
Physicians and Managed Care: Employees or Professionals?

By Kate T. Christensen

There are features of managed care that best promote patient welfare and those that do not. The managed care organization (MCO) that results in the highest quality of patient care allows the physician control over clinical practice and minimizes incentives to withhold care. The nonprofit group practice HMO structure holds the greatest potential for promoting both physician autonomy and benign financial incentives.

The delivery of health care in this country is undergoing a profound transformation, as evidenced by the almost daily news reports of mega-mergers among hospital systems. One dominant emerging theme is the corporatization of health care delivery, with nonprofit health care systems converting to for-profit status, and the public health system either collapsing or converting to private enterprise. Most of these health care systems are or will become organized as for-profit managed care entities. It has been predicted that by the year 2000, managed care organizations (MCOs) will provide the majority of health care services, and that within twenty years (Rodwin 1993), the majority of physicians will be salaried by an MCO (Friedman 1993).

Given the scope and pace of these changes, the current debate over the pros and cons of managed care versus fee-for-service is rapidly becoming irrelevant. Instead, we need to analyze the features of managed care that best promote patient welfare and those that do not. I believe that the MCO that results in the highest quality of patient care is the one that minimizes incentives to withhold care and in which physicians control clinical practice (Christensen 1995).

The for-profit staff model MCOs typically put physicians in the role of employees with the resultant loss of control over practices and incomes. These MCOs often use negative financial incentives to discourage overuse of the health plan's

resources. By comparison, the nonprofit group practice HMO structure holds the greatest potential for promoting both physician autonomy and benign financial incentives. Belonging to a group practice instead of being employed by an HMO gives physicians the opportunity for greater control over such crucial practice functions as utilization review and quality control. And because the nonprofit plans are not obligated to maximize net profits in order to satisfy shareholders, there is less need to employ perverse incentives to squeeze extra profits out of the physicians' practices. This arrangement offers the best opportunity to combine managed care with quality care.

Professionals or Employees?

Traditionally, physicians have considered themselves professionals, highly trained practitioners of the art and science of medicine. Our society has endorsed this role by rewarding physicians with generous incomes, respect bordering on reverence, and a great deal of professional autonomy. Most physicians in fee-for-service have been self-employed, and, until recently, have had control over their practice styles and schedules.

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However, with health care services becoming big business, physician income and autonomy are rapidly eroding. Within the medical profession, we now see a spectrum of physician autonomy, from the complete control over one's practice in pure fee-for-service, to the employee status of physicians in some of the staff model MCOs. The growing dominance of managed care in many urban areas has created a situation in which thousands of physicians are leaving independent practices and becoming either employees of MCOs or indentured to them through contractual arrangements. In doing so, they may gain the benefits of working in an integrated group setting but at the same time face a diminution of their professional autonomy.

For those who work in for-profit staff model MCOs, this loss of autonomy can be dramatic. As employees, they are subject to sudden discharge, unpredictable drops in income, and changes in their schedules or professional duties. Other physicians may work with MCOs through their independent practice associations (IPAs). These physicians keep their private practices and self-employed status, thus maintaining some control over their practice and working conditions, but their remuneration is still subject to market pressures and changing conditions of the MCOs that pay them. At any time they may find themselves "decapitated and disempaneled," often without advance notice or justification.

For all these physicians, clinical skills have become just one more commodity the MCO offers to the public as an inducement to enroll. But as the most expensive commodity, many MCOs will reduce the amount paid to physician-employees as much as the job market will allow. Some will argue that physicians' incomes have been over-inflated in recent years, and that this downward trend is a welcome correction. Nevertheless, given the current oversupply of physicians in urban areas (in particular subspecialists), combined with market pressures, the decline in physician incomes has not yet reached bottom.

Why is physician income important to

maintaining quality patient care? The amount physicians are paid is not so important (except to physicians), but the loss of control over income, coupled with the nature of financial incentives employed by the MCO, can create a harmful conflict of interest within the physician-patient relationship and threaten patient care.

Physician Incentives and Patient Care

As physicians lose control over incomes, new measures are being used to reshape how physicians are paid. MCOs are using their new control over income as a way to influence their physicians to comply with the standards or guidelines of the organization. Various incentives are employed to minimize utilization of health plan resources and optimize patient outcomes. When these incentives emphasize the former goal over the latter, conflicts of interest and degradation of patient care may result. The type of incentives used and how they are applied also can have an impact on patient care and the ethical conflicts experienced by conscientious physicians (Emanuel 1995).

