A Physician’s View Of Managed Care
by Lawrence Kahn

These are times of difficult adjustment for American physicians. Their longstanding, established, and exclusive governance of the nation’s health care delivery system is being challenged successfully. Commercial health care companies are preempting physicians’ traditional control by instituting new methods of payment for professional and hospital services. Through such reimbursement mechanisms, these businesses claim the ability to manage health care, institute cost containment, and assure the distribution of care to the sick.

Evidence of increasing complexity, cost, and inaccessibility of health care for many people argues convincingly for change in the structure and management of health care for Americans. The commercial health care industry has recognized this and has developed health management companies that are growing rapidly in size and number. It is predicted that almost all health care will come under formal management within the next decade. With the Reagan administration showing interest in privately funding Medicare, private insurance may well increase its share to include government programs.

Commercial health management companies base their operations on changing business relationships with physicians. This new approach can harm American health care. The manner in which commercial organizations are managing health care, not the concept of managed care itself, is at fault. The hazard is in the excessive financial vulnerability imposed on physicians and the negative influence of that vulnerability on their professional behavior.

Profession Or Business?

American physicians are indoctrinated in professional principles that reflect Western concepts of the rights and responsibilities of patients and those that serve them. Modern ethicists have translated these concepts as

Lawrence Kahn, a pediatrician, is professor of pediatrics and health care research at Washington University School of Medicine, St. Louis, Missouri.
forms of social covenants or contracts between patient and physician. They emphasize physicians’ essential obligations to their patients. Medicine is governed by explicit measures of competence and performance, a code of behavior, and rules of responsibility. These criteria establish physicians as those who are capable of and responsible for caring for the sick. Medicine is a profession, not a business.

The process of delivering medical care is another matter. It concerns the process of providing appropriate medical skills at affordable costs, the adequate and timely distribution of those skills according to the standards of the society it serves. Medical care includes organizational structure, cost control, and efficiency. While closely allied to the implementation of professional skills and judgment, those aspects of providing health care lend themselves readily to management skills. In some countries, health care delivery is considered a public service and is placed under public governance. In the United States, organized medicine has resolutely defended the policy of delivering medical care in the private sector. Physicians consistently have chosen to play by the rules of marketplace economics, preferring the vagaries of private entrepreneurship to government regulation. Until now, health care delivery mainly has been in the hands of private, self-employed physicians. Today it remains in the private sector; however, it is rapidly being “cornered” by corporate entities and will be produced, packaged, marketed, and governed by them.

The major attraction of health management companies is their effort to contain costs. These companies offer payers more controlled delivery systems for comprehensive health care at premiums competitive with conventional indemnity health insurance. Terms and structure vary, but, in general, subscribers to these plans may obtain care at modest or no personal cost, beyond any premium contribution, as long as they are attended by physicians and go to hospitals that are under contract with the management company. Management companies control the system through contracts with payers, patients, physicians, and hospitals.

The business functions of health management companies are principally those of insurance companies plus the added undertaking of actively controlling costs. This is implemented by negotiating lower rates from physicians and hospitals and by limiting the management company’s risk for provider costs. It is also accomplished by requiring authorization for a range of services including subspecialty consultation and inpatient care, as well as by assigning physicians the responsibility to monitor utilization.

Payment to physicians may be by discounted fee-for-service according to prescribed fee schedules or by fixed pricing in the form of capitation for each enrolled patient. In many plans, personal financial risk is imposed on physicians to indemnify the company’s potential losses. If
the plan loses money, a portion of the physicians’ assigned reimbursement is forfeited. Capitation and risk are presented to the physicians as “incentives to encourage cost containment.” Physicians view it as being forced to assume the underwriting role for the company.

Physicians contract with these organizations to retain established patients and to be accessible to new ones. Rewards for the companies come from the financial use of the money they hold through premium collection and profits gained from premium income less cost of health care. Their success depends on enrolling large numbers of subscribers. In a competitive marketplace, the key variable is a low premium.

For cost constraint, health management companies depend mainly on physicians, who play the major role in determining the costs for their patients’ care. Since the company controls the physicians’ compensation, methods of reimbursement have been established that correlate directly to the physician’s performance in containing costs. Physicians are required to act as gatekeepers controlling access to health services. They are expected to stay within allocated costs by prudent use of technology, consultation, inpatient care, and their own time.

Impact Of Managed Care On Quality

There are good reasons why physicians are discontented with these arrangements. Governance by commercial management companies can lower the quality of health care in several major ways. First, and of greatest concern, physicians who are required to assume financial risk based on utilization costs may be intimidated sufficiently to alter professional judgment in caring for sick people.

Second, that nonmedical persons govern physicians as gatekeepers is a pernicious intrusion on the physician/patient covenant. It erodes confidence in professional advice. Patients do question physicians’ motives for outpatient versus inpatient care or for discouraging consultation.

Third, since commercial companies own the patient contracts, physicians will have to accept the imposition of lower rates of remuneration through various payment arrangements to avoid the risk of losing some of their practice. Currently, the impact of these agreements under managed care is still usually minor, since relatively small numbers of patients are involved. If all health care were to come under health management in the private sector, however, physicians would have to prepare themselves for substantial reductions in income. Primary care physicians at the lower end of the range of physician incomes would feel this most acutely. Even the simplest discount arrangement without personal financial risk would require severe economic penalty. Risk arrangements are potentially even more pernicious. Young physicians entering practice may reluctantly accept this as part of the new world, but
established physicians may not be in a position to adjust to this condition. Accepting income loss will be destructive for many physicians with established financial commitments. To regain income, physicians would have to work harder; however, seeing more patients in less time or in a state of fatigue can only lead to dangerously low quality of care.

