Policy Review

April 1, 2002

The doctor-patient breakdown: Trouble at the core of the medical economy.

Alper, Philip R.

WITH AMAZING SPEED, American medicine is evolving in uncharted directions. Managed care has transformed a "cottage industry" run by highly individualistic physicians into a far more controlled enterprise in which many other players wield major influence, both financial and professional. In the process, two medical economies with greatly differing perspectives and fortunes have emerged. Once mutually supportive, their relationship has deteriorated.

The core economy comprises the work and economic output of physicians and related professionals who diagnose and treat patients themselves. Though medical doctors are licensed and regulated, they have historically been accorded substantial autonomy and a primacy among peers, much like that accorded the captains of ships. Privileges and authority have been closely coupled with reciprocal obligations and responsibilities for both. The captain may command, but he is the last to leave the ship; physicians may give the orders, but they are not free to abandon patients or to refuse to give care in emergency circumstances. Physicians tend to work longer hours and more years than other professionals.

The peripheral economy provides the financing, management, and technology that support the care of patients. Enterprises as diverse as manufacturing drugs and writing health insurance policies all contribute to

patient care, though not independently. The face of modern medicine would be very different without this peripheral economy, but it is physicians who ultimately give the orders that are required to diagnose and treat patients.

The distinction between core and peripheral medical economies may appear to be either arbitrary or a misnomer, not least because the "peripheral" medical economy accounts for more than 80 percent of health dollars. Remarkably, until recently, the "core" earnings of physicians have remained fixed at 18 percent to 20 percent of health expenditures despite all the innovations of the past 50 years – Medicare, managed care, new technologies, and a doubling of the number of practicing physicians. The consistency of physician earnings in relation to the rest of the medical economy suggests that physicians have occupied a constant place even as the structure of health care has undergone dramatic change. The peripheral economy, meanwhile, has enjoyed remarkable success under managed care. In one fabled success story, nonprofit California Blue Cross was on the verge of insolvency in 1992 when it reinvented itself as for-profit WellPoint and went on to become a $6.77 billion corporation by 2001. The pharmaceutical industry has also enjoyed record profitability. On the other hand, Healtheon, now WebMD, failed to realize its dream of "capturing the doctor's desktop" and making itself indispensable to health care – despite the prestige and resources of its founders. And physician management companies, once Wall Street favorites, have failed spectacularly, leaving physicians skeptical of overarching controls.

But in general, the peripheral economy has been successful. And perhaps unsurprisingly, the success of the peripheral economy has provoked a backlash. State

medical associations in New York, Florida, and California are suing major managed-care insurers for a variety of practices, including take-it-or-leave-it contracting and retroactive lowering of physician fees. Frequent inflammatory statements from CEOs of Aetna and WellPoint have heightened the adversarial climate; the two companies have recently been embroiled in litigation over unfair business practices. Physicians have protested bitterly as their incomes have fallen and their autonomy has eroded in a managed-care world that blurs the roles of insurer, physician, and patient.

Ironically, managed care first emerged with the pledge to modernize and streamline medicine's cottage industry. Yet, in practice, fragmentation of authority has become pervasive. Employer associations and even individual employers sometimes set target standards – and specify dosages for medications. HMOS decide whether to pay for MRI scans, angioplasties, and bypass surgery. At the same time, alternative health practitioners – chiropractors, acupuncturists, herbalists, spiritualists, and a host of others – see more patients than all primary-care physicians and osteopaths combined. (Incongruously, many managed-care plans provide insurance coverage for a portion of this care.)

Reduced authority does not diminish physicians' legal liability. Most risk remains with the physician, rather than with the insurer or the employer who chooses and funds HMO insurance, because generally only physicians are legally empowered to direct patient care. More important, the Employee Retirement Income Security Act of 1974 (ERISA), which aimed to stimulate the growth of HMOs, continues to shield HMOs from responsibility even when there is reason to believe their actions have injured

patients. This exemption has been one of the key points of dispute in the congressional and White House wrangling over the Patients' Bill of Rights.

Is it the HMO, with its power to approve or deny payment, that is realistically at fault when coverage for care is withheld and the patient then fares poorly? Or is the physician who prescribes the treatment, but who has no authority to compel payment, responsible for the consequences? Is refusal of payment merely that – or is it tantamount to vetoing the physician's therapeutic recommendations? Passionate disagreement over such issues preoccupies the courts, the Congress, and the media. Not only is it a matter of who is in charge, but also of who should be in charge. The core medical economy and the peripheral medical economy, then, are often at odds. Yet it is hard to imagine how medicine can long be successful unless the two economies support each other. They are, however, drifting farther apart – and in certain respects, it looks like a reckoning is drawing closer by the day.

Searching for "best practices"

AT THE HEART OF THESE disputes is a concern that doctors do not entirely know what they are doing. For both financial and quality reasons, government and the managed-care industry agree that non-doctors should monitor and stimulate change in physician behavior.

