A Balanced Framework for Change

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Journal of Health Politics, Policy and Law, Volume 24, Number 5, October 1999, pp. 1107-1114 (Article)

Published by Duke University Press

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Managed care consists of a set of approaches, organizational arrangements, and strategies with considerable diversity of practice. A key element, which requires considerable management of available resources, is prepayment for care with limited consumer out-of-pocket obligations. Most common among management strategies is the use of capitation, risk-sharing and payment incentives, utilization review, and services substitution. Other developing strategies include physician profiling, use of practice guidelines and clinical pathways, disease management, and quality monitoring.

The growth of managed care organizations (MCOs) has resulted in considerable private centralization of the management of health care services. It has shifted considerable power and control from individual professionals, who viewed themselves as autonomous experts, to administrators and managers, who increasingly establish constraints on health care practice. It should be no surprise, then, that physicians and other professionals who see their autonomy diminished and their incomes threatened react negatively and emotionally to these changes. With hundreds of millions of medical transactions, instances of poor judgment, avarice, stupidity, and negligence will occur, as they always have. One major difference today, though, is that the centralization of medicine under large managed care organizations makes managed care an easy target for criticism. Any untoward incident is no longer simply a mistake or misbehavior of an individual practitioner but in the public mind an attribute of managed care itself (Mechanic 1997a). The media, focusing

Journal of Health Politics, Policy and Law, Vol. 24, No. 5, October 1999.

more on human interest anecdotes than on aggregate and representative data, portray a negative and untrusting image of managed care (Brodie, Brady, and Altman 1998) that poses a significant public relations problem for the industry. Because some managed care decisions may reflect organizational policy, and not simply the capriciousness of an individual decision maker, anecdotes may reflect, however unreliably, widespread practices.

Anecdotes are sometimes guides to serious organizational and professional practice issues (Rochefort 1998). There are as many as one thousand managed care organizations in the United States and more than six hundred health maintenance organizations varying in size, value orientations, management strategies, and expertise. There is considerable diversity of practice even within the same national managed care organizations. Our task should be to devise approaches that improve managed care practices, bring them to a higher common standard, and build public trust (Mechanic 1998a). Cooperation among health professional organizations, the managed care industry, consumer groups, and government is needed to create the framework where this "work in progress" can evolve to a higher level of overall performance.

If managed care simply consists of a variety of organizational forms and strategies, why does it elicit such great public emotion? One answer, of course, is that certain strategies, such as restrictions on choice of doctors or access to specialists, or denial of care, violate consumer expectations and wants. To some extent they clearly do, but, more fundamentally, the public distrusts the motives of decision makers who increasingly are more accountable to private interests and stockholders than individuals or the community. A recent survey, for example, found that 47 percent of insured respondents and 61 percent of respondents in "heavy managed care" were very or somewhat worried that their health plans would be more concerned about saving money than about what is the best treatment for them when they are sick (Blendon et al. 1998).

Practitioners of managed care more than a half century ago were drawn to prepaid group practice because they believed that this was the proper way to provide care to individuals and communities and to promote community health. Prepayment, they believed, provided security that care would be there when needed and the group practice mechanism provided the context for colleague collaboration and for developing programs for prevention and health maintenance. They carried out their visions at personal risk, vilified and discriminated against by their local medical societies and by the American Medical Association (Starr 1982).

These advocates did not visualize the form managed care takes today, with most practices under private sponsorship of national corporations and most care being provided by virtual networks of doctors rather than established group delivery systems. The aspirations and philosophies that guide managed care are interlinked in many ways with the way strategies are devised and implemented. While debates will continue on the relative merits of care under nonprofit and private forms of organization, it is clear that we need a regulatory framework for managed care that provides incentives for responsible and accountable practice and that makes it less possible for organizations to pursue agendas contrary to the public interest and good health care.

The private provision of managed care services skyrocketed when it became clear that government was failing to devise a framework for successfully containing the growth of medical care costs. Private employers concerned about growing health care costs turned to MCOs and more recently, they have been followed by Medicaid and Medicare administrators. In many ways, managed care continues trends already established in health care practice. It aggressively promotes the reduced use of hospitals, shorter lengths of inpatient stays, and substitution of outpatient for inpatient services. Though it is not the basic cause of such deinstitutionalization, it clearly helps accelerate it. Its greatest cost savings have come by significantly reducing inpatient stays.

