Physician Collective Bargaining in the Era of Managed Care: A Turning Point in U.S. Medicine

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Nearly thirty years ago, the economist Albert O. Hirschman published his now classic treatise, *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States*, demonstrating how analysis of certain fundamentally economic processes can illuminate a broad range of social and political phenomena. In particular, Hirschman modeled two options or categories of response to lapses in performance by firms and organizations as reflected by deterioration in the quality of their products or services: *exit*, a binary opposition whereby consumers stop (or do not stop) buying a product or members leave (or do not leave) an organization, and *voice*, a gradient or continuum whereby consumers or members express through varying degrees of petition or protest their dissatisfaction to management or some higher authority and attempt to change, rather than escape from, the objectionable state of affairs. These options are not mutually exclusive, nor are they equally suitable or even available across all situations and contingencies of decline. As Hirschman details throughout his book, all sorts of complex permutations in selection of the options play out in the marketplace and in the real world at large, whether in response to the failings of economic operators or to those of social and political actors and institutions. What is noteworthy about Hirschman’s model is not only its broad applicability but also the way in

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which his seemingly simplistic formulation captures the ideology and aims (and sometimes guile) of dissenters as they seek remediation and wield influence via countermoves to others’ “lapses from efficient, rational, law-abiding, virtuous, or otherwise functional behavior (1970: 1)”

Hirschman’s exit-voice model originates in his effort to account for the enduring inefficiencies of the Nigerian railways and, more curious to him as an economist, the prolonged incapacity of system administrators to reverse the ensuing course of revenue loss despite active competition (i.e., no monopoly) in the country’s transport industry. Reduced to the essentials of the model, in the case of a less-than-efficient railway system in Nigeria, consumers opted for exit, in droves, with no compelling need for voice. In this article, I explore a case in point of what happens when marketplace realities for all practical purposes block exit, rendering voice the only viable option in response to an objectionable state of affairs. The “realities” of interest are defined by where, in response to economic pressures to contain and slow health care cost inflation, the private sector’s commercialization of the U.S. health care system over the past two decades has led us, and the impact of those changes on the health care workforce. Specifically, I attempt to answer briefly two central questions: What have the phenomenal growth of managed care and the attendant unleashing of market forces such as risk shifting, changing financial incentives, and intensity of competition meant to physicians in terms of income, productivity, and how and where they practice; and how does Hirschman’s exit-voice dynamic help to clarify the currently intensifying movement toward unionization and collective bargaining among this particular group of providers?

Within the past few years in particular, the news media and the health care industry and health care policy literature have been replete with reports of voice, that is, of physicians joining, forming, or otherwise inquiring about unions, guilds, and other vehicles of collective action so as to garner forces and “recapture” the health care system from the clutches of big business (e.g., Appleby 1996; Beall 1998; Budrys 1997; Greenhouse 1999; Havighurst 1999; Howland 1998; Lowes 1998; and Lutsky 1997). The litany of complaints by physicians against managed care organizations (MCOs) bears a direct relationship to the dramatic changes in health care financing and delivery wrought by the rapid shift from fee-for-service billing by individual physicians and hospitals to capitation and risk sharing between payers and providers, and to group practices and integrated delivery systems (Scheffler 1996, 1999). To contain costs, MCOs have imposed controls on the settings in which patients can obtain
services and on the particular services they receive, including limiting patient access to specialty care and negotiating discounted fees from providers for the services rendered. As a result, physicians, particularly specialists and especially physicians who practice in markets with a high penetration of managed care, perceive a negative impact on their clinical autonomy and working conditions (Baker and Cantor 1993; Burns and Kuramoto 1999; Enthoven and Singer 1998; Todd 1996) and on their job and income security (Cejka 1999; Crane 1997; Enthoven and Singer 1998; Rice 1998; Simon, Dranove, and White 1998)—in short, issues that in part demarcate the traditional or generic terrain of worker grievances and labor unions.