There is a real basis for their distrust. John Wennberg's landmark study of "small area variation" revealed that hospital utilization for equivalent illnesses in Medicare patients was significantly higher in Boston than in New Haven. In other studies, hysterectomy and prostate surgery rates showed comparable discrepancies

from one locale to another – sometimes between adjacent towns. Angioplasty and cardiac surgery rates varied in similar fashion. In these and many other cases, there was no discernable medical reason to explain a disparity that seemed to be more a question of medical style than anything else. The physicians in question, despite their widely differing approaches, were all convinced that they were doing the right thing for their patients.

Intuitively, one would think there ought to be a "right" way, or at least a best way, to treat an infection or heart attack or to do a particular operation, but doctors seem to have trouble reaching agreement. Where treatment methods differ, are there negative consequences for patients? As medical journals considered the question, employers and insurers joined in the search for "best practices." Since employers finance their employees' health insurance, they reasoned, the employer ought to receive maximum value for his money. Insurers claim that better preventive practices and treatment yield better patient outcomes at a lower cost.

A new statistical tool – meta-analysis – aids the quest to identify the best treatments. Heretofore, it was difficult to compare one research project with another because studies are never identical; even minor differences in method make drawing conclusions difficult. Meta-analysis circumvents this problem by analyzing all published studies together, differences notwithstanding, and using statistical methods to extract useful information. Acceptance of meta-analysis is not universal, however. In one case, proponents reported unsuspected cardiac risks with two of the newer antiarthritic drugs. Opponents deny the significance of the report.

In any event, more powerful literature review has boosted the international effort to create an "evidence-based medicine." The Cochrane Collaboration, headquartered in Great Britain, coordinates input from around the world. Evidence-based medicine and best practices lead seamlessly to the creation of "clinical guidelines," templates for physicians to follow in the care of specific illnesses or clinical situations. Detractors call this cookbook medicine. Proponents praise it as state-of-the-art.

Medical specialty societies, the National Institutes of Health, as well as individual health plans and physician groups have produced several thousand guidelines. Because no guideline can encompass all cases – and because some guidelines remain more a matter of expert medical opinion than of proven fact – guidelines generally are considered advisory rather than mandatory. When medical cases end up in court, however, plaintiffs' attorneys portray clinical guidelines as immutable laws and deviation from them as malpractice.

Ironically, the original impetus to put medical practice on a sounder scientific footing, to limit variations in practice, and to improve patient outcomes came from within the medical establishment – not as a response to employers, insurers, or angry consumers. Academic physicians pioneered the application of scientific analysis to medical practice. Major journals, including the New England Journal of Medicine and the Journal of the American Medical Association, have devoted significant space to such efforts. But to their collective chagrin, the reform effort was commandeered by the employer-insurer-consumer coalitions that represent the managed-care movement. From the start, issues of quality, freedom, and money undermined the fundamental logic of this medical

revolution. The primary physician, for example, was loudly touted as the best person to decide when to make specialty referrals. After all, who knows the patient better? And who else could better understand the medical issues? Besides, hadn't research shown that specialists spend much more money than primary physicians when they treat the same illnesses? And weren't all parties in the coalition united in wanting to reduce rapidly rising medical costs? But in so designating the primary physician, the managed care movement also in effect recast that doctor's role in the system.

From personal physician to gatekeeper

FOR YEARS, the American Society of Internal Medicine had spoken For of the internist as a "personal physician," who would act as a patient's guide through the health system. It was clear that the relationship between doctor and patient would be voluntary and focused exclusively on the patient's welfare. The patient would command the total loyalty of the doctor. Managed care adopted the concept of the personal physician but changed its meaning in a major way.

The personal physician became the "gatekeeper" physician – a manufactured being with multiple loyalties extending far beyond the actual patient. Gatekeeper primary physicians were to approve referrals to appropriate specialists and authorize in-patient hospital care – all within the context of making the best use of each health plan's financial resources. As it later turned out, this often proved to be a thankless task, the primary physician serving as a barrier to consultations and treatments that patients desired but which did not fit the doctor's or health

plan's definition of medical necessity. During the patients' rights debate, a New York Times editorial praised the pending legislation because both the House and Senate versions "provide patients with prompt access to emergency care and specialists, such as pediatricians and gynecologists, without a referral from a primary care physician." Primary care case management is now seen as safeguarding the profits of insurance companies.

Many physicians worried about an inherent conflict of interest. A few chafed at being required to conserve resources without any influence on how such savings would be redirected. But none could argue that there wasn't waste in free-choice medicine. The American Academy of Family Physicians actively promoted the idea of managed care as a more rational way to maximize resources, rein in excesses found in specialty care, and bring payers and physicians closer to agreement on what constitutes good medical practice. They promoted family practitioners as the ideal primary care providers because of their wider range of services compared to internists or pediatricians. Federal and state governments allocated funds to support an increase in the proportion of primary versus specialist physicians from the one in three found in the United States to closer to two out of three, the typical ratio in other Western nations where per capita health expenditures were lower.

