Research Suspension Sparks Systemwide Review

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After the U.S. Department of Veterans Affairs shut down research programs in its Greater Los Angeles Healthcare System (GLAHS) in March, the VA's undersecretary of health, Kenneth W. Kizer, realized that, rather than defending the facility's "failure to correct deficiencies," he would need to launch a reform initiative.

It is now obvious to most knowledgeable observers that managed care will transform the American health care system. Managed care brought competitive market forces into medicine, and demonstrated that the right financial initiatives can reverse a century of rising professional standards and make health care just another lean and mean downsizing industry.

Economists, like the Nobelist Kenneth Arrow, had cautioned against this. It was axiomatic to him that information is essential for efficient markets. He warned that ordinary families would never have enough information to make prudent decisions in a free health care market. Lester Thurow of the Massachusetts Institute of Technology emphasized that free markets also cannot solve ethical problems of equitable distribution. Harvard's medical economist Rashi Fein wryly observed that in health care, "The invisible hand of the market is all thumbs." None of these warnings were heeded.

As it turns out, managed care may pose more risks for ordinary Americans than these economists had anticipated. Managed care is not a free market for doctors and patients. The market is dominated by organized health plans that exercise enormous market power. These health plans are more responsive to their primary clients, corporate America, than to patients who want better care. Many economists had recognized that the kind of market competition necessary to reduce the spiraling cost of health care would involve organized systems (like HMOs) competing for enrollment. That is what we now have, and even advocates of such market competition have begun to acknowledge that there are problems.

Virtually all Americans are now subjected to the methods of managed care or are enrolled in managed care plans (where they are now counted as covered lives). It is helpful to think of this as private sector regulation imposed by middlemen who require doctors to treat patients in ways that will reduce the cost of health benefits paid by corporate America.

Managed care plans have had enough market power to force doctors and hospitals to accept private regulation and lower their professional standards of care. The most dramatic examples of this are the shortening of hospital stays, the decline in the length and number of doctor visits, and the marked decline in referrals to specialists.

Although this is typically defended as "cutting out the fat," there is by now considerable evidence of adverse consequences for patients. Managed care's middlemen are themselves insulated from liability for these adverse consequences even if the harm to the patient can be traced directly to their restrictions. They are legally immunized by a 1974 federal statute (ERISA) originally intended to protect employee benefits. Market forces and ERISA protection are the two blades of the scissors that are cutting up American health care.

Mental health care is a small but salient piece of this complex tapestry of change. Health insurance policies have traditionally limited the coverage available for mental health care. Consumers, led by the National Alliance for the Mentally Ill, lobbied long and hard for parity-coverage for mental illness equal to physical illness.

This effort in the past few years has resulted in the passage of federal and state laws requiring parity in mental health benefits, but the inroads of managed care have made it a meaningless paper victory. Managed care had already been working behind the scenes to ration the psychiatric treatment patients receive no matter what benefits they have been promised on paper.

The impact of managed care on psychiatric services, in fact, provided many early examples of what was in store for the rest of health care. Managed care was particularly ruthless in restricting psychiatric hospitalizations and long-term psychotherapy. Even with parity, the mentally ill will end up receiving less care than ever before.
The general public has slowly begun to realize that managed care may not be about better or more comprehensive health care, as the advertisements on television have claimed. The pinch of managed care is not felt until someone in the family is really sick and people suddenly confront restrictions and limitations they did not expect. Titanic and the Iceberg

As more and more families have begun to feel that pinch, so has the medical profession. Hospitals are closing all over America. Many in the medical community are demoralized, particularly psychiatrists who have been replaced by social workers in many managed care plans. Unfortunately, the public debate about managed care for the past two decades has been a confusing melange of opinions in which lobbyists, lawmakers, ethicists, physicians and economists argue about different paradigms. Physicians can certainly debate within the paradigm of science which treatments and systems of treatment are more efficacious based on outcome studies. Bioethicists can debate in their paradigm about distributive equity and professional ethics. But market forces constitute the iceberg that makes all of these arguments irrelevant.

