BEDSIDE MANNA

MEDICINE TURNED UPSIDE DOWN

BY DEBORAH A. STONE

For more than 150 years, American medicine aspired to an ethical ideal of the separation of money from medical care. Medical practice was a money-making proposition, to be sure, and doctors were entrepreneurs as well as healers. But the lodestar that guided professional calling and evoked public trust was the idea that at the bedside, clinical judgment should be untainted by financial considerations.

Although medicine never quite lived up to that ideal, the new regime of managed care health insurance is an epic reversal of the principle. Today, insurers deliberately try to influence doctors' clinical decisions with money—either the prospect of more of it or the threat of less. What's even more astounding is that this manipulation of medical judgment by money is no longer seen in policy circles as a corruption of science or a betrayal of the doctor-patient relationship. Profit-driven medical decisionmaking is extolled as the path to social responsibility, efficient use of resources, and even medical excellence.

How did such a profound cultural revolution come about? What does the new culture of medicine mean for health care? And where does it leave the welfare state and the culture of solidarity on which it rests when the most respected and essential caregivers in our society are encouraged to let personal financial reward dictate how they pursue patients' welfare?

MONEY AND MEDICINE

Before the mid-nineteenth century, the business relationship between doctors and patients was simple: The patient paid money in exchange for the doctor's advice, skill, and medicines. However, to win acceptance as professionals and be perceived as something more than commercial salesmen, doctors needed to persuade the public

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that they were acting out of knowledge and altruism rather than self-interest and profit. Organized medicine built a system of formal education, examinations, licensing, and professional discipline, all meant to assure that doctors' recommendations were based on medical science and the needs of the patient, rather than profit seeking.

In theory, this system eliminated commercial motivation from medicine by selecting high-minded students, acculturating them during medical training, and enforcing a code of ethics that put patients' interests first. In practice, medicine remained substantially a business, and no one behaved more like an economic cartel than the American Medical Association. The system of credentialing doctors eventually eliminated most alternative healers and, by limiting the supply of doctors, enhanced the profitability of doctoring. Nonetheless, medical leaders espoused the ideal and justified these and other market restrictions as necessary to protect patients' health, not doctors' incomes.

It took the growth of health insurance to create a system in which a doctor truly did not need to consider patients' financial means in weighing their clinical needs, so long as the patient was insured. As Columbia University historian David Rothman has shown, private health insurance was advertised to the American middle class on the promise that it would neutralize financial considerations when people needed medical care. Blue Cross ads hinted darkly that health insurance meant not being treated like a poor person—not having to use the public hospital and not suffering the indignity of a ward. Quality of medical care, the ads screamed between the lines, was indeed connected to money, but health insurance could sever the connection.

By 1957, the AMA's Principles of Medical Ethics forbade a doctor to "dispose of his services under terms or conditions that tend to interfere with or impair the free and complete exercise of his medical judgment or skill. . . ." This statement was the apotheosis of the ethical ideal of separating clinical judgment from money. It symbolized the long struggle to make doctoring a scientific and humane calling rather than a commercial enterprise, at least in the public's eyes if not always in actual fact. But the AMA never acknowledged that fee-for-service payment, the dominant arrangement and the only payment method it approved at the time, might itself "interfere with" medical judgment.

Meanwhile, as costs climbed in the late 1960s, research began to show that fee-for-service payment seemed to induce doctors to hospitalize their patients more frequently compared to other payment methods such as flat salaries, and that professional disciplinary bodies rarely, if ever, monitored financial conflicts of interest. Other research showed that the need for medical services in any given population was quite elastic, often a matter of discretion, and that doctors could diagnose enough needs for their own and their hospitals' services to keep everybody running at full throttle.

Still, the cultural premise of these controversies expressed a clear moral imperative: Ethical medicine meant money should not be a factor in medical decisionmaking. The new findings about money's influence on medicine were accepted as muck that needed raking. Occasional exposés of medical incentive schemes—for example, bonuses from drug and device companies for prescribing their products or kickbacks for referrals to diagnostic testing centers—were labeled "fraud and abuse" and branded as outside the pale of normal, ethical medicine.

The Path Not Taken

Sooner or later, the ideal of medical practice untainted by financial concerns had to clash with economic reality. Everything that goes into medical care is a resource with a cost, and people's decisions about using resources are always at least partly influenced by cost. By the 1970s, with health care spending hitting 9 percent of the gross national product (GNP) and costs for taxpayers and employers skyrocketing, America perceived itself to be in a medical cost crisis. Doctors and hospitals, however, resisted cost control measures. By the late 1980s, neither the medical profession, the hospitals, the insurers, nor the government had managed to reconcile the traditional fee-for-service system with cost control, even though the number of people without health insurance grew steadily.