Initially, employers were reluctant to interfere with their employees' choice of physicians and hospitals. "Indemnity" insurance that paid a percentage of charges was the norm. In order to promote and lend respectability to a theoretically less expensive medical "system," Congress passed the HMO Act in 1973. It required businesses with more than 25 employees to offer at least one HMO option

among their health insurance choices. Physicians were promised access to more patients in return for discounted fees.

This was a marriage seemingly made in heaven. With access to discounts, employers escaped the double-digit rate of medical inflation in the 1980s. Insurers were able to limit their risk not only by securing discounts, but also by contracting with individual physicians or medical groups to supply a range of services at pre-determined rates, usually on a per-patient-per-month basis. These "capitation" payments essentially exported the insurance risk from the carriers to the physicians.

For the first time in medical history, physicians were pressed to consider the welfare of the entire population of patients served by an insurer's health plan as their collective responsibility – even if it meant not doing all they could for any individual patient. Thus, managed care began to affect medical practice on an unprecedented scale. Power passed from health professionals to insurers and coalitions of employers like the Pacific Business Group on Health.

Throughout this process, "trimming the fat in the system" was supposed to save money without harming patients. There were some notable successes. Ever since the 1946 Hill-Burton Act provided federal money for hospital construction, the number of U.S. hospitals had steadily increased to more than 7,000. Many had low occupancy rates and raised charges to offset high fixed costs. There seemed to be no political will to eliminate unnecessary beds and even less to close unnecessary facilities. As with military bases, local jobs and patronage were involved. Insurance carriers kept writing ever-larger

checks and passing on the costs to employers, who ultimately rebelled. Only then did contracting with hospitals for special rates for newly minted HMO or preferred provider organization (PPO) patients in advance of care replace paying blank-check "usual and customary charges." The result was the elimination of many surplus beds, closure of some facilities, and substantial savings. Medical inflation leveled off – for a while.

The California experience

ECONOMISTS MIGHT ARGUE that the customary laws of supply and demand also apply to physicians. If true, the relationship must be complex. According to the U.S. Census Bureau, California placed eighth in the U.S. in the per capita ratio of doctors in 1990. And yet managed care took firmest root in California – a state that did not have the greatest physician surplus, where fee discounts in exchange for volume should make the most competitive economic sense. Today, many doctors are leaving the state, which has now slipped to twelfth in doctor-patient ratio. Low pay and high living costs are cited.

Managed care is currently embattled not only with the Patients' Bill of Rights, but also with the more fundamental problem of a public tired of restrictions but unwilling to pay more for less intrusive management. Nevertheless, managed care should have considerable staying power, given its incentive structure that empowers insurers, acting on behalf of employers (and less clearly of patients), to bottom-fish the medical marketplace and pay the minimum acceptable contractual rates to physicians and other providers of care.

California Blue Cross has justified questionable practices – including unilateral retroactive fee reductions to physicians – as attempts to secure the most services from providers of care at the least cost, thereby benefiting consumers. As a result, the California Medical Association has been pursuing litigation against Blue Cross for several years. Judge David Garcia of the San Francisco Superior Court, who recently approved class action for the latest suit, noted the power imbalance between the plan and the physicians – and the threat to physicians' economic survival of not agreeing to treat the more than 2 million Blue Cross patients on Blue Cross's terms.

Until recently, employers considered nothing but price in choosing health insurance. One survey of insurance benefit managers showed that only 7 percent even considered quality of care to be a principal consideration in their choice of health plan. Physicians are incredulous that, in an age of gourmet foods, designer clothing, and custom housing, medical care has been relegated to lowest-dollar status. From the physicians' perspective, their vocation has been commoditized.

A recent study in the Archives of Internal Medicine tracked this process in San Mateo County, California, where medicine has experienced a managed-care-induced industrial revolution of sorts that has dramatically affected all aspects of medical practice. From 1993 to 1998, two very large purchaser organizations spearheaded a four-year progressive reduction in health premium rates throughout California. The Pacific Business Group on Health – comprising 45 large employers who purchase health benefits for 3 million employees, retirees, and their families – and CalPERS, the retirement fund which plays the same role for 1.2 million public employees, had

demanded and won reductions that then benchmarked the market rates for other insurers. Statewide premiums fell to 21 percent below the U.S. national average by 2000. San Mateo County, where the costs of living and of producing services are among the highest in the country, was especially impacted. The county now has the lowest cost-adjusted medical insurance payouts in the nation.

The funding gap has created a medical depression in San Mateo County, which has otherwise participated in the unparalleled wealth creation of the hitech boom. In centrally located Burlingame, the average house price is $810,000; physicians are failing to qualify for home loans. The renowned Palo Alto Medical Clinic, despite more lucrative insurance contracts than its neighbors and a well-funded foundation, was forced to stop accepting new patients for primary care in 2001 by an inability to attract new physicians to provide care.

