicians. Within an alliance system, information about how plans compensate physicians would be provided to all consumers, and the new industry of consumer advisory services would make arcane information about plan operations comprehensible to the public. Many physicians rail against individual capitation incentives that arguably cause physicians to underserve their patients. Consumers will understand how individual physician capitation works, and if they agree that it is not compatible with high-quality care, they will receive the information necessary to avoid the plans that use it.

**Liability for negligence.** Even though the Clinton administration, in the end, did not endorse an immediate move to enterprise liability, its proposal’s practical effect would be to place greater liability on plans for the actions of their affiliated practitioners. Increasingly, the courts will assign vicarious liability to the plans because of the credentialing, quality assurance mechanisms, and utilization management techniques that plans will use to comply with alliance requirements and to compete effectively.14 Plans will not be able to do what many managed care organizations do today: adopt strict utilization review criteria that limit care and then, when something goes wrong, turn around and argue that only physicians practice medicine and, therefore, only physicians should be held liable for bad outcomes. Plans will have to rationalize their utilization management policies with their liability risk management and quality enhancement programs. Physicians, who are often caught in the middle today, facing conflicting policies and pressures to both achieve cost containment and avoid medical liability, likely will get some measure of relief in the new system as health plans are brought into the same legal arena. In addition, increased corporate liability should undermine the fiction that physicians remain in total control of clinical decision making and should lead to more responsi-
ble corporate practice of medicine.\(^1\)

**The market for physician services.** Physicians, especially specialists, in many areas commonly contract with a dozen or more different managed care plans. With too many plans in the area, it is impossible for plans to develop the kind of collaborative relationships with physicians that organized delivery systems promise. Innovation is hampered when any product differentiation is seen by providers as bothersome rather than useful. Yet when a physician is involved with too many plans, that is precisely how even improved ways of managing care are often perceived. Working with fewer plans will reduce administrative expenses and permit physicians to concentrate their business relations on plans with compatible cultures.

The requirements for plans under managed competition and the rules restricting permitted forms of competition surely will force many insurers to leave the market and will lead to consolidation of existing managed care organizations. Indeed, active antitrust enforcement will be necessary to prevent consolidation that results in the exercise of market power.\(^2\)

**Plan ownership and control.** Although the larger insurance companies and dominant HMOs surely will survive and remain major forces, integrated networks made up of physicians, other health professionals, and hospitals will become health plans, assuming full insurance risk. Certain components of the Clinton administration proposal, such as the relatively spare solvency requirements and the availability of low-interest loans, support the idea of integrated provider networks assuming a much larger role in organizing the delivery system than in today’s markets.

Indeed, the Clinton proposal seems to tilt toward this model by permitting a health plan to serve only a limited geographic area, which it can serve with its own limited group of providers. My concern about this provision is that provider-controlled plans can “cherry pick” just as easily as insurer-owned entities.

A better approach would be to set rules starting with the presumption that health plans will serve the entire geographic area covered by the alliance. Under this formulation, integrated provider groups could still become the exclusive “franchise” for a geographic area within the larger alliance area. As the provider for this area, the integrated group would assume capitation for the large part of the premium that represents medical care and related activities, that is, utilization management and quality assurance. The plan itself would do marketing and perform centralized management activities. As physicians and hospitals themselves assume more risk for a large share of the premium, the amount skimmed off by the insurer or HMO to support its own administration and generate profits would be reduced. The net effect of regulating the managed care market might be to shift control of business and medical care decisions back to
providers. Although some correctly caution that this shift will not be easy, physicians will not be able to argue that managed competition leaves them pawns of profit-seeking insurers, as they find in many situations today.\(^{17}\)

**Fair process.** In today’s system few rules define how providers should be treated by plans. As private entities enter into private contracts with practitioners, physicians do not enjoy constitutional due-process protections as they would if involved with a government-run single payer. Indeed, this ability of plans to select their own provider networks without burdensome due-process or any-willing-provider requirements is a fundamental advantage that the market has over a would-be governmental payer.

Nevertheless, physicians often are treated unfairly in the current system. Insurer-dominated plans often do not seek input on issues in which physicians have an obvious interest, such as quality assurance mechanisms, utilization review protocols, practice guidelines, physician profiling, and credentialing. Although specific antitrust relief may not have been necessary, the Clinton administration plan explicitly permits physicians to collectively discuss clinical issues with plans. Elsewhere, the proposal requires disclosure of utilization review criteria, requires plans to have advisory boards of providers with access to plan information, and generally provides for a fairer process governing provider contracting.

**Concluding comments.** Given the complexity of health reform and increasing diversity within the medical profession, it is not surprising that physicians no longer speak with one voice. Unfortunately, many physicians do not seem to understand what is in their own long-term professional and financial interests. Organized medicine might have preserved much of the professional paradigm by disciplining itself to hold down costs and encouraging government involvement to help control resource capacity. By demonstrating leadership on cost constraint, the profession would have had greater moral authority to demand universal coverage for all Americans.

Instead, corporate practice has become the preferred mechanism to achieve cost containment for many employers and some government payers. Now physicians face the choice of supporting open or managed markets. Accustomed to opposing government authority, a large segment of organized medicine is opposing direct and delegated government functions that would, in fact, make things better for most physicians.

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**NOTES**

2. Testimony of David Murray, chairman of the Board of Regents of the American College of Surgeons, before the House Committee on Education and Labor, 10 February 1994.


6. In *Health Security Act* provisions describing “essential community providers,” point-of-service requirements on low-cost-sharing plans, and alliance discretion to require plans to contract with particular providers for care of specified health problems, market protections are provided to publicly funded organizations serving special populations, fee-for-service physicians, and academic health centers.


9. R.E. Bloch and D.M. Falk, “Antitrust, Competition, and Health Care Reform,” *Health Affairs* (Spring 1994): 206-223. The *Health Security Act* goes only as far as giving unaffiliated physicians the right to negotiate collectively with an alliance over the fee-for-service plan fee schedule. Although worrisome in itself, so far this immunity does not extend to physician negotiations with health plans.


11. The authors of managed competition seek to dissociate their concept from the Clinton proposal. See A.C. Enthoven and S.J. Singer, “A Single-Payer System in Jackson Hole Clothing,” *Health Affairs* (Spring 1994): 81-95. My point here is to contrast managed competition with the current marketplace in which physicians function. In this context various versions of managed competition have a lot in common. As targets of attack from advocates of open, rather than managed competition, both the Cooper and Clinton plans stand accused of wanting “government regulation to substitute for market processes.” M. Tanner, “Cooper Plan, Clinton Lite,” *The Wall Street Journal*, 14 February 1994, A18.

12. Berenson, “A Physician’s View of Managed Care.”

13. The logic of this argument would lead to alliances that include all residents of the area. Because of concerns about untested new bureaucracies and the concentration of power in the new entities, I believe that the Clinton designation of 5,000 workers as the size of the employer permitted outside the alliance is too high, at least initially. At a mandatory participation level of 100–200 workers, in many communities about half of the population would fall inside the regional alliance, more than adequate to achieve the goal of giving physicians negotiating leverage resulting from direct patient choice of health plan.