During these decades, a pervasive antigovernment sentiment and a resurgence of laissez-faire capitalism on the intellectual right combined to push the United States toward market solutions to its cost crisis. Other countries with universal pub-

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lic-private health insurance systems have watched their spending rise, too, driven by the same underlying forces of demographics and technology. But unlike the U.S., they rely on organized cooperation and planning to contain costs rather than on influencing individual doctors with financial punishment or reward. Some national health systems pay each doctor a flat salary, which eliminates the financial incentive to over-treat, though it might create a mild incentive to under-treat. Systems with more nearly universal health insurance schemes also eliminate expensive competition between insurers, because there is no outlay for risk selection, marketing, or case-by-case pretreatment approval, and far less administrative expense generally.

Countries with comprehensive systems typically plan technology acquisition by doctors and hospitals to moderate one of the chief sources of medical inflation. Most also limit the total supply of doctors, or of specialists, through higher-education policy. They may restrict doctors' geographic location in order to meet needs of rural areas and dampen excess medical provision in cities. Most countries with universal systems have some kind of global budget cap. But the difficult medical trade-offs within that budget constraint are made by clinicians under broad general guidelines, and not on the basis of commercial incentives to individual doctors facing individual patients. Significantly, although government is usually a guiding force in these systems, planning is done by councils or commissions that represent and cooperate with doctors, hospitals, other professions, medical suppliers, insurers, unions, and employer associations.

The distinctive feature of the emerging American way of cost control is our reliance on market competition and personal economic incentive to govern the system. For the most part, such incentives are contrived by insurers. In practice, that has meant insurers have far more power in our system than in any other, and it has meant that they insert financial considerations into medical care at a level of detail and personal control unimaginable in any other country.

Reconfiguring the Role of Money

The theorists of market reform reversed the traditional norm that the doctor-patient relationship should be immune to pecuniary interests. Law professor Clark Havighurst, HMO-advocate Paul Ellwood, and economist Alain Enthoven and their disciples celebrated the power of financial motivation to economize in medical care. In the process, they elaborated a moral justification for restoring money to a prominent place in the doctor's mind.

In what is probably the single most important document of the cultural revolution in medical care, Alain Enthoven began his 1978 Shattuck Lecture to the Massachusetts Medical Society by explaining why he, an economist, should be giving this distinguished lecture instead of a doctor. The central problem of medicine, he said, was no longer simply how to cure the sick, eliminate quackery, and achieve professional excellence, but rather how people could "most effectively use their resources to promote the health of the population." Enthoven dismissed government regulation as ineffective. The key issue was "how to motivate physicians to use hospital and other resources economically." It was time, he concluded, for doctors to look beyond the biological sciences as they crafted the art of medicine, and to draw on cost-effectiveness analysis.

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In Enthoven's vision, researchers would incorporate cost-benefit calculations into clinical guidelines; health plans would give doctors incentives to follow these guidelines; and if patients were allowed to shop for plans in an open market, the most efficient plans would win greater market share. We could succeed in "Cutting Costs Without Cutting the Quality of Care," as the title of his lecture promised. The ultimate safeguard against financial temptations to skimp on quality or quantity of care, according to Enthoven, was "the freedom of the dissatisfied patient to change doctors or health plan."

In market theory, consumers are the disciplinary force that keeps producers honest. In applying classical market theory to medicine, theorists such as Havighurst and Enthoven confused consumer with payer. By the late 1970s, when medical care

was paid for by private and public insurers or by charity, patient and payer were seldom the same person.

Precisely this ambiguity about the identity of the consumer gave market rhetoric its political appeal. It papered over a deep political conflict over who would control medical care—insurers, patients, doctors, or government. Market imagery suggested to insurers and employers that they, as purchasers of care, would gain control, while it suggested to patients that they, as consumers of care, would be sovereign. For a brief while in the 1970s and 1980s, the women's health movement and a Ralph Nader-inspired health consumer movement adopted market rhetoric, too, thinking that consumer sovereignty would empower patients vis-à-vis their doctors. For their part, many doctors came to accept the introduction of explicit financial incentives into their clinical practice, because, they were told, it was the only alternative to the bogey of government regulation. ("Health care spending will inevitably be brought under control," warned Enthoven in his Shattuck Lecture. "Control could be effected voluntarily by physicians in a system of rational incentives, or by direct economic regulation by the government.")