Nearly three-fourths of the local populace now belongs to an HMO. As the least expensive non-charitable health choice, employers often offer only HMO coverage to their employees. If Medicare, Medicaid, and PPO patients are added, the number of patients treated under contract rises above 90 percent. One-third of the population is treated by the Kaiser-Permanente system, a prepaid multispecialty HMO 0 group practice. Given these numbers, only a handful of physicians do not participate in managed care. Robert Merwyn, president of Mills Peninsula Hospital in Burlingame, reports that 97 percent of patient billings at his hospital are subject to contractual discounting. Most of the remaining 3 percent of the charges are never paid.

All health providers have struggled to deliver care more economically. A majority of physicians have joined

independent practice associations (IPAS), which interface with insurance companies, negotiate payments to doctors, and set fees. Some are paid fee-for-service. Other physicians receive the per-head, per-month "capitation" payments in exchange for their agreement to provide all necessary care within their expertise around the clock. Capitation rates vary from $8 to little more than $20 monthly, except for infants and the elderly, where rates are higher.

IPAS save physicians from the Herculean task of dealing with the contracting, utilization review, and other administrative departments of multiple insurance carriers – a necessity unless the physician wants to put all his financial eggs in one or two insurance-carrier baskets. IPAS really are quasi-insurance organizations. In California, the recent Speier law has subjected them to solvency standards. With little beyond the doctors' own capital to support most of them, more than 20 IPAS filed for bankruptcy in zooo. More than half currently fail at least one of four tests of fiscal solvency, according to Daniel Zingale, director of the California Department of Managed Health Care. The CEO of one of the surviving IPAS concedes that he lacks the funds to audit the payments made by insurance carriers.

Physicians have seen their investment in IPAS disappear along with large chunks of their accounts receivable. (IPAS are less common outside California, but IPA failures in Texas, a state very medically different from California, shows that their vulnerability is not a local aberration.) IPA critics also observe that IPAS insert a layer of administration that consumes 10 percent to 15 percent of the insurance premium beyond the 20 percent

to 30 percent taken by health plans for administration and profits.

Pressure on physicians relates to physician supply, the extent of penetration of managed care, and the degree to which employers exert downward financial pressure on insurance premiums. Massachusetts, for example, has a high managed-care presence and 52 percent more physicians than the national average. Median physician earnings reported by the Massachusetts Medical Society were $219,300 in 1998, dropping to $120,600 in 2000 – and much lower than the median national physician earnings reported by the American Medical Association of $199,600 in 1997 and $194,400 in 1998. As HMO penetration increases, non-HMO insurance premiums tend to fall and financial stress is brought to bear on the system. California has six of the top 10 HMO counties in the nation, the highest being Sacramento with 75 percent penetration. San Mateo County is fourth at 72 percent.

The inefficiencies of managed care

TO WHAT DEGREE are these processes self-adjusting? Physician recruiter Martin Fletcher explains that a high managed-care presence is just as likely to undermine physician earnings in high cost-of-living areas (Boston and San Francisco) as in places where costs are low or marginal (Florida and Philadelphia). Pockets of acute distress occur when steep discounting, rapidly rising office expenses (up 61 percent in Massachusetts since 1994 after adjustment for inflation), and high cost of living combine. A physician exodus has become apparent in Boston, Buffalo, New York, and Sacramento County,

California, where the number of physicians dropped 20 percent from 1995 to 2000.

Until recently, most HMO patients were very happy. But approximately 80 percent are not ill and never experience the more burdensome restrictions of HMO care. At the same time, they benefit from low rates and freedom from paperwork, both of which are highly popular. Under California's Knox-Keene law, patient liability is limited to small co-payments, usually $5 to $15. Even if the health plan cannot pay its bills, physicians are prohibited from charging patients for care rendered but for which the physician was never paid. Nor can physicians immediately stop treatment.

Patients who are accustomed to the lower out-of-pocket costs of HMOS (which typically include prescription drug benefits) are loath to leave. A Kaiser Family Foundation survey reported in September 2001 that despite the brouhaha about patient rights, the majority of HMO patients remains satisfied. Since most of the discontent is found among the minority who use medical services more intensively, this is unlikely to change radically anytime soon.

Financial pressures normally stimulate economies, but physicians have encountered a paradox. Managed care has demanded and imposed elaborate bookkeeping, slowdowns in payments, difficult processing of patient eligibility, burdensome paperwork, and numerous bottlenecks to care, such as lengthy approval processes for individual prescriptions. Many of these provisions infantilize physicians, who must repeatedly seek permission from lesser-trained employees of health plans. The complexities also drastically raise overhead costs. Over the past two

decades, typical primary care office expenses rose from one-third to two-thirds of income, mainly due to the increased administrative demands of managed care and Medicare, both of which have been superimposed on other inflationary pressures.