Managed care also is a strategy for rationing the provision of health care services. As the gap grows between what is medically possible and the willingness of employers, employees, or government to finance all medical possibilities, rationing becomes more strict and unpleasant. Middle-class Americans like to believe that health care is not rationed, just as they like to believe that only the poor receive housing subsidies. Typically, the public does not appreciate how the market rations medical care provision or how the growing number of uninsured persons reflects increased market constraints. In truth, MCOs use a wide range of rationing strategies including denial, deterrence, delay, and dilution of service (Klein, Day, and Redmayne 1996). Thus the larger American public is confronted for the first time with the visible fact that medical care is rationed, and indications are that they don't like it very much.

Health care rationing isn't necessarily bad, of course, since American health care abounds in well-intentioned provision of uncertain, ineffective, and even harmful services. More intelligent use of resources allows coverage for many more people. Many of the structures of managed care offer the potential for developing a more evidence-based medical prac-

tice, a more scientific and thoughtful approach to decision making, and a more intelligent use of resources. Major impediments to such developments include the high degree of uncertainty in medical practice, the limited amount and range of health services research to inform decisions, and the fact that agreement on best practice is difficult to achieve in many areas. MCOs ration, though there is little evidence that they ration on an evidence-informed basis (Boyd, Kleinman, and Heritage 1997). But the potential clearly is there and such approaches will evolve over the next several decades.

The public challenge is how to induce MCOs to compete by promoting quality of care and best practice. Under existing financing arrangements strong incentives persist to market aggressively to the most healthy and to avoid the highest risk clients. Health plans that distinguish themselves by providing quality care services in many chronic disease areas put themselves at risk of attracting too many high-cost clients and financial difficulty, and managers outside of major research and teaching centers commonly acknowledge their unwillingness to promote quality efforts in these areas.

Neither of the major remedies to the quality issue are sufficiently developed to adequately address the existing disincentives. The first such remedy, risk adjustment of premiums, capitation, or payments, is not sufficiently refined or predictive to reasonably compensate plans and providers for the large differences in risk they assume with varying types of clients. Nor are various risk adjustment or compensation proposals immune from gamesmanship. Nevertheless, it is inevitable that such reimbursement instruments will improve with more analytic work and experimentation and that they will eventually contribute to raising the priority of marketing on the basis of quality.

A second challenge is to make the public more aware of and more sophisticated about quality differences in performance, and make the market work better. Evidence to date suggests that the public is poorly informed and confused about the information available about health care plans. They have difficulty in anticipating possible future needs and, in any case, they have no sense of how to integrate conflicting information from different indicators (Hibbard, Slovic, and Jewett 1997). Cost is an element they do understand, and cost typically drives many health care choices. Studies also consistently find that information about experience and quality of care from relatives and friends is a more powerful motivator than other sources of information. Indeed, most people, when given

the choice between a familiar hospital and one chosen as preferable by expert opinion, chose the former (Robinson and Brodie 1997). Thus, we face a number of significant informational challenges. First, we must improve the relevance and meaningfulness of data on quality of care for individuals who have a choice. Second, we must improve the ability to convey this information in an easily understood format and in a timely way. Third, we must elevate the credibility of expert sources of information about quality. Such informational sources must be authoritative and free of the taint of any special interest. Fourth, the information has to be directly relevant to the person's medical experiences and not simply descriptive of aggregate performance over a large population. Most of the public does not view sources of information available to them as having these characteristics.