Enthoven's early approach relied only partly on the discipline of personal reward or punishment for doctors. He also advocated doing more research on cost-effectiveness and educating of doctors to make better use of scarce resources. And like Ellwood, Havighurst, and most advocates of market competition in medicine, Enthoven recognized the differences between medicine and ordinary commerce when he argued that competition had to be regulated in order to limit opportunism and enable patients to discipline insurance plans. But the heavy overlay of regulation originally envisioned by Enthoven and others was not established. While some HMOs have been more diligent than others in bringing quality and outcomes research to bear on medical practice, monetary incentives have become the paramount form of cost discipline.

Remaking the Doctor as Entrepreneur

Today, financial incentives on doctors are reversed. Instead of the general incentives of fee-for-service medicine to perform more services and procedures, contractual arrangements between payers and doctors now exert financial pressures to do less. These pressures affect every aspect of the doctor-patient relationship: how doctors and patients choose each other, how many patients a doctor accepts, how much time he or she spends with them, what diagnostic tests the doctor orders, what referrals the doctor makes, what procedures to perform, which of several potentially beneficial therapies to administer, which of several potentially effective drugs to prescribe, whether to hospitalize a patient, when to discharge a patient, and when to give up on a patient with severe illness.

In most HMOs, doctors are no longer paid by one simple method, such as salary, fee-for-service, or capitation (a fixed fee per patient per year). Instead, the doctor's pay is linked to other medical expenditures through a system of multiple accounts, pay withholding, rebates, bonuses, and penalties. Health plans typically divide their budget into separate funds for primary care services, specialists, hospital care, laboratory tests, and prescription drugs. The primary care doctors receive some regular pay, which may be based on salary, capitation, or fee-for-service, but part of their pay is calculated after the fact, based on the financial condition of the other funds. And there's the rub.

Studies of HMOs by Alan Hillman of the University of Pennsylvania found that two-thirds of HMOs routinely withhold a part of each primary care doctor's pay. Of the plans that withhold, about a third withhold less than 10 percent of the doctor's pay and almost half withhold between 11 and 20 percent. A few withhold even more. These "withholds" are the real financial stick of managed care, because doctors are told they may eventually receive all, part, or none of their withheld pay. In some HMOs, the rebate a doctor receives depends solely on his or her own behavior—whether he or she sent too many patients to specialists, ordered too many tests, or had too many patients in the hospital. In other plans, each doctor's rebate is tied to the performance of a larger group of doctors. In either case, doctors are vividly aware that a significant portion of their pay is tied to their willingness to hold down the care they dole out.

Withholding pay is itself a strong influence on doctors' clinical decisions, but other mechanisms tighten the screws even further. Forty percent of HMOs make primary care doctors pay for patients' lab tests out of their own payments or from a combined fund for primary care doctors and outpatient tests. Many plans (around 30 per-

cent in Hillman's original survey) impose penalties on top of withholding, and they have invented penalties with Kafka-esque relish: increasing the amount withheld from a doctor's pay in the following year, decreasing the doctor's regular capitation rate, reducing the amount of rebate from future surpluses, or even putting liens on a doctor's future earnings. A doctor's pay in different pay periods can commonly vary by 20 to 50 percent as a result of all these incentives, according to a 1994 survey sponsored by the Physician Payment Review Commission.

Of course, not all HMOs provide financial incentives that reward doctors for denying necessary care. In principle, consumers could punish managed care plans that restricted clinical freedoms, and doctors could refuse to work for them. But as insurers merge and a few gain control of large market shares, and as one or two HMOs come to dominate a local market, doctors and patients may not have much choice about which ones to join. The theorists' safeguards may prove largely theoretical.

In the early managed-market theory of Enthoven and others, the doctor was supposed to make clinical decisions on the basis of cost-effectiveness analysis. That would mean considering the probability of "success" of procedure, the cost of care for each patient, and the benefit to society of spending resources for this treatment on this patient compared to spending them in some other way. But in the new managed care payment systems, financial incentives do not push doctors to think primarily about cost-effectiveness but rather to think about the effect of costs on their own income. Instead of asking themselves whether a procedure is medically necessary for a patient or cost-effective for society, they are led to ask whether it is financially tolerable for themselves. Conscientious doctors may well try to use their knowledge of cost-effectiveness studies to help them make the difficult rationing decisions they are forced to make, but the financial incentives built into managed care do not in themselves encourage anything but personal income maximization. Ironically, managed care returns doctors to the role of salesmen—but now they are rewarded for selling fewer services, not more.