Spyros Andreopoulos, former public affairs director at Stanford Medical Center, has examined the inefficiencies of managed care. California's problems are anything but unique, he writes, "a symptom of a widening national crisis driven by ill-considered actions and flawed market-driven health policies." Yet few such commentaries exist apart from the complaints of those working within the system.

Medicine has been fragmented by a maze of ever-changing contracts that may make economic sense to insurers but whose success often comes at the price of exporting additional costs and inconvenience onto physicians and patients. Given the implausibility of adhering to a dozen or more Aetna or Blue Cross or other carrier-specific drug formularies, practice guidelines, and preventive medicine schedules (and of altering them every time a patient changes insurance carriers), it appears that managed care has invented the horse – in the automobile age. Unfortunately, it is not yet politically correct to say so.

Physicians accuse managed care of not covering their costs and of "predatory pricing," while managed care responds that they are paying market rates. Blue Cross in California and Texas have aroused particular ire because of especially low payments and hard-nosed bargaining techniques, such as permitting contracts to lapse and then negotiating after enormous patient-care dislocations have

already taken place. The fee pressures of HMOS also apply to PPOS, which are misleadingly named because the preferred providers in these organizations are distinguished only by a willingness to sign the carriers' typically non-negotiable contracts.

Under the year 2000 Blue Cross PPO contract, reimbursement dropped from $5 per minute for the first five minutes to under $2 per minute for 45 minutes. For a full-hour consultation, the physician donated the last 15 minutes free of charge. Considering that office overhead for an internist generally runs at $130 to $150 hourly, it is hard to economically justify remaining in practice without creating something akin to a Medicaid mill. Other insurers also compress their fee schedules, similarly punishing physicians who spend more time with their patients or who accept complex time-consuming cases.

In California, six health plans control more than 80 percent of the market. Physicians have followed lawyers and accountants in "bulking up" to augment their negotiating clout, but unlike the Sutter Hospital Group with its statewide network of hospitals, they have not been successful in winning either substantially better rates or anything close to a pro rata share of rising health insurance premiums. The average capitation rate reached its pinnacle of $45 per patient per month in 1993, according to PriceWaterhouseCoopers. By 1999, it had fallen to $29 while the cost of living jumped 25.2 percent over the intervening six years.

"There's cost sharing between all of us – hospitals, insurers, doctors – because of growing inflation, pharmacy costs, etc.," PacifiCare spokesman Tony Salters told the Dallas Morning News. "Everyone is being affected by it."

There are some odd features to the relationship, however. Physicians in separate practices cannot bargain collectively because of anti-trust laws. They find themselves sitting at the table with far more powerful and wealthy competitors for the same dollars and, as in the story about the man who eats with a lion, discover that the lion eats first. At the moment, local lions are flexing their muscles. Stanford hospitals have canceled all HMO contracts and the University of California has cancelled its agreement to see San Mateo Medi-Cal patients. Such events make physicians nervous because they must take up the slack during contract disputes. Primary physicians become the ultimate guarantors of the system when specialty care becomes unavailable.

Some physicians, hoping to level the playing field, supported legislation by California Rep. Tom Campbell that would have allowed limited collective bargaining. The bill passed the House in 2000, surviving concerted Republican attempts to amend or undo it on behalf of the insurance industry (presaging the debate on the Patients' Bill of Rights). The Senate, however, did not act on it. In the process, the American Medical Association became convinced that its longtime Republican political allies were now so much in thrall to the insurance industry that they no longer cared about physicians. In zoo 2001, the AMA's campaign contributions to Democrats for the first time exceeded those to Republicans – and by a wide margin. This reflects an emerging reality: that the free market in which doctors compete against one another for patients is being transformed into a competition among insurance carriers that marginalizes physicians.

Managed competition vs. managed care

MOST AMERICANS RECEIVE health care on a fee-for-service basis, but a different delivery mode has been offered by the Kaiser-Permanente Plan, the nation's largest pre-paid group practice health plan that is responsible for the care of 8.1 million patients. This is the model that Stanford's Alain Enthoven had in mind when he conceived the idea of "managed competition" among a handful of integrated care systems analogous to the major automakers.

The Kaiser-Permanente structure was the original conception of "managed care," a large physician group setting its own professional standards, while financing and the provision of facilities are handled by the "Kaiser" component of the duality forged by Henry Kaiser and Dr. Sidney Garfield in the 1930S. Permanente physicians do not need formal permission to make referrals. They choose their own drug formularies and create their own preventive and treatment guidelines. In order to achieve this professional independence, the medical group went toe to toe with Henry Kaiser, who would have preferred to control what he paid for.

Apart from Kaiser-Permanente, managed care allows little or no participation by contracting physicians in setting standards for care or in choosing covered laboratories, consultants, preventive care guidelines, and formulary drugs. Typically, plans adapt guidelines like those of the Cancer Society or the Centers for Disease Control of the National Institutes of Health and implement them without external discussion. They hire pharmacy benefit managers to cut deals for the inclusion of drugs on

proprietary formularies. Physicians are then given their marching orders.

