COMMENT

The dangers of managed care

Aniruddha Malpani

The delivery of medical care in India today leaves a lot to be desired. The government has failed dismally in its goal of providing health care for all. While private medical care can be excellent, not only is it often very expensive, its quality can also vary considerably. Since the healthcare industry today is so poorly organised, it is tempting to treat medicine as a business in order to manage medical care more efficiently. The hope is that managing medical care can not only help to control costs, it can also help to provide better medical care by standardising it to maintain quality control. After all, if health care is a service industry, why not manage it as one?

In its broadest sense, managed care can be defined as any attempt to influence the access, delivery, or financing of health care. It can also be considered to simply be the application of business principles to health care. In current everyday use, the term managed care often refers specifically to managed care organisations (MCOs), such as health maintenance organisations (HMOs) (1).

The concept of managed care is a US model, which also explains why it is so attractive for Indians - after all, anything made in the US must be good! Managed care has become a buzz word in medical journals, which are now full of guidelines, protocols, and pathways, created to help doctors to provide standardised high quality medical care. It seems to be the perfect marriage, in which business managers concentrate on minimizing costs and running hospitals efficiently, allowing doctors to concentrate on being doctors and providing medical care to their patients. This is why when managed care companies send out their executives with their sales pitch to doctors, most are happy to sign up. Isn't this is win-win situation? The doctor now becomes a 'preferred provider', and gets more patients through the managed care referral network. After all, isn't this simply a better method of paying for medical treatment? The doctor does not have to worry about collecting payment from the patient, since the managed care organisation pays. Isn't this just a form of third party payment?

The key difference, of course, is that with regular indemnity insurance (such as MediClaim), it is the doctor who decides the medical treatment and the insurance company simply pays the treatment money (fee for service) according to their published guidelines. Thus, the financial risk of falling ill is underwritten by the insurance company, leaving the doctor the sole medical authority, with no one to second guess or cross-question his medical decisions. However, managed care organisations (usually called HMOs, or health maintenance organisations), play an active role in managing how money is spent. They set guidelines for medical care, choice of medications, and can limit access to specialists in order to improve cost-effectiveness. Treatment decisions by physicians often require the blessings, or "authorisations", of utilisation reviewers and HMOs can refuse to pay for care if they do not think it is appropriate - and this can hurt both patient and doctor.

The list of problems which plagues HMOs is a long one, and affects everyone concerned adversely - doctors, nurses, hospitals, and patients. In fact, the only people happy with HMOs today are the HMO executives, who are laughing all the way to the bank. We need to learn from the US, before we find ourselves in the same mess they are in now - at least we have the wisdom of hindsight to help us. Let's start with the problems patients face (2). The biggest one is of access, and it's very difficult for patients to get an appointment to see their physician - waits of upto 3-4 weeks are the norm. For complex problems, the difficulty is far greater. It can be very difficult for the "primary care physician" to refer the patient to an expert - because the doctor needs authorisation from the HMO before he can refer the patient for an expert opinion, and HMOs are understandably reluctant to refer patients to specialists - after all, specialists are expensive. Also, it's not possible for the doctor to even choose whom to refer the patient to. He is forced to send the patient to an approved specialist on the HMO's panel - and this specialist may not be the best for the patient's particular problem. However, the effects of HMOs on doctors are much worse (3). Most HMO doctors in the US no longer look forward to seeing patients, because they are compelled by the HMO efficiency experts to see "x" number of patients per day. They are treated as mindless automatons on a factory assembly line, who have to process one patient in 10 minutes, no matter how complex the problem. Doctors who spend too much time on a patient actually get pulled up, because the bottom line is no longer the quality of care, but rather its cost.

This is why doctors working for HMOs are often under considerable stress, and many burnout quickly. For one, their actions are always being scrutinized and analysed. "Big brother" watches the HMO doctors closely, by a mechanism called utilisation review (UR), in which clerks scan medical records to ensure HMO guidelines are being obeyed to keep costs down. Since HMOs are run by bureaucrats, they believe medical care can be applied by following "cookbook" rules, and any deviation from these guidelines leads to punishment. The ability of the doctor to make decisions individualized for the particular patient is taken away, making medical care very impersonal and uncaring. Since the focus is on maximising profits, doctors spend more time on the paperwork, rather than with the patient. Everything needs to be documented, never mind caring about the patient. Also, because doctors need authorisation for everything, they spend half their life on the phone, talking to clerks, explaining why their patient needs a particular medical procedure, or why hospitalisation needs to be extended in a given case. The exasperation factor is tremendous, and the waste of time and energy is huge . Doctors are also hamstrung in making decisions. Thus, only drugs which are in the HMO's formulary can be prescribed -if the patient needs an alternative which may be superior, but more expensive, the HMO will simply not pay for it.