Fourth, despite procedural and financial constraints, commercial health management companies take the position that they do not deny care. They limit their management only to their financial responsibility to cover patient care within the range of benefits. If the care proposed is not covered, the physician and patient are so advised. Physicians have difficulty with this arrangement because benefits are developed exclusively by the company and may not allow for the necessary flexibility for the individuals served.

Fifth, using physicians to reduce cost to operate for-profit businesses successfully could create a deeply resentful medical profession. Relationships between physician and manager could be bitter and antagonistic. Disillusionment and frustration could be reflected ultimately in a dissatisfied and poorly served public.

Finally, in the long run, the greatest risk to physicians and their patients is that physicians under commercial health management often are totally dependent on the company and have no power to affect corporate decisions. What will protect physicians, and how can they defend patients from increasingly stringent rules of performance and decreasing pay, when competition for commercial dominance becomes heated in the health care marketplace?

A serious moral and economic hazard exists when the physician serves as economic gatekeeper under certain contracts now imposed by commercial health care companies. Physicians are required to respond to two masters simultaneously. Patients seek them out as healers, while the company requires that corporate dollars be preserved. The interests of each will be in conflict when the needs or wants of one master become harmful to the other. These arrangements challenge the primacy of professional obligation.

Physicians' Role In Managed Care

In a culture in which the demand and need for health care exceeds the ability to pay for it, prudent use of health resources is a necessity. How that can be accomplished equitably and effectively remains a question. Imposing on physicians an intolerable mechanism derived from rigorous business concepts is not the answer. Physicians must contribute to the solution.

Managed health care is needed. Physicians will be gatekeepers and will have to work with health managers. Physicians, by education and
training, are most qualified and must be important participants in implementing such activities. It is a role they traditionally have had no interest in filling, and their performance shows it. That must change. The medical profession must participate vigorously in accountability. What is dangerous is that the concept of physician accountability is being abused by some commercial companies. That applies to reward as well as risk. Evidence suggesting the detrimental effects of such abuse has already begun to appear.

Veatch has addressed this issue eloquently in discussing the role of physicians in for-profit organizations. While they are obligated to put patients’ interests before their own, it is unrealistic and unreasonable to expect physicians to adhere to this concept no matter how damaging the exercise of their professional behavior will be to their own interests. Some degree of self-interest is inextricable from professional behavior.

There is a role for management organizations in the health care system, but not in the control of professional behavior. If command of health care is placed with commercial health management companies, one can expect the primary function to be to conduct their enterprise in a proper, rigorous, and disciplined fashion; business is business. But when companies focus on cost and profit rather than on delivering health care as the major objective to achieve success, then it is cost and profit alone, not from what they are derived, that determines the level of health care. Thus, the business of health management companies should be confined to the services they provide well, such as development and marketing. They should manage actuarial and underwriting services and information systems, not physicians.

Physicians must manage physicians. The transition in delivering medical care brings the new function of modern administrator to the medical profession. Physicians need to know how health management or insurance companies work. They need to understand the setting of premiums, ranges of benefits, and payment of claims. They will have to learn about the percentage of premium retention and margins of reserve. Physicians must participate in setting the limits of risk based on objective and measurable criteria of safety for patient care, limits that are, as yet, unknown. No way now exists to measure when the threat of personal financial loss or the lure of extra monetary reward becomes large enough to encroach on professional allegiance to the patient. Most of all, physicians should establish in clear terms their obligations to their patients.

What assurance is there that physicians can and will do a better job than those, however well-meaning, who are not physicians? As persons, physicians are no different from the rest of their community. However, there is a single characteristic factor for believing they will be medically responsible health care managers. In exchange for their unique authority as physicians, they have undertaken the inherent obligation to serve as
the moral agent for their patients. That position, the root of their profession, cannot be abandoned.

In a society that encourages pluralism, it is likely that new and improved systems will be developed that allow for a more equitable apportionment of financial risk on physicians, patients, and insurance carriers. To that purpose, physicians from all practice settings need to work together to protect their profession and their patients in the newly emerging environment of managed health care.

NOTES

6. How a typical primary care physician would be affected if all fees were discounted can be shown by using the example of a general pediatrician, since a recent study has revealed the economics of that practice. (American Medical Association, Council on Long-Range Planning and Development in cooperation with the American Academy of Pediatrics, “The Future of Pediatrics: Implications of the Changing Environment in Medicine,” Journal of the American Medical Association (10 July 1987): 240-245.) The average annual gross income of pediatricians is $166,200 with an average overhead of $89,100, leaving a net income before taxes of $77,100. The reported average discounted fee is approximately 13 percent (Gabel et al., “The Commercial Insurance Industry in Transition”). Thus the discount applied to the gross income amounts to $21,600. The discount of $21,600 can be deducted from the net income only, since overhead cost is not reduced. Pediatricians’ personal income would be $55,500, actually a 27.3 percent reduction under this arrangement.
9. Pelligrino, “Toward a Reconstruction of Medical Morality.”