

Managed Health Care¹

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Health care has recently undergone the most thorough transformation outside of corporate America, and it has done so largely by rationalizing the delivery of health care services along corporate lines. The health care system in America has undergone a remarkable transformation in the last twenty years. This transformation has been mandated by spiraling costs brought on by increasingly sophisticated technology, the labor intensive nature of medical treatment, and increasing amounts of third-party money (private insurance and government Medicare and Medicaid) in the system. Third-party money led to spiraling costs because of the special nature of health care. Patients are not likely to shop around for the best medical deal when it comes to their health, particularly when they are not directly paying the bill. Physicians and hospitals had no check on the cost of their treatment--patients were not likely to go elsewhere, more tests and procedures would be covered without question. As a result of this system medical costs rose faster than the consumer price index (sometimes twice as fast!) every year since the 1950s. By the 1990s, the health care system was one of the largest industries in America, accounting for some 14 percent of the Gross Domestic Product. Governments and corporate America (which pay a good portion of the cost of medical care) found it increasingly more difficult to pay the bills. It is through government and corporate initiative that there has been a shift of cost over to the individual through higher premiums and deductibles. A second more recent initiative

¹ An excerpt from *Industrializing America*, 1999, Praeger Publishers, pp. 106-109

has been to restructure health care delivery so that health care providers have a stake in limiting the cost of care.

One method of cost control, instituted by government in the 1980s, was the Diagnostic Related Group (DRG). Under this system the government sets both the number of days hospital stay warranted for specific treatments and the amount it would pay for that treatment. If a hospital could treat the patient for less, or discharge the patient sooner, it made a profit. If it cost the hospital more, it would lose money on the procedure. Private insurers quickly followed suit. The purpose of the DRG is to rationalize the delivery of hospital care. It does this partly by removing professional judgment from the physician-patient relationship, and partly by providing incentives for hospitals and physicians to control costs.

Perhaps the most startling transformation of American medicine concerns the spread of managed health care. Managed care refers to an institutional arrangement whereby all medical services are coordinated under a single administration. The institutional arrangement can vary from a single entity owning everything to a coordinating body that contracts services out to several different service providers. The single coordinating agency is typically a for-profit corporation. The corporation can be an insurance company, a hospital or chain of hospitals, or a group of doctors (Light, 1994). Insurance companies are the largest of this group in forming managed care networks around the US. The top five health insurance companies have increased their share of total HMO membership from 55 percent to about 70 percent from 1988 to 1994 (Meyer, 1994).

Managed health care is fast becoming the dominant form of health care financing in the United States (Merline, 1994). Enrollment in Health Maintenance Organization (HMOs) reached 50 million in 1994, and is expected to exceed 56 million by the end of 1995 (Mitka, 1994c). The "doctors' dilemma" of whether or not to join an HMO is caused by the likely collapse of private practice as HMOs expand in their region (Woolhandler and Himmelstein, 1994). Almost half of all physicians (42%) in the US have HMO contracts (Meyer, 1994), and nearly 90 percent of all group practices (Mitka, 1994b). Increasing numbers of physicians are giving up private practices and joining the corporate ranks (Walsh, 1994). Because more patients are being treated with fewer doctors, the trend could result in a physician surplus (Mitka, 1994a). The entire hospital industry is also restructuring around managed health care and big-corporate medicine (Mahar, 1994). Wholey et al. (1993) found that corporate interests predominated over professional interests on the formation of HMO practices. Managed care systems rely upon a number of strategies to contain the costs of health care:

- First and foremost, they depend on primary care physicians to use a frugal approach to tests, surgery, hospital admissions, length of hospital stays, and referrals to specialists. "Typically, managed care plans use direct financial incentives to discourage doctors from authorizing the use of tests and referrals to specialists or hospital care. In some cases, the doctors receive bonuses at the end of the year, with the size of the bonus tied to the amount of money the doctor costs the plan. The less the doctor does in a given year, the bigger the bonus" (Merline, 1994: 11).
- Second, managed care systems set the pace of primary care medical labor. Nurses, technicians and aids are reporting huge caseloads. One indication of this

quickened pace is that HMOs average about one physician for every 800 enrollees, the US average is one physician for every 400 (Woolhandler and Himmelstein, 1994).

- Third, managed care systems use their marketing power in setting capitation arrangements with hospitals and fixing medical fees of outside service providers.
- Fourth, the widespread use of health service research data to provide for elaborate patient tracking, coordination of treatments, costs, and marketing. "Using figures on differential rates of treatment, surgery, diagnosis by practitioners, hospital related infections, complications, and deaths, employers and insurers make decisions on what to pay for or where to seek services" (Birenbaum, 1993: 20). This data is also used to closely monitor the medical and financial performance of physicians (Vander Veer, 1997).
- Fifth, managed care tends to place heavy reliance on rules and procedures to guide providers in the determination of appropriate care.
- Sixth, most managed care plans review clinical decision making by in-house review committees or by review companies. "Nurses employed by a review company--Value Health Sciences, for instance--match up symptoms with proposed treatment regimens. When a match occurs, approval is granted to provider and patient that the procedure will be paid for by the insurance company. If there is no match, a referral is made to a physician advisor employed by the review company. A negotiation process between the clinician and the adviser usually follows on the heels of the denial of authorization, a time consuming and often irritating process" (Birenbaum, 1993: 21).

- Seventh, the use of computer and communications technology is being used to further extend physician expertise and control costs. Hundreds of experimental telemedicine programs have been started around the country largely because of the lower costs. "With a nurse in the patient's home, the video is beamed to the doctor through a camera-equipped laptop computer and telephone lines. With video medicine, 'we can improve home care and customer service while reducing costs,' says Ann Schmidt, who heads Columbia's home-health-care operation. . . . And when a 47-year-old immigrant laborer's leg was mangled in a chain saw accident in 1995 near Fort Worth, the employer saved transportation and other costs, Graves said. Columbia orthopedic surgeon James Heerwagen, more than 40 miles away in Lewisville, walked an on-site health-care worker through the draining and closing the wound" (Anonymous, 1997: C1-C-9).
- Eighth, delaying treatment or denying patients access to newer tests, procedures or expensive drugs is yet another strategy for controlling costs widely practiced by managed care systems (Merline, 1994;). These delays and denials can stem from the complicated rules, the cumbersome bureaucracy, and the sheer pecuniary interests of the third party payer.

With the focus on the bottom line, many are concerned that patient care will suffer (Meyer, 1994). The new administrative bureaucracies that manage care in the US create high overheads in the form of managers and their salaries (which, like other top executives in US corporations can run into hundreds of thousands of dollars per executive), elaborate data gathering and analysis for monitoring and marketing, costs in time and money in generating all of the documentation on the part of the providers, fees

for review agencies, and of course the need for profits (Light, 1994; Birenbaum, 1993). All of this has to take money away from patient care itself. Recently there has been evidence that the cost of health care in the United States is again rising faster than the cost of other services.

Further, there is still the irrationality factor. "Health plan administrators demand industrial 'efficiency' at the level of each doctor/patient encounter, producing chaotic inefficiency for the health care system as a whole" (Woolhandler and Himmelstein, 1994: 265). There are many horror stories of HMO putting profits before the life of a patient (McCormick, 1994; McCarthy, 1994). "The managers and financiers who increasingly dominate care are not bad people (if so, we'd need only replace them); they're just responding appropriately to a system that demands misbehavior: Put profits before patients or go under" (Woolhandler and Himmelstein, 1994: 206).