Managed care is still early in its evolution and will be a work in progress for years, possibly decades. To function effectively it must develop within a regulatory framework that establishes direction and boundaries but does not micromanage professional decision making. Certain protections, however, are essential. Choice among plans is one important protection and that contributes importantly to trust. Many people, however, lack choice of plan because their employers select the plan. Choice limitations are also increasingly common in Medicaid programs. Although multiple choice of plans is desirable, it may not be possible to require that purchasers provide it. However, plans should be required to provide a sufficient selection of clinicians so that patients can exercise some countervailing influence within plans and deselect unresponsive care providers. Plans should also be required to provide a reasonable network of specialists with the requisite training and experience to deal with predictable needs. Most large plans now have reasonable complaint and grievance mechanisms but these should be brought to a uniform satisfactory standard, with the availability of timely review from experts outside the plan if needed.

Managed care inevitably must retain constraints that many people oppose, such as gatekeeping to specialist referral, utilization review, and restrictive networks of providers. Such opposition is understandable, but without referral constraints, managed care lacks many of the basic strategies necessary to manage the system. This is the aspect of the managed care contract that consumers have the most difficulty accepting. Managed care plans have not been sufficiently clear in communicating that the product being sold is a system that trades off increased benefits

and lower cost sharing for acceptance of a certain amount of care rationing. As individuals have expressed their displeasure with these arrangements, insurers have allowed direct access to some specialists within their HMOs and offered expanded point-of-service and preferred provider options. But ultimately, if managed care is to be successful in containing the growth of costs it must constrain unnecessary utilization and have enrollees understand the implicit contract. Some pressures on the system are relieved by offering more expansive options to those willing to pay.

Capitated plans with comprehensive benefits purport to provide all medically necessary services. The concept of medical necessity in light of uncertainty and major disagreements as to appropriateness of care in particular circumstances becomes the rope in a tug-of-war between narrow and more expansive concepts of care (Rosenbaum et al. 1999). Underlying these controversies is the important question of the authority of physicians or administrators to make the decisions about care in particular circumstances. Sara Rosenbaum and her colleagues (1999:232) suggest that professional decisions should only be negated "if the insurer can show that the proposed treatment conflicts with clinical standards of care, or that there is substantial scientific evidence, regardless of clinical practices, that the proposed care would be unsafe or ineffective, or that an alternative course would lead to an equally good outcome." This is a good starting point for discussing the relative balance of rationing and professional judgment (Mechanic 1997b) and where the burden of evidence should lie.

Any willing provider efforts represent a different attack on managed care, but one that also undermines it. If managed care is to work properly, the system of care must be able to select providers who are prepared to function within the norms and culture of the organization. Such selection criteria should be specific, uniformly applied, and reviewable. It is alleged that managed care organizations drop physicians from their networks simply because these providers incur higher costs than others. Deselection on this basis alone should not be permissible without documentation that the pattern of practice fails to follow the kinds of criteria suggested by Rosenbaum and her colleagues (1999).

A future challenge is to make health care plan networks accountable for appropriate standards of practice. The early HMOs, despite restrictions on physician choice, had significant advantages in developing a peer culture and health professional collaboration. Their centralized settings allowed innovative prevention and chronic disease management pro-

grams as well as patient education and other initiatives. Developing such a culture and programs within decentralized networks is a much more difficult undertaking and one that will challenge the ingenuity of managers. Almost everyone agrees about the virtues of integrated clinical care but such systems are almost nonexistent.

In sum, while the record of managed care in the public and political arena leaves much to be desired, the evidence is that managed care has performed no worse in providing medical care than the traditional system (Miller and Luft 1994; Seidman, Bass, and Rubin 1998). Possible exceptions include care for the treatment of psychiatric disorders (Mechanic 1998b) and chronic care for the elderly (Ware et al. 1996). Performance in these areas should be monitored closely. It is worth noting, however, that these are relatively new populations for managed care organizations and it seems reasonable that with more experience and consumer feedback, performance in these areas will improve.

One needs to take account of the rapidity with which managed care has penetrated American medical care and how little time there has been to develop the information and management systems required to monitor and fine-tune decision processes. With changes so large and extensive, there have been opportunities for greed, fraud, and incompetence, and we have seen some of each. To simply focus on these aberrations misses the more central transformation that has occurred. This transformation provides a beginning framework for systems of care that are better suited than the traditional system to the realities of future constraints, changing population dynamics, and new technologies. Managed care, in some form, is here to stay, but it will need continuing redirection and fine-tuning.

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