Inside the "Titanic," experts can debate about economic class stratification, the qualifications of captain and crew, the high technology advances in its naval architecture and so forth, but the critical issue for the Titanic was the iceberg, and for American medicine it is market forces. Managed care may be bigger and move faster than previous health care systems, but when it hits the iceberg of market forces it will sink and there will not be enough life boats for all the patients. Doctors who advocate managed care have underestimated the power of the market and they have overestimated their own professional autonomy.

Your managed health care plan (MHCP) is a business, and doctors are its de facto employees. Business success is measured by the difference between how much money MHCPs collect in premiums (how many covered lives) and how much their doctors spend on care. For-profit MHCPs are the fastest growing sector of the market, and it is estimated that the most profitable MHCPs take in as much as 30 cents out of every premium dollar they collect for management, marketing and profit.

This business-oriented approach to health care now dominates an increasingly lean-and-mean system of competing MCHPs. And, as we shall see, the not-for-profit MHCPs have been forced into that competition. The near future looks like a race to the bottom in which for-profit and not-for-profit MHCPs will employ even more drastic cost-cutting methods while their television ads misleadingly promise patients more comprehensive and personalized care.

The key to managed care is control of doctors. Doctors make the decisions that allocate most of a health plan's money. Under managed care, however, they no longer have the freedom to use their own professional judgment, and are subject to private regulation. Every decision that a doctor makes is computerized, micromanaged and manipulated by the MHCP. For example, a psychiatrist now typically needs the MHCP's permission to hospitalize a depressed and suicidal patient. The plan, not the psychiatrist, controls the patient's length of stay. It may even limit the choice of antidepressant medication, all with the intention of reducing costs. MHCPs routinely limit the number of psychotherapy sessions and divert patients from more qualified to less qualified mental health professionals.

Using the least costly provider is standard practice in MHCPs. In the treatment of physical ailments, nurses replace general practitioners, who in turn replace specialists. In mental health care, whenever possible, technicians replace psychiatric nurses, who replace social workers, who replace psychologists, who replace psychiatrists. Market forces have driven the most prestigious not-for-profit MHCPs to utilize the least expensive providers. All this private regulation goes on without patients being informed or giving their consent.

Many MHCPs now dictate the kind of psychotherapy the patient can have as well as who the therapist will be. Typically the MHCP claims to be concerned about clinical efficacy, but the obvious trend in psychiatry is toward the least expensive alternative. Computerized records allow the MHCP to identify as "outliers" the mental health professionals who adhere to higher and more expensive standards.

Most physicians participating in an MHCP are "employees at will." The MHCP has the legal right to eliminate any or all of them from their list of qualified providers without "showing cause" or explaining its reasons. Doctors who do not follow the dictates of the MHCP are in fact eliminated and their patients sent elsewhere.

The power the MHCP has over medical professionals has made doctors seriously consider unionization. The medical profession has also lobbied for legislation that would change the legal status of physicians as employees at will. But MHCPs have developed computerized profiles allowing
them to select only those doctors who have adapted to their lean-and-mean standards of care. And the evidence suggests that when physicians control their own MHCPs, they are at least as sensitive to market pressures as are non-M.D. entrepreneurs.

All of these top-down constraints on the treating physicians are intended to protect the health plan's bottom line. Many MHCPs use ingenious economic incentives to induce doctors to lower costs. A percentage of fees and salary is withheld and then given as a year-end bonus depending on the doctor's bottom line. These practices are widely accepted, and the only debate concerns such a large a percentage of money creating an unacceptable conflict of interest. Many MHCPs simply shift their own economic incentives directly onto the doctor-patient relationship. Doctors' incomes in those MHCPs are based on capitation, i.e., covered lives. The more covered lives doctors take responsibility for, the greater their income. Doctors, just like MHCPs, can maximize their economic advantage under capitation by delegating care to nurses, spending less time with their patients and covering more lives. The inevitable result is less consideration for patients and more doctors with their eyes on the bottom line. Managed care is bringing welfare medicine to the middle class.