Management guru Peter Drucker, who wrote a seminal paper on the utilization of knowledge workers, would point to the lack of buy-in and participation by physicians. Neither morale nor quality of output is facilitated this way. Moreover, the managed care model that treats all physicians as essentially identical when they enter practice and then, years later, still considers them the same regardless of their achievements is unlikely to foster excellence. Likewise, with patients coming and going depending more on the results of employers' changing choices of insurance plans than on the quality of care or patient satisfaction, there seems to be little future in primary care medicine for physicians who thrive on long-term relationships. Indeed, it is hard to identify another business in which good service does not automatically lead to a loyal clientele and long-term relationships.

Managed care's impact in San Mateo County is pervasive. Most physicians are unhappy. More than half experienced actual declines in income and three-fourths failed to keep up with inflation in the 1990S. But dissatisfaction is statistically independent of falling income or medical specialty. Most physicians believe the quality of care has suffered and express frustration with their practices. Most would not want their children to become physicians. The financial and psychological data support the diagnosis of significant depression in both dollar and emotional terms.

The managed-care wars also buffeted Kaiser-Permanente. For three years, the company recorded unusual financial losses due to adverse experiences in

California and the East. According to the Archives study, San Mateo Kaiser Permanente physicians began to reflect the negativism of office-based community physicians, though to a lesser degree. They were far more likely to look with favor on their drug formulary and treatment guidelines, which they or their representatives played a part in creating. Of course, these physicians were preselected for a belief in managed care, or at least a willingness to work with it, so it is difficult to know whether non-Permanente physicians would be good job candidates for managed care in either venue. At present, there seems to be either a maladapted work force or an inappropriate system – or both.

Quality control

"THE SINGLE GREATEST error consumers make is to assume that if doctors disagree, one has to be wrong," says medical librarian Shirley Maccabee. That error also underlies the effort to "manage" medicine, to systematically identify the right way to do things and then call any deviation poor quality. In a sudden shift, employers are no longer satisfied with the lowest insurance premiums. They now want the highest quality for their money. The insurers sponsoring HMOs and PPOs now compete for recognition of the "quality" of their programs as measured by the percentage of women who get annual mammograms and Pap smears, the percentage of diabetics who see an eye doctor, and the number of patients with diseases like congestive heart failure who take specific drugs that are judged to show benefits. The privately owned National Committee for Quality Assurance (NCQA) rates plans by collecting data in a program called the Health Plan

Employer Data and Information Set (HEDIS) and makes the information available to the public online.

But such measures of quality control are problematic. Are primary physicians to hunt down people who don't want to come in? Are they to be penalized for choices made by the patient? Are checklists really a good marker for the overall quality of a physician's skill? Physicians are bewildered as non-physicians continually expand the lists and pontificate about quality, as if physicians are either too lazy or stupid to seek it themselves. It follows that the only reliable advocates for quality patient care are employers and insurers, and that their comprehension of medicine is as least as good as the physician's – so good, in fact, that they don't even need to see the patient to evaluate the quality of care.

But it's inconceivable that a doctor actually treats each patient differently according to the quality precepts of each insurer (Blue Cross backache, Aetna asthma, and Cigna congestive heart failure, for example). It would be utterly confusing to tailor each patient's care to the specific desires of his insurer. Nevertheless, statistics are collected and touted in the marketplace as proof of the quality of one insurer's product over the other. Claimed differences in the results of treatment for asthma, heart failure, or diabetes are more likely to be statistical accidents than indicators of real differences in quality rendered by the doctors seeing each plan's patients. Distortions are guaranteed because NCQA's "Quality Compass" is a marketing tool for employers with more public relations than science behind it. Absurdly, in 2000 and 2001, the NCQA reported great progress in HMO quality at the same time that public anger against HMOs

was mounting rapidly – and the average HMO stock price rose 25 percent.

Medical practice and the human beings who deliver care are surely imperfect. But does that justify shifting so much clinical, financial, and administrative control to non-physicians with enormous vested interests of their own? Should all doctors have to think and do alike in order to be considered good doctors? Should patients put their lives in the hands of physicians who are intent on polishing their report cards under the benevolent guidance of employer-insurer management? That these questions are barely debated points to one of history's greatest bait-and-switch operations. Insurers who have no commitment to any geographic area and who cancel policies at will when profits drop have been made the guardians of medical quality even at the local level. Industry now vies with government in regulating medicine, as Betty Leyerle has eloquently described in The Private Regulation of American Healthcare (M.E. Sharpe,

Whither health care?

WHERE, THEN, IS American medicine headed? If present trends continue, the widespread dissatisfaction with both income and the quality of professional life will extend the decline in applicants to medical schools beyond the nearly 30 percent drop over the past five years. With an average medical school debt of $97,400 in 1999, fewer physicians will come from the middle class because of an unfavorable risk-reward ratio. The wealthy will avoid medicine as a profession, and the need for scholarships to enlist students will grow.

