Cite this article as:
William F. Jessee, Reed V. Tuckson and Linda L. Emanuel
Perspective: Going Beyond A 'Philosophy Of Care'
Health Affairs 16, no.6 (1997):126-128
doi: 10.1377/hlthaff.16.6.126

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/16/6/126.citation

For Reprints, Links & Permissions : http://content.healthaffairs.org/1340_reprints.php

Email Alertings : http://content.healthaffairs.org/subscription_s/etoc.dtl

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

Not for commercial use or unauthorized distribution
Going Beyond A ‘Philosophy Of Care’

A focus on providing quality and value to patients is what’s most important, says the American Medical Association.

by William F. Jessee, Reed V. Tuckson, and Linda L. Emanuel

The “philosophy of care” set forth as a part of the American Association of Health Plans’ (AAHP’s) “Putting Patients First” initiative is and should be welcomed. It represents an important first step in assuring that persons enrolled in managed care plans can receive good health care. And managed care at its best can be a valuable tool for maintaining and improving patient and community health. A well-designed and well-operated managed care plan emphasizes prevention of illness and promotion of health as well as treatment of illness. Such a plan educates its enrollees to be prudent users of health care. And it uses a multidisciplinary approach to managing illness, both acute and chronic, to maximize patient health status and minimize illness-related dysfunction.

The American Medical Association (AMA) has set forth its perspective on high-quality managed care in a recent document, “Essential Characteristics of a Quality Health Plan.” As one might expect from organizations concerned with the provision of the best possible health care services, there is considerable consistency between the AMA “essentials” and the general philosophy of the AAHP’s initiative.

However, managed care organizations have demonstrated in a number of highly visible and widely publicized instances in recent years that they do not always function in accordance with the principles now espoused by the AAHP. Issues such as constraint of open patient/physician communication, restricted access to needed services, and utilization management policies indifferent to individual patient needs are important concerns for patients, health professionals, and responsible health plan administrators alike. When these issues are not appropriately addressed and when quality of care is not the primary concern, skepticism is inevitable. In the final analysis, it is the quality of the medical care available to all American people and the outcomes of that care that are significant.

Beyond the various care models. Physicians, the health plan industry, and—most importantly—patients are not well served by polemical diatribes among advocates for different models of care. The common goal of physicians and health plans is to provide all patients with care that is both appropriate and accessible. High-quality managed care, focused on patients’ health, can be one approach to achieving that goal. But managed care, like its more traditional “unmanaged” forebear, may be abused. When such abuses occur, whether they are intentional or unintended side effects, patients and communities may be harmed. Patient advocates from both the medical profession and the health plan industry have an ethical obligation to point out such circumstances when they arise and to demand improvements.

Of particular importance to physicians and to the public in this era of market-driven health care, with its many, often competing interests, is protecting the sanctity of the

William Jessee is vice-president, quality and managed care standards, at the American Medical Association (AMA), in Chicago. Reed Tuckson is group vice-president, professional standards, and Linda Emanuel, vice-president, ethics standards, at the AMA. All three authors are physicians. Health Affairs invited this Perspective in response to the Commentary by David Jones.
patient/physician relationship. What is important is not whether managed care is “good” and fee-for-service is “bad” or vice versa. It is not whether the media have blown anecdotes out of proportion or whether an association’s response is “serious” or a public relations ploy. What is important is for physicians, health plan managers, and associations to share a common focus on providing quality and value to patients.

■ Tension of interests. If the primary concern of the health plan community is to determine the most responsible means through which it can help to achieve this goal, then it must carefully assess the issues it faces. A central theme of David Jones’s paper is what he calls “an inevitable tension of interests” among purchasers, consumers (patients), practitioners, and health plans. For many large, publicly traded health plans there is yet another party to that tension: shareholders seeking the best rate of return on their investment. Chief executive officers (CEOs) of such health plans face an inherent tension between the goals of their shareholders and the needs of patient care. Investors invest in publicly owned health plan companies to earn a good return on their investment from plan profits, and plan CEOs have a fiduciary obligation under state law to take prudent actions toward that end. Health care goals, on the other hand, require maximum availability of resources for health care services and in this sense compete with profit margins. Unfortunately, some health plan managers may at times resolve these tensions by actions that do not give preeminence to the interests of the patient.

The tensions among the parties involved in health care need to be understood in all of their complexity and must not be oversimplified. For example, are purchasers really only interested, as Jones states, in “cutting costs”? Or are purchasers really more interested in assurance of value in the health care they buy? Do we believe that consumers want “unlimited choice” of plans? Or do they really want access to the services that they need, when they need them, in a fashion that makes them feel that their concerns about illness are recognized and respected, not trivialized and ignored? Don’t most patients want to have a relationship with their physician that is based on mutual trust and caring, not confused by potential economic or ethical conflicts or subject to disruption by administrative intrusions into a very private part of their lives? And do most physicians simply want “to be left alone”? Or do they really want to be recognized as professionals, respected for their clinical knowledge and judgment, and supported in the unique patient/physician relationship so necessary for therapeutic action? Responsible physicians are willing to be accountable for the cost and quality of the care they provide, so long as they are judged by scientifically valid guidelines and standards to which they have easy access. The AMA’s new program for physician accreditation, the American Medical Accreditation Program (AMAP), is one concrete example of the profession’s willingness to be accountable.

■ Steps toward accountability. At the end of the day, what matters is whether health plans, and health professionals, are successful in maintaining and improving patients’ health. For the individual patient and physician, it is more important to know the quality of their health plan, including patient outcomes and satisfaction with care, than to know the philosophy embraced by the managed care industry as a whole. The positive aspects of the AAHP’s Putting Patients First statement of philosophy are welcomed by physicians, as they should be by society at large. But the AAHP and its member plans must do more to make that philosophy a recognized part of the managed care industry. As first steps, we propose the following:

“The use of unvalidated ‘black box’ clinical guidelines should be foresworn by AAHP member plans.”
(1) The AAHP must develop a mechanism through which it can enforce its philosophy among its member plans and that enforcement must involve some form of credible external review. Accreditation of all member plans might be one mechanism for accomplishing this objective.

(2) The health plan industry and its trade association must acknowledge that there is variation in performance among health plans, just as there is among practitioners and among hospitals under the “old system.” Comparisons of plan satisfaction rates and measures of quality and regular publication of those comparative data will enhance public confidence as well as stimulate plans to improve.

(3) AAHP member plans must submit the clinical guidelines and utilization protocols that they use to scientific review. The AMA recently started a “clinical guidelines recognition program” to encourage the use of evidence-based, scientifically valid, clinically current practice guidelines. The use of unvalidated “black box” clinical guidelines should be foresworn by AAHP member plans.

(4) Health plans should be aggressive in assuring that they provide fair, open, and understandable due-process procedures for reviewing and resolving patients’ and physicians’ grievances.

Action on these recommendations will go far toward assuring the public that health plans, like physicians, are willing to be accountable. That healthy accountability is necessary and welcome. What matters is that health care professionals and the organizations they work with and in share a commitment to the health of the patients that we all serve.

NOTES
4. Millenson, “‘Miracle and Wonder’.”