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Who Cares?

Because doctors in managed care often bear some risk for the costs of patient care, they face some of the same incentives that induce commercial health insurance companies to seek out healthy customers and avoid sick or potentially sick ones. In an article in *Health Affairs* last summer, David Blumenthal, chief of health policy research and development at Massachusetts General Hospital, explained why his recent bonuses had varied:

> Last spring I received something completely unexpected: a check for $1,200 from a local health maintenance organization (HMO) along with a letter congratulating me for spending less than predicted on their 100 or so patients under my care. I got no bonus the next quarter because several of my patients had elective arthroscopies for knee injuries. Nor did I get a bonus from another HMO, because three of their 130 patients under my care had been hospitalized over the previous six months, driving my actual expenditures above expected for this group.

Such conscious linking of specific patients to paychecks is not likely to make doctors think that their income depends on how cost-effectively they practice, as market theory would have it. Rather, they are likely to conclude, with some justification, that their income depends on the luck of the draw—how many of their patients happen to be sick in expensive ways. The payment system thus converts each sick patient, even each illness, into a financial liability for doctors, a liability that can easily change their attitude toward sick patients. Doctors may come to resent sick people and to regard them as financial drains.

Dr. Robert Berenson, who subsequently became co-medical director of an HMO, gave a moving account of this phenomenon in the *New Republic* in 1987. An elderly woman was diagnosed with inoperable cancer shortly after she enrolled in a Medicare managed care plan with him as her primary care

doctor, and her bills drained his bonus account:

> At a time when the doctor-patient relationship should be closest, concerned with the emotions surrounding death and dying, the HMO payment system introduced a divisive factor. I ended up resenting the seemingly unending medical needs of the patient and the continuing demands placed on me by her distraught family. To me, this Medicare beneficiary had effectively become a "charity patient."

Thus do the financial incentives under managed care spoil doctors' relationships to illness and to people who are ill. Illness becomes something for the doctor to avoid rather than something to treat, and sick patients become adversaries rather than subjects of compassion and intimacy.

Here is also the source of the most profound social change wrought by the American approach to cost containment. Health insurance marketing from the 1930s to the 1950s promised subscribers more reliable access to high-quality care than they could expect as charity patients. But as it is now evolving, managed care insurance will soon render all its subscribers charity patients. By tying doctors' income to the cost of each patient, managed care lays bare what was always true about health insurance: The kind of care sick people get, indeed whether they get any care at all, depends on the generosity of others.

Insurance, after all, is organized generosity. It always redistributes from those who don't get sick to those who do. Classic indemnity insurance, by pooling risk anonymously, masking redistribution, and making the users of care relatively invisible to the nonusers, created the illusion that care was free and that no one had to be generous for the sick to be treated. It was a system designed to induce generosity on the part of doctors and fellow citizens. But managed care insurance, to the extent it exposes and highlights the costs to others of sick people's care, is calculated to dampen generosity.

Putting the Doctor-Businessman to Work

The insulation of medical judgment from financial concerns was always partly a fiction. The ideal of the doctor as free of commercial influence was elaborated by a medical profession that sought to expand its market and maintain its political power and autonomy. Now, the opposite ideal—the doctor as ethical businessman whose financial incentives and professional calling mesh perfectly—is promoted in the service of a different drive to expand power and markets.

Corporate insurers use this refashioned image of the doctor to recruit both doctors and patients. The new image has some appeal to doctors, in part because it acknowledges that they need and want to make money in a way the old ethical codes didn't, and in part because it conveys a (false) sense of independence at a time when clinical autonomy is fast eroding. Through financial incentives and requirements for patients to get their treatments and tests authorized in advance, insurers are taking clinical decisions out of doctors' hands. Hospital length-of-stay rules, drug formularies (lists of drugs a plan will cover), and exclusive contracts with medical-device suppliers also reduce doctors' discretion.