Consumers and non-doctors will play a greater role, with more liberal licensure for non-physician providers of care and more consumer influence over tests and treatments. Consumers will expand self-ordering of hi-tech tests such as total body scans and will win insurance coverage when there are positive findings. Managed care will continue narrowing the role of primary physicians as nurse practitioners and physician assistants perform some of their work for lower fees. This will continue until earnings drop low enough to make primary physicians, with their greater ability to diagnose and treat, more economical than non-physician substitutes.

The use of hospitalists, hospital-based medical specialists for in-patients, will also grow and relegate most primary physicians in metropolitan areas to office practice only. Specialists will continue to dominate American medicine because of public demand for new technology (but they will not regain their former authority over fees). Owing to the use of lower-cost and lesser-trained substitutes, fewer people will have primary physicians for more than short periods. The sole exception will be patients with complex problems involving multiple specialists, in which case primary physicians will be required to integrate care.

Employers and insurance carriers will change tactics in response to anti-HMO sentiment. Health plans are already starting to distance themselves from tight control of consumer choices. Higher co-pays rather than denials of service will continue to grow. Physicians will need to contend with angry patients when their recommendations do not accord with each plan's favored approach, thereby raising out-of-pocket costs. Patients will need to contend with angry physicians as other plans follow PacifiCare's

lead in rating doctors on how low they can keep out-of-pocket costs for patients. Barring catastrophic events that drastically increase the number of uninsured from its current level of 43 million, neither Congress nor the administration will even discuss a single-payer, one-size-fits-all health system.

The outlook for the peripheral medical economy looks bright because the freedom to innovate continues. Health insurance and pharmaceutical and medical device manufacturing, unlike the provision of medical or hospital services, have escaped the price controls of the Mediplans and the major financial hits of managed care. Surging health insurance premiums – up 11 percent from 2000 to 2001 – did not significantly benefit physicians.

Most physicians face major impediments to innovation because, under managed care, compliance has greater survival value than creativity – at least in the short run. Denial of services is viewed as a strike, something most physicians do not favor. The antitrust laws significantly inhibit joint action. Some specialists, notably those in renal dialysis and cancer care, have established their own businesses and negotiate collectively for their services. Primary-care innovation is far less common and has mainly involved substituting lesser-trained personnel for doctors. Furthermore, most physicians seem to have neither interest nor aptitude in creating new business arrangements. Physician executives are increasing in number, but, lacking broad business experience and divorced from patient care, they have an uncertain future.

It appears that the closer to the patient one gets, the less desirable the job becomes, the more the risk of burnout increases, and the greater the appeal of non-medical

jobs at often higher salaries. But high-earning health care executives with an average income of $800,000, not counting deferred compensation, are reportedly seeking retirement before age 65 – also due to job pressures. Paradoxically, health care delivery has grown more dysfunctional even as medical science continues to make unprecedented gains.

As Richard Nixon once said, "Solutions are not the answer." The statement seems applicable to medicine, since no nation has produced a model health system. The U.S. has so far avoided the single-payer "solution" that is finding favor with an increasing number of frustrated physicians. Instead, U.S. medicine continues to make medicine more "businesslike." Given the trends – the majority of young physicians now taking jobs rather than setting up their own practices, increasing educational debt, less willingness to commit oneself entirely to medicine at the expense of family, and fewer opportunities to remain independent – Alain Enthoven's proposal of "managed competition" makes sense.

Enthoven envisioned the appearance of other megaplans modeled after Kaiser-Permanente. But the Kaiser-Permanente system has not been replicated; risking capital in enterprises with limited upside potential and no good exit strategies remains unappealing. What's more, Kaiser-Permanente itself has recently withdrawn from several eastern states and closed facilities due to large financial losses.

Managed care's principal accomplishment has been a temporary slowing of surging health care expenditures. At the same time, HMO growth has stalled and physicians, patients, and their employers are all frustrated. It's

unsurprising that a system that never underwent prototype field-testing before widespread implementation is encountering so many problems. Nor is it surprising that turning a blind eye to waste, duplicative effort, and inefficiency has allowed these problems to multiply.

San Mateo County physicians overwhelmingly agreed that the quality of time spent with patients has deteriorated since the mid-1990S. Much of their time now must be spent choosing drugs that won't be rejected or require lengthy negotiation for approval, checking lists of network consultants, obtaining permission for tests and referrals, and explaining the mysteries of the system that no patient learns in advance. The regulatory hurdles divert attention from what brought the doctor to medicine in the first place and leave both parties dissatisfied. Alternative practitioners are increasingly popular partly because they have fewer distractions and can focus attention more fully on their clients.