Perhaps the most unfortunate aspect of this economic pressure on the doctor-patient relationship is that doctors will no longer have the time to get to know their patients or establish a real caring relationship of trust with them. Primary care physicians are told that to be more "productive," they must spend no more than 10 to 15 minutes with patients. Nurses or technicians take the patient's history to speed the process, and patients are directed to nurse practitioners when they have questions and for routine care.

By controlling their doctors in these ways, MHCPs can cut costs and even be very profitable in the short term. Entrepreneurs recognizing this opportunity have jumped into the MHCP market, competing with the idealistic physicians who had started not-for-profit plans like the Harvard Community Health Plan.

The for-profit sector of MHCPs expanded quickly through mergers and acquisitions and invested heavily in Madison Avenue marketing to increase enrollment, while pushing for still greater reductions in cost and lower prices for corporate America. Every health care plan in America, including not-for-profits, has felt compelled to follow this example as they are caught up in the competition for enrollees or (in the new jargon) covered lives.

The methods of managed care are now everywhere in American medicine. Use of the least expensive provider and lower standards of care were a necessary part of market competition imposed on medical professionals who, as individuals, had no market power. When independent physicians tried to organize and resist these competitive pressures as a group, they were accused of violating the antitrust laws.

As previously noted, MHCPs are particularly restrictive of the patients' length of stay in psychiatric hospitals. General hospitals with surplus beds are best situated to provide the short-term hospitalization emphasizing psychopharmacological treatment that the MHCPs increasingly demand. Indeed, managed care has created a new specialist, the "hospitalist," whose only contact with patients is during the few days of hospitalization.

This kind of specialization is heralded as an example of efficiency, but it has a hidden cost for patients. There is no longer even the expectation that there will be continuity of care. Psychiatric hospitals geared to long-term care are now on the endangered species list, and the infrastructure of long-term care has been dismantled. This means that the next generation of psychiatrists increasingly will be trained in outpatient clinics and general hospitals under the restrictions imposed by managed care, and inevitably they will accept those restrictions as the prevailing professional standard. How Did we Get Here?

How did American physicians, with their great traditions and scientific breakthroughs, become just another commercial enterprise vulnerable to the iceberg of market forces? There were many steps along the way to the current competing systems in which physicians are de facto employees rather than independent professionals.

One important step was mistakenly called the health maintenance organization. The ideal of the HMO was to reduce medical costs by providing patients more preventive health care based on the age-old idea that an ounce of prevention is worth a pound of cure. That kind of commonsense wisdom sounds right, but is it feasible in practice? For example, it would be wonderful if HMOs could prevent people from overeating, substance abuse, smoking and high-risk sexual activity. But the track record of the medical profession in this kind of prevention is not very good. Furthermore, it turns out that beyond routine inoculations, preventive health measures can be quite expensive and of debatable value to patients. And if staying healthy is the goal, much more depends on what patients do for themselves than what the HMO can provide.
In any event, the evidence suggests that the HMO's ideal of preventive health care has become more of a Madison Avenue slogan (still much in use) than a reality. In fact, the HMO is like any other prepaid group plan (PGP) that reverses the doctor's economic incentives, because the less care it gives the more money the HMO makes. Whether it is called an HMO, a PGP or an MHCP, the cost-effective "prevention strategy" is to prevent sick people from entering your plan. Obviously, the healthier patients are, the less care they will need. MHCPs, therefore, compete for healthy populations and try to avoid sick people.

The key organizational feature of the HMO and the MHCP is the consolidation of the role of the insurance company/fiscal intermediary with the role of provider. Although consolidation occurs in many different ways, the ultimate objective is the control of doctors. It is important to reemphasize that these consolidated organizations compete to serve corporate America, which has been trying for decades to reduce the costs of health benefits to employees. Before MHCPs became available, employers would try to reduce relentlessly rising health care costs by limiting benefits or shifting some of the premium costs to employees. Employees recognized what was happening and resisted losing their established benefits.

MHCPs, because they work behind the scenes regulating doctors' decisions, allowed corporate America to lower costs in ways that their employees did not recognize as consequential. Typically, the MHCPs promised the same or greater health benefits including all "medically necessary care." By managing doctors, they redefined what was medically necessary and rationed out the promised benefits within the constraints of the plan's new protocols.