Some incentives, appropriately applied, can serve as a needed nudge to encourage a physician to follow state-of-the-art practices, apply preventive services effectively, and avoid wasteful overuse of tests and procedures. Other incentives, however, may create a conflict of interest, pitting the physician's economic self-interest against his or her commitment to good patient care. For example, many MCOs pay bonuses to physicians, or release a withheld portion of income, for meeting specific cost and utilization targets. If the physician is paid a basic salary, which is in the range for his or her specialty, then the bonus money is unlikely to influence treatment decisions. But if the bonus or withheld income makes up a significant portion of the physician's income, the temptation to compromise patient care to meet specific goals is heightened (Council on Ethical and Judicial Affairs 1995). In the for-profit MCOs, the percentage of income withheld is in the highest end of the spectrum, often more than thirty percent.

The criteria used for rewarding bonuses are

also important. Health care organizations use a variety of criteria to decide who gets a larger bonus and who does not. Those criteria range from the benign — evaluating physicians on the basis of the quality of care, patient satisfaction, and efficient use of resources — to the malignant — grading physicians according to certain cost-containment measurements and punishing or rewarding accordingly. Given that physicians have their own internal incentive systems based on a commitment to do their best for their patients,

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these reward systems still can cause moral stress when they pit the good of the patient against the physician's own self-interest. Rewarding good patient management creates much less conflict for physicians than rewarding cost-containment. For example, if the largest bonuses are rewarded to those who have ordered the fewest tests, a physician will have a negative incentive to provide important preventive services such as mammograms. If physicians are rewarded for preventing hospitalizations, they will have added motivation to keep their patients well.

Physician Practice Autonomy Under Managed Care: Utilization Review and Practice Guidelines

Along with loss of control over incomes, many physicians also have experienced loss of control over their clinical practices. External utilization review and requirements for pre-approval for tests, treatments, and admissions to the hospital are creating new constraints on the way physicians practice medicine. In general, staff model for-profit MCOs tend to employ these intrusive management methods more than the non-profit MCOs. Utilization review can be a barrier to good patient care when performed by someone who has

no clinical experience and makes treatment decisions based on written algorithms and protocols. However, when managed and implemented by physicians, utilization review can both promote better patient care and save money. It can minimize unnecessary treatments or hospital stays, and encourage preventive care. It is a different experience for a physician to get a call from a colleague, asking if the patient with pneumonia really needs to remain in the hospital, than to get a call from a reviewer in a distant city who informs the physician that reimbursement will be discontinued if the patient remains in the hospital. In the first scenario, the two physicians can discuss whether there are exceptional circumstances that mandate continued hospitalization or if, as is often the case, discharge is being postponed until a convenient rounding time for the physician. Utilization review should not put up barriers to good patient care, and in the hands of physicians, it is less likely to do so.

Practice guidelines are another feature of practice management that can have an important impact on patient care (Eddy 1993). When applied inappropriately, practice guidelines are imposed on physicians and used as standards to measure, reward, and punish physician behavior. But when physicians are involved with development and implementation of practice guidelines, this process can become a useful extension of peer review and help to maintain a high quality of care. For example, Kaiser Permanente physicians were involved in an important clinical research project, which showed that routine screening of the bowel for colon lesions is only useful after the age of fifty and then only every ten years in low-risk persons (Selby et al. 1992). Adapting those guidelines into the clinical practice of Kaiser Permanente primary care physicians has not been difficult because they trust the data and those who developed the guidelines. Furthermore, they know that they will not be penalized for ordering a colon test for a patient more frequently, or at a younger age, if they believe it is necessary. Applied with physician involvement, it is less likely that guidelines will be mistaken for standards (which require more

stringent outcomes studies and stricter enforcement) and less likely that practice guidelines will be used to reward and punish inappropriately (Crosson 1995).

Conclusion

We are moving rapidly into a future in which physician autonomy and income arrangements will be changed forever. Physicians will be more accountable to the health plans which pay them, to the employer groups and health plan enrollees who provide the funds, and to the other physicians in their MCO. These changes can ultimately improve the practice of medicine. But this loss of physician autonomy must be tempered by the involvement of physicians in the "manage" part of managed care. If physicians are restricted to providing only the "care," as employees who vend their services without playing a role in practice management, they will suffer increasing moral stress, and quality of care will suffer as well.

Under the umbrella term "managed care" there are important variations in financial incentives and physician involvement in clinical practice management. A system that rewards good outcomes and patient satisfaction, which does not withhold a crucial portion of physician income, and which involves physicians in the development and implementation of practice guidelines and utilization review, will in the long run provide the best patient care. Because the nonprofit, group model MCOs more often embrace these principles and practices, they hold out the best hope for balancing cost-control with the highest standards of patient care.

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