Currently, physicians are treated almost generically in high managed care areas. Patients eventually feel the depersonalization experienced by the doctor. PacifiCare is trying to counter this with bonuses for physicians who win high marks from their patients. Whether this will inspire kinder and gentler care is an open question. At least some physicians are offended by popularity contests with insurance companies as scorekeepers. In their view, marketing becomes too important and hard-earned professional competence gets taken for granted.

Continued travel down the current managed-care road will require a new type of doctor with sufficient detachment to function comfortably in the new environment. How well the humanitarian impulses that motivate most

physicians can survive this rather dehumanizing process is unknown. It is a critically important question because doctors must be allowed to be doctors if they are to leaven their technical skills with the empathy that is needed to truly heal patients. For this to happen, the two medical economies must converge and cooperate. The biggest challenge will be to use free-market mechanisms to control costs, improve efficiency, and create a climate in which physicians and patients both can thrive.

M.D., Inc.

TO DO THIS, should doctors become corporate employees? California is one of 37 states that ban the corporate practice of medicine, meaning that non-physicians cannot be the owners of businesses in which physicians treat patients. The law is based on the premise that physicians should be free to exercise professional judgment and remain fully accountable for their actions. But this view has been increasingly challenged as antiquated, anti-efficiency, and blind to current market realities.

Economists and lawyers who wish to reverse the corporate ban see medicine as no different from other business endeavors in which corporate structure has proved useful. Strikingly, however, they have failed to investigate why Kaiser-Permanente, the nation's largest HMO, deliberately chose not to have physicians work for the Kaiser Corporation. Permanente Medical Group historian Steven Gilford explains that the doctors were ready to walk away from i years of work with Kaiser unless they were allowed to retain control of patient care and resource allocation.

Moreover, fluctuations in the business cycle – the idea of hospitals coming and going, personal and business bankruptcies afflicting providers of care, and sudden disappearance of services as corporate assets are redeployed in response to changing market conditions – is a dubious basis for health policy. Sick patients are not likely to be persuaded that the benefits of brand-name medicine are worth the risks. Nevertheless, the experience in states that do allow corporate medical practice does merit scrutiny.

The redesign of health care would benefit from a human resources approach that is free of ideological bias and ill will toward physicians. California is experiencing such growing animosity. The state's HMO czar wants consumers to know whether their doctors are facing insolvency. State Sen. Jackie Speier feels that the solvency legislation she sponsored is being perverted and will fatally undermine doctors' negotiating position with managed care if their private financial status is made public. News coverage insinuates that Speier is coddling doctors. But such coverage proceeds from the widespread (and mistaken) belief that to be pro-consumer, one must be anti-doctor.

A neutral analysis of the doctor's job and the qualities needed to perform it is essential. Efficiency studies should follow. Managed care has shunned this aspect of management because the industry perceives doctors as outside contractors whose welfare and productivity are not of direct concern. Doctors are expensive to train, however; their time would best be spent caring for patients rather than doing paperwork. In order to meet the needs of a varied public, doctors should not be expected to be clones of each other. Checklists should not replace the doctor's

brain if the doctor is to remain clinically sharp. Freedom to prescribe should permit taking advantage of the subtle differences among similar pharmaceuticals to suit the specific needs of each patient. Creativity should not be extinguished in the service of compliance. Accountability – a virtue – becomes a vice when it overwhelms the person subjected to it.

Moreover, excessive regulatory control favors large, well-funded companies and may even put smaller companies out of business without any contest in the marketplace. Since small organizations cannot spread compliance costs in dollars and manpower across a large base, overregulation threatens the economic viability of otherwise healthy solo and small-group practices. Patients who prefer this kind of care may thus experience both a decreased selection of caregivers and higher costs as regulatory expenses pad the ultimate bill.

No solutions have yet emerged because, as yet, there is no agreement on goals. Policymakers should carefully consider the long-term consequences of decoupling the medical economy from the surrounding local economy, as occurred in San Mateo County. Lethal competition among physicians, the young cannibalizing the practices of their seniors with no premium awarded for achievement and experience, promises to compromise the quality of care – as does below-cost contracting for essential services. The economics of putting caregivers at personal risk with no ability to react rapidly to sudden cost increases (such as the recent jump in malpractice premiums) must also be addressed. The emotional needs of physicians and of patients, including the ability to forge long-term relationships, should not be ignored, because they determine the ultimate acceptance of any system. And the question,

"How does being treated by a depressed doctor measure up against flying with a depressed pilot?" should be taken seriously. Most of all, a vibrant, creative, and pluralistic medical profession should not be sacrificed cavalierly.

Managed care has a great deal of work to do if it is to justify the pretension embodied in its name. Legislative assistance may be needed to redirect medical competition toward healthier ends. In the end, a failing core medical economy will not long support the massive health care edifice that surrounds it.

Philip R. Alper, M.D., is a practicing physician, clinical professor of medicine at the University of California, San Francisco, and a visiting fellow at the Hoover Institution.