

ACC NEWS



President's Page: What Concerns Us About Managed Care?

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As I visit College members around the country, the predominant concern is the impact of managed care on cardiovascular practice. Whether one is in a location where managed care is well entrenched or in which little penetration has occurred, cardiologists are concerned. In 1994 almost two-thirds of people insured through employers received their care from some type of managed care arrangement involving a limited choice of doctors and tighter cost controls (1).

The extraordinary growth of managed care is a response by insurance and other business interests to the rising costs of medical care. It is a typically American solution to the problem of cost containment in which insurance companies bring organizational and management skills to the health care sector in exchange for profits.

Victor Fuchs (2) has pointed out that only three mechanisms exist for determining how much health care to produce, how to produce it and how to distribute it among the population: 1) market forces, 2) central (government) regulation, and 3) traditional norms.

Market forces presuppose economic competition unfettered by regulation in which individual buyers and sellers do not have monopoly or monopsony power to take advantage of their customers or suppliers, and purchasers have good information about price and quality. Unfortunately, there will always be incomplete understanding of "quality" of health care services by purchasers, and the cooperation and trust necessary for the interaction between doctors and patients precludes the tension between buyers and sellers envisioned in a market having "perfect competition."

Government regulation of health care delivery is not politically possible at this time in this country, judging by the resounding rejection of the Clinton proposal in the recent legislative session.

Voluntary solutions based on norms of health care delivery developed by professionals have not worked in the past in a

fee-for-service system where financial incentives are aligned to encourage extra care at the margin.

Health economists tell us two important facts about cost containment in health care: 1) Little is gained by eliminating "waste" (3); and 2) ultimately, the key to restraining medical costs is to restrain technology (4).

If costs are to be controlled, then less care must be given. Data show that hospital utilization (5) and use of medical specialists are lower in managed care systems. The ratio of specialists to primary care physicians in not-for-profit staff model health maintenance organizations (HMOs) is 1.1 to 1.4 (6) compared with more than twice this ratio overall (7). These ratios may reflect the fact that HMO-enrolled populations are younger working people, but the adequacy of these staffing patterns has gone unchallenged (8).

What concerns us about managed care is the arrogance of some business interests to ration care by arbitrarily setting staffing ratios for specialists, creating financial incentives to discourage referral to specialists, abridging clinical decision making by specialists and camouflaging these business decisions with bold statements about quality and emphasis on preventive services.

We recognize the right of business interests to seek profits in the medical sector. We understand the monopsony power of powerful insurance companies to dictate discounted fees and to intimidate physicians. We smile at the promotional marketing suggesting that quality care is the primary goal of these efforts.

We shall continue to point out that increasing barriers to treatment by specialists is not in the public interest. One has only to consider the large number of legal actions generated by patients denied specialty care within managed care systems to understand that what is occurring is nothing less than an assault on specialty care and the rationing of specialty care services. Managed care is the vehicle by which progress in medicine could be slowed if it develops without the guidance of physicians and specialists whose primary concern is rooted in the beneficence of the physician-patient relationship.

We recognize that at least three of four College members have a relationship with a managed care plan (9). Most of these members have contracts with multiple plans, but a small

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number work full time for group or staff model HMOs, and some serve as plan medical directors. Prior to the 1995 Annual Scientific Session, the College leadership is planning to meet with College members who are active managed care participants to better understand how managed care policies are affecting the delivery of cardiovascular care. This dialogue will help the College to define its role in this rapidly changing environment and clarify the messages that we will take to the public.

The College will continue to make its case for the right of patients to choose their own physician and for the importance of access to specialty care. At the same time, we will continue to emphasize appropriate, timely and effective use of technology. And, yes, we believe that care by experts can save money as well as bring life-extending and life-enhancing benefits to patients. American leadership in health care is built on a proud record of achievement by medical and surgical specialists.

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