Mental health benefits were an early target of these protocols. Instead of being hospitalized, a patient would be sent home with depression. Instead of seeing a psychiatrist for psychotherapy, the patient would be referred to a social worker. Instead of being provided with more expensive medications, the psychiatrist would be limited to a list of less expensive, older generic drugs prepared by the MHCP. Whether or not one believes that such restraints on professional judgment lead to better or worse care, one thing is quite clear: Ordinary families had no idea what was happening, while corporate America knew what it wanted and got it. Lee Iacocca, for example, claimed that managed care saved Chrysler billions of dollars.

Corporate America is the most important client for MHCPs not only because it chooses the plans and pays most of the bills, but because its employees and their families tend to be healthier and are therefore cheaper lives to cover. The MHCP bottom line "prevention" strategy, as we saw, is to enroll these healthy people. MCHPs compete for them by lowering the premium corporate America has to pay.

This economic reality of price competition for healthy patients is part of the iceberg the idealistic physicians who began HMOs like the Harvard Community Health Plan did not adequately take into account. They hoped to create community-based health systems that would reach out to the whole population, rich and poor, sick and well. They wanted to provide quality care to the entire community. Physicians, they thought, would be in control of the plan and would maintain the high clinical standards promulgated by their profession.

The Harvard Community Health Plan was to be for the future what the great Harvard teaching hospitals had been for the past. Their plan would be "not-for-profit," and there would be no economic incentive to overtreat. They thought they could do all of this for less than the going rate of traditional fee-for-service health insurance, and 25 years ago they were right. They did not expect that in time other MHCPs, some of them profit-oriented, would be able to compete with them. These competitors would try to "pick the cherries" out of their community-the healthy employees of corporate America. Price competition from MHCPs that offered lower premiums to get lower risk populations pulled the economic rug out from under the high-minded doctors. The patients who stayed with the better quality plans tended to be sicker people who knew the value of what they were getting. Employers could easily induce healthier, younger populations to shift to the least expensive MHCPs. Sick people who were loyal to the plan that had treated them well drove up the cost of its premiums.

This was a kind of market competition in which better care to grateful patients paved the way to financial doom. The iceberg of market forces loomed ahead for their Titanic. Idealistic physicians tried and are still trying to resist lowering their standards of care, but eventually they will be forced to adopt the methods and standards of their competitors or their plans will go bankrupt.

It is important to recognize that MHCPs are supposed to cover all the health care needs of enrollees, mental as well as physical. Mental health care has always been the stepchild of medicine, and under managed care it is increasingly an unwanted stepchild. Market Forces and Ethics

The market forces that I have been describing inevitably have a significant impact on traditional medical ethics, which are rooted in the doctor-patient relationship. Managed care gives doctors an
economic incentive to redefine and ration necessary care. This creates a conflict of interest for the doctor, who loses money if he gives his patients too much care. This conflict has been obscured and rationalized by proponents of managed care. One of the idealistic goals of some physicians who began the not-for-profit HMOs that became competing MHCPs was the idea of equal access. Equity of access is an important social and political goal, but it is not derived from the essence of medical ethics, which is fidelity of the doctor to the patient. It may be a higher moral principle than is found in medical ethics, but it can and does conflict with the doctor's traditional duty and the patient's traditional expectations.

The idea that physicians have an ethical responsibility to conserve and distribute equitably the resources of the community, the so-called medical commons, was proposed as an ideal by physicians who cared about social justice. The basic idea is that if everyone unrestrainedly consumes a limited resource there will soon come a time when there is nothing left for anyone. Promoters of MHCPs, in addition to their claims of economic efficiency and more comprehensive care, have sometimes made the moral claim that they are protecting the medical commons.

Many of the leaders of the managed care movement in psychiatry were drawn from the ranks of the community mental health movement-the public sector-where equal access and distributive justice is a critical responsibility. Public sector psychiatrists had long worried about how to make do with a limited budget, and they were responsible to the community rather than to individual patients. Whether or not these psychiatrists' moral convictions are correct, their distributive commitments and the newly conceived duty of stewardship were not fully understood by people who considered themselves private patients fully covered by health insurance.