In contrast to this reality of diminished clinical authority, images of the doctor as an entrepreneur, as a risk taker, as "the 'general manager' of his patient's medical care" (that's Enthoven's sobriquet in his Shattuck Lecture) convey a message that clinical doctors are still in control. If they practice wisely, in accord with the dictates of good, cost-effective medicine, they will succeed at raising their income without cutting quality. HMOs have long exploited this imagery of business heroism to recruit physicians. Here's Stephen Moore, then medical director of United Health Care, explaining to doctors in the *New England Journal of Medicine* in 1979 how this new type of HMO would help them fulfill "their desire to control costs" while keeping government regulation at bay:

> Incentives encourage the primary-care physician to give serious consideration to his new role as the coordinator and financial manager of all medical care. . . . Because accounts and incentives exist for each primary-care physician, the physician's accountability is not shared by other physicians, even among partners in a group practice. . . . Each physician is solely responsible for the efficiency of his own health care system. . . . In essence, then, the individual primary-care physician becomes a one-man HMO.

The image of entrepreneur suggests that doctors' success depends on their skill and acumen as managers. It plays down the degree to which their financial success and ability to treat all patients conscien-

tiously depend on the mix of sick and costly patients in their practices and the practices of other doctors with whom they are made to share risks.

The once negative image of doctor-as-businessman has been recast to appeal to patients, too, as insurers, employers, and Medicare and Medicaid programs try to persuade patients to give up their old-style insurance and move into managed care plans. Doctors, the public has been told by all the crisis stories of the past two decades, have been commercially motivated all along. They exploited the fee-for-service system and generous health insurance policies to foist unnecessary and excessive "Cadillac" services onto patients, all to line their own pockets. Patients, the story continues, have been paying much more than necessary to obtain adequate, good-quality medical care. But now, under the good auspices of insurers, doctors' incentives will be perfectly aligned with the imperatives of scientifically proven medical care, doctors will be converted from bad businessmen to good, and patients will get more value for their money.

If patients knew how much clinical authority was actually stripped from their doctors in managed care plans, they might be more reluctant to join. The marketing materials of managed care plans typically exaggerate doctors' autonomy. They tell potential subscribers that their primary care doctor has the power to authorize any needed services, such as referral to specialists, hospitalization, x-rays, lab tests, and physical therapy. Doctors in these marketing materials "coordinate" all care, "permit" patients to see specialists, and "decide" what care is medically necessary. Meanwhile, the actual contracts often give HMOs the power to authorize medically necessary services, and more importantly, to define what services fall under the requirements for HMO approval.

In managed care brochures, doctors not only retain their full professional autonomy, but under the tutelage of management experts, they work magic with economic resources. Through efficient management, they actually increase the value of the medical care dollar. "Because of our expertise in managing health care," a letter to Medicare beneficiaries from the Oxford Medicare Advantage plan promised, "Oxford is able to give you *100% of your Medicare benefits and much, much more*" [emphasis in original]. Not a word in these sales materials about the incentives for doctors to deny expensive procedures and referrals, nor in some cases, the "gag clauses" that prevent doctors from telling patients about treatments a plan won't cover.

In an era when employers and governments are reducing their financial commitments to workers and citizens, the image of the doctor as efficient manager is persuasive rhetoric to mollify people who have come to expect certain benefits. To lower their costs, employers are cutting back on fringe benefits and shifting jobs to part-time and contract employees, to whom they have no obligation to provide health insurance. The federal and state governments are similarly seeking to cut back the costs of Medicare and Medicaid. The image of the doctor as an efficient manager—someone who can actually increase the value to patients of the payer's reduced payments—helps gain beneficiaries' assent to reductions in their benefits. Thus, the cultural icon of doctor-as-businessman has become a source of power for employers and governments as they cut back private and public social welfare commitments.

The old cultural ideal of pure clinical judgment without regard to costs or profits always vibrated with unresolved tensions. It obscured the reality that doctoring was a business as well as a profession and that medical care costs money and consumes resources. But now that commercial managed care has turned doctors into entrepreneurs who maximize profits by minimizing care, the aspirations of the old ideal are worth reconsidering.

In trying to curb costs, we should not economize in ways that subvert the essence of medical care or the moral foundations of community. There is something worthwhile about the ideal of medicine as a higher calling with a healing mission, dedicated to patients' welfare above doctors' incomes and committed to serving people on the basis of their needs, not their status. If we want compassionate medical care, we have to structure both medical care and health insurance to inspire compassion. We must find a way, as other countries have, to insure everybody on relatively equal terms, and thus divorce clinical decisions from the patient's pocketbook and the doctor's personal profit. This will require systems that control expenditures, as other countries do, without making doctor and patient financial adversaries. There is no perfect way to reconcile cost containment with clinical autonomy, but surely, converting the doctor into an entrepreneur is the most perverse strategy yet attempted.□