For players in the health care system who were once accustomed to sitting at the head of hospital boardroom tables, exercising near-total control over their fees and how and where they practice, and, in general, calling all of the shots, the centralized, cost-cutting dictates of the managed care business world have been, understandably, challenging and, for many doctors, demoralizing. So why don’t physicians just select the exit option and refuse to contract with MCOs? The obvious answer is, I believe, also the correct one. With the rare exceptions of practitioners with the patient-drawing power of brand name identity and/or with atypical patient bases composed of the very wealthy with very deep pockets, most U.S. physicians today depend on managed care contracts for a substantial percentage of their practice revenues. According to the latest figures of the American Medical Association (AMA) (1998: 114, 116), around 92 percent of all nonfederal physicians nationwide have managed care contracts, which comprise an average of nearly 45 percent of practice revenues. As these data suggest, physicians are locked into the corporate medical care system financially, but also, at the most fundamental level of professional oath and obligation to their patients, morally. That is, for doctors to turn their backs on managed care is hazardous not only to their incomes but also to the well-being of their patients, who cannot afford to follow their doctors out of their health plans and out of their insurance coverage.

With exit blocked, what kind of relief can physicians achieve through voice? Bargaining power in managed care contracting, especially as maximized through collective mobilization and organization of large numbers of physicians and especially as focused not only on physicians’ contractual rights but also on patients’ therapeutic rights. There is no question that one such route, physician unionization, has undergone a resurgence in the past few years, with union membership estimates up
from 25,000 in 1996 to 35,000–45,000 in 1998 (approximately 5 to 6 percent of U.S. physicians), and expected to grow by at least 15 percent annually (Greenhouse 1999; Havighurst 1999). But it is also the case that the efficiency strategies that physicians have employed in the managed care environment to exploit economies of scale and expand scope of practice—namely, formation of integrated single-specialty and multispecialty group practices and application of a collaborative team delivery model—serve as well to enhance voice. By 1997, 44 percent of all self-employed nonfederal physicians were engaged in group practice (AMA 1998: 134), with the number of group practices increasing by 362 percent between 1965 (4,289 groups) and 1996 (19,820 groups) (Havlicek 1999: 40, 52). As this trend continues and an increasing number of physicians abandon solo practice and become employees of group practices, oftentimes with equity stakes, virtual collective bargaining units will be created. Moreover, as these groups affiliate with one another and leverage forces and resources through independent practice associations and similar arrangements—the functional equivalents of unions—their collective bargaining power will potentially become formidable.

Ultimately, the success of physicians in their collective bargaining for more favorable managed care contracts will depend on at least two major elements falling into place, one legislative and the other tactical. First, federal antitrust statutes still block groups or networks of self-employed physicians from engaging in joint negotiations with health plans. An exemption from antitrust law, as enjoyed by most of organized labor, is thus needed to eliminate once and for all among health care providers the vexing distinction between “employee” and “independent contractor.” Indeed, having recently recognized that physicians want more aggressive representation from their professional societies and associations, the AMA first formally broached the topic of a national labor organization of physicians in its June 1997 Resolution 239, which strongly endorses the right of all physicians “to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment.” Just two years later, after intense debate among the membership, the AMA voted to establish an affiliated national labor organization to represent salaried doctors and medical residents and therein “give America’s physicians the leverage they now lack to guarantee that patient care is not compromised or neglected for the sake of profits” (Smoak 1999). In addition, the AMA is aggressively lobbying Congress for passage of the Quality Health-Care Coalition Act of 1999, sponsored by Representative Tom Campbell (R-Calif.), which will
extend antitrust immunity to independent practitioners who negotiate collectively with health plans.

Second, whatever the formats or vehicles of their collective bargaining efforts, physicians must demonstrate a concern for more than their own pocketbook issues. Collective bargaining power foremost represents an opportunity to seize the initiative from MCOs in accountability, credibility, cost containment, and quality improvement, all part-and-parcel of effective care management practices (Shortell et al. 1998). Physician oversupply, which will exert further downward pressure on income, is a key factor here and underscores the point that a realistic and responsible approach to care financing among physicians is vital as they attempt to reap the benefits of collective bargaining on fees (Feldman and Scheffler 1982).

In sum, if physicians are to have an effective seat at the table with the corporate executives and bean counters of today’s managed care world, and warrant widespread public support in the process, their collective voice must be backed by economic power and legal standing. As physicians are increasingly coming to understand about the managed care market, where there is no exit, a wise and disciplined voice is not only the best course but also the only viable one.

References