Payment is another sore issue. Since the HMO has so much financial muscle. it is the HMO who decides payment terms - when and how much to pay. Often, payments are too little and too late, with the result that doctors get squeezed - and in fact, doctors in the US today often end up losing money by seeing patients (since the reimbursement from the HMO does not cover their overheads). Many are now finding that they need to work harder and harder for less and less, so that like the Red Queen in Alice in Wonderland, they need to run in order to remain in the same place. With the introduction of HMO commercialisation, doctors are forced to become businessmen - and learn all about new terms such as cost containment,

authorisation, capitation, and gatekeeper (which you won't find on any medical textbook) (4). However, the sad fact is that physicians are very naïve as businesspersons, and even though they think they are very clever, they are easily manipulated by HMOs, so that they often end up fighting against each other because of ego hassles, medical politics and professional rivalry.

One of the most harmful effects of HMOs has been the poisoning of the physician-patient relationship (5). The doctor has simply become a health care provider, and his professional status and reputation has been destroyed. Doctors are given financial incentives for reducing costs - and this is obviously going to affect the quality of care the doctor provides, as he tries to skimp on expensive treatment. In fact, patients have become very distrusting of doctors in an HMO system, because they feel that doctors are denying them the medical care they need. Thus, in a few short years in the US, the trust patients used to have in their doctors has been wiped out, and a doctor v/s patient adversDefault Font relationship has been created.

To add insult to injury, the HMO applies constraints as to what the doctor can do and cannot do - but if something goes wrong, then it is the doctor who has to bear the full brunt of the patient's wrath - after all, how can an HMO clerk be held responsible for medical decisions? This means that doctors are now sandwiched between the HMO management and their patients - and receive flak from both sides. In fact, some experts even wonder if it is possible for doctors to practise medicine ethically in an HMO setting, when they are answerable to two different masters - the HMO management (to keep costs down) and their patients (to provide high quality medical care). Physicians now have to play a fine balancing act between their duty to their employer (the managed care organisation), the health interest of their patients, and their personal livelihood. What a far cry from the 'good old days' when all the doctor had to worry about was looking after the patient's best interests.

Patients and doctors have already started rebelling against the excesses of the HMOs in the US. Laws for patient rights, to protect them against HMO abuses, are being passed; doctors are now joining unions, and offering creative alternatives to HMO models, such as private practice physician networks.

Managed care will be introduced in India. It's simply a matter of time that it will be 'exported' to India as it has been to Latin America (6). After all, we are talking big bucks. As Dr Arnold Relman, the past Editor of the New England Journal of Medicine, noted, "Health care is being converted from a social service to an economic commodity, sold in the marketplace and distributed on the basis of who can afford to pay for it." (7) However, if we import the US model, the only ones who will benefit will be HMO managers. Doctors in India need to band together to withstand this danger, for the sake of their patients - and for their own sake. Let's not forget that it's not possible to provide medical care without doctors. If we are united, we can act as our patient's advocates, and support a model that's patient-centered as opposed to one that just cuts costs.

References:

1. Fairfield Gillian, Hunter David J, Mechanic David, and Rosleff Flemming. Managed care: origins, principles, and evolution. BMJ 1997; 314: 1823.

2. Fairfield Gillian, Hunter David J, Mechanic David, and Rosleff Flemming. Managed care: Implications of managed care for health systems, clinicians, and patients. BMJ 1997; 314: 1895.

3. Rodwin MA. Conflicts in managed care. N Engl J Med 1995;332:604-607

4. Kassirer JP. Managed care and the morality of the marketplace. N Engl J Med 1995; 333: 50-52.

5. Kassirer, J. P. Managing care - should we adopt a new ethic?. N Engl J Med 1998; 339: 397-398

6. Stocker K., Waitzkin H., Iriart C. The exportation of managed care to Latin America. N Engl J Med 1999; 340:1131-1136.

7. Relman, A. Criticizing the takeover of public hospitals by commercial businesses, New York Times January 25, 1985. Simpson's Contemporary Quotations.

Dr Aniruddha Malpani, Malpani Infertility Clinic, Mumbai 400 005. Email: malpani@vsnl.com.

Choose article

Back to index

See all comment headings

See all comments in detail