When someone in your family is sick you want everything possible to be done. You are not prepared for the idea that your physician has an "ethical" concern about expending too much of the community's resources. The ethical principle, however, is somewhat easier for the doctor to justify when the MHCP is not-for-profit and he is not getting a bonus or enriching the shareholders by conserving the "medical commons."

But as noted, many MHCPs are now in fact run for profit! The treating doctors in such plans who continue to claim they are conserving communal resources seem to have lost their moral compass. They are like the employees of any other commercial enterprise. The resources that those doctors save line their own pockets and become the profits of the shareholders. Even in not-for-profit plans, salaries and bonuses depend on conserving resources. Until we eliminate the economic incentives, the ethics of saving the commons is self-interest masquerading as distributive justice. Oligopsony This highly critical description of MHCPs and their changing standards of practices, if it is accepted, provokes two questions that have not yet been answered. First, how did MHCPs get so much market power? And second, if standards of care have deteriorated, why are the MHCPs not worried about huge malpractice suits?

The answer to the first question requires the reader to understand an obscure term used by economists, "oligopsony." Oligopsony describes a market in which there are only a few purchasers and very many sellers. When MHCPs began to consolidate the insurer and provider functions, one of the first steps they took was to tell patients which doctors and which hospitals they could use. This is the foundation of their market power. Instead of millions of patients making choices, the plans chose. Hospitals and doctors had previously relied on their professional reputations to attract patients. That typically meant that they provided noticeably high-quality care. Plans, however, were interested in price, not quality. If hospitals and doctors did not accept their more frugal standards of care and the attendant savings, they sent their patients elsewhere.

By restricting hospitalizations and referrals to specialists, MHCPs sharply reduced the demand for medical services, and in many parts of the country they created an oversupply of hospital beds and specialists. Then, using their oligopsonistic purchasing power, MHCPs forced even the best teaching hospitals and academic physicians to lower their standards and the attendant cost. The middlemen who controlled MHCPs could make or break the most high-minded doctors, because they had oligopsonistic control of the marketplace.

The final question to be answered here is why MCHPs are not worried about malpractice liability when they are systematically reducing standards of care. After all, if depressed and suicidal patients are now being kept out of the hospital or sent home too soon, there have to be risks—but they are usually not the burden of the MHCP.

The legal issues are complicated, but the general outline is clear. ERISA has allowed managed care to thumb its nose at prevailing medical standards of care and tailor its services to the needs of its primary consumer, corporate America. Two of ERISA's provisions have been interpreted by the federal courts as specifically protecting corporate America's health plans from any interference by
state legislation or malpractice claims. Until ERISA is amended, state legislatures can pass laws that allow patients to have greater access to specialists or longer hospital stays, but they cannot require corporate America's MCHPs to comply with such state laws. State legislatures have already passed a variety of laws to restrain MCHP practices and protect the autonomy of physicians, but until the federal courts break with precedent or Congress amends ERISA, these state laws can have no effect. Even more remarkable is ERISA's protection of MCHPs and their private regulators from malpractice liability. The Department of Labor has argued in recent cases that the courts have misunderstood the intentions of Congress in interpreting this provision of ERISA. However, under current law the patient cannot sue the plan for damages even though its protocols, restrictions and incentives clearly caused harm. Patients can, of course, still sue their doctor, the hospital and any other provider who is not protected by ERISA. But the people who regulate the doctors for corporate America are free and clear of liability. Congress now fully recognizes these unintended consequences of ERISA, and legislation to amend it has been filed (PT February). As one might imagine, corporate America is lobbying tooth and nail against such amendments. Even if Congress does have the fortitude to amend ERISA, the risk of malpractice liability is not enough to reverse declining standards of care. If the for-profit sector of MCHPs continues to grow, the doctor-patient relationship will probably continue to be "commodified" and driven by market forces in the restructured systems of health care. As we approach the millennium, America's health care system in its commercial version continues the race to the bottom. The smart money on Wall Street will get in and then get out of MCHPs before the system crashes into the iceberg and middle-class Americans realize what unrestrained capitalism has done to their once vaunted system of health care.

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