1040-5488/96/7305-0341$03.00/0
OPTOMETRY AND VISION SCIENCE

Vol. 73, No. 5, pp. 341–343

symposium paper

Professional Practice in an Era of Cost Constraints

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Greetings, I come to you from another world. A world where insurance companies are health care providers and doctors are "double agents."[1] A world where physicians (including optometrists) concern themselves with both patient advocacy and resource allocation.[2] I come to you from a health maintenance organization (HMO).

An HMO is all these things and more, but my focus today is on the needs of the public, so I will spend the next few minutes discussing how HMOs may impact the public's health and the ethical and professional ramifications of HMO practice.

OUR HIPPOCRATIC TRADITION

The traditional model of American medical education and practice emphasizes the one-to-one physician-patient relationship. "To the Hippocratic physician, nothing and no one [is] more important than his patient; this has always been a guiding principle of clinical medicine. Other patients, future patients, and the rest of mankind have been secondary considerations. . . . "[3] This tradition is echoed in the gold standard of medical ethics—the primacy of the patient's well being.[4] Our Hippocratic tradition provides the ethical framework within which practitioners feel justified in maximizing the care of individual patients free from concerns regarding cost. In today's cost containment environment some practitioners now perceive themselves as having an ethical responsibility to serve as their patient's advocate in battles with administrators and insurers that are attempting to place constraints on the delivery of health care services.[5] Unfortunately, these practitioners do not realize that when physicians hoard resources for their own patients, they are not taking from administrators or insurers; they are taking from other patients.[6]

THE FEE-FOR-SERVICE INCENTIVE

The traditional fee-for-service system of delivering health care economically rewards physicians that provide more services. Many analysts believe that the fee-for-service incentive to maximize care is a major contributor to the rapid rise in health care costs in the United States today.[7] Let me give you an example of how the fee-for-service incentive can drive up the cost of care unnecessarily. A corneal topography unit costs on the order of $20,000, whereas a standard keratometer costs less than $1000. There is no question that videokeratography provides a better indication of corneal contour than manual keratometry, and for scientists it is an important research tool; however, with the possible exception of astigmatic keratotomy, there is currently no evidence that the clinical use of this emerging technology improves clinical outcomes.[8,9] Nonetheless, computerized videokeratography systems are being marketed to optometrists and general ophthalmologists as a means to improve care for their patients and, not surprisingly, as a way to generate additional fees. One recent article[10] recommending routine use of topography showed how a doctor could cover the cost of the unit and make an annual profit of $4258 by performing topography on all new patients, all contact lens fittings, all refractive surgery patients, and all patients with known corneal disease. This is clearly a case of the fee-for-service incentive at its worst.

FROM ADVOCACY TO ALLOCATION

The drive to contain the rapid growth of health care costs has spawned numerous new models for delivering care that either eliminate or dampen the fee-for-service incentive to maximize care.[11] Collectively known as managed care, these new

This paper is part of the Optometric Care in Hospitals, Medical Centers, and Comprehensive Health Care Environments Symposium presented at the Annual Meeting of the American Academy of Optometry, San Diego, California, Tuesday, December 13, 1994.

Received August 16, 1995; revision received March 26, 1996.

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methods of financing and organizing the delivery of health care attempt to control costs by controlling the provision of services.[12] Now the incentive is to avoid all unnecessary care and expense. Physicians and managers in managed care settings are required to take a broader, more population-based view of the care they provide and allocate their finite resources where they will do the greater good for the community that they serve. An eye care example of population-based decision making is to free-up resources by performing elective cataract surgery only when there is clear evidence of functional impairment[13] and a good prognosis for postoperative functional improvement.[14, 15] It has been estimated that 25% of all procedures performed by ophthalmologists are unnecessary,[16] and there are data suggesting that up to 16% of cataract extractions are inappropriate.[17] Those resources could then be applied toward efforts to ensure that virtually all persons with diabetes receive at least yearly eye examinations through dilated pupils and are offered appropriate treatment when indicated.[18] One recent study found that over 50% of diabetics in the United States had not had such an eye examination in the past year.[19] The cost-effectiveness of screening for and treating diabetic retinopathy is well established,[18] not to mention its value in preventing blindness.[20]

CULTURE OF PRACTICE

The goal therefore of a managed care organization is to maximize the health of its members, subject to the limits on its resources.[6] To be fully effective HMO physicians need to take a broader, more population-based view of the care they provide, and to recognize that in addition to the one-to-one doctor-patient relation there is an equally important "one-to-n" obligation to the members of the plan.[21] This reorientation is often referred to as a "culture of practice" and is most evident in prepaid group and staff model plans. Other forms of HMOs, such as the independent practice association, lack this culture of practice at least in part because of the mixing of prepaid and fee-for-service patients within a single practice setting. In fact, this mix of patients raises questions of a physician's ability or willingness to maintain an equal standard of care between patients with "high option" fee-for-service coverage and patients in managed care plans.[1]

THE DOCTOR AS DOUBLE AGENT

Population-based medicine is nothing new to those engaged in public health and epidemiology, but it does represent a significant departure from the traditional Hippocratic mode of clinical practice. The resulting conflicts in moral and legal obligations are complex and as yet unresolved.[4] I shall address one such issue: the challenge of balancing advocacy and allocation roles successfully in managed care organizations.

For many people, the most troubling aspect of HMO practice lies in its gatekeeping function, raising the image of chairside cost-benefit analysis and resource allocation.[1] It has been argued that as pressure mounts to control costs, insurance plans will have to go beyond eliminating unnecessary care and also withhold potentially beneficial care; or, in other words, to begin rationing medical services.[22] To gain physician compliance in cost cutting measures, many HMOs appeal to the physician's self-interest through a variety of financial and other incentives tied to cost savings.[2, 4] The physician's loyalties are thereby divided among the needs of his or her patients, the needs of all patients served by the system, the plan's economic directives, and his or her own self-interest.[4] This conflict is most difficult to reconcile in investor-owned profit-oriented plans with stockholders to satisfy and bottom lines to maximize.[1]

MANAGED CARE: JEKYLL OR HYDE?

It is important to recognize that HMOs are not a homogeneous group. To borrow an analogy, there are Jekyll and Hyde HMOs.[23] Jekyll plans, on the one hand, adopt a population-based approach to clinical practice that incorporates public health as well as individual medical care strategies. They cultivate a culture of practice characterized by physicians who equate good patient care with cost-effective care. They foster collaborative relations between primary care and medical specialists. These plans tend to have higher medical loss ratios because profits are reinvested in patient care. Jekyll plans are more often found in older staff and group model HMOs where the management structure guarantees that fiscal considerations do not unduly intrude on the medical care of individual patients. Hyde plans, on the other hand, are more often found in the latest generation of investor-owned profit-oriented managed care systems that revolve around the assembly of a network of doctors and hospitals. The loose knit structure of these networks lacks the Jekyll culture of practice. In fact, primary and specialty physicians often feel themselves pitted against each other as the plan strives to ratchet down costs. Hyde plans, therefore, can only control costs by alternative means—such as exclusion of sicker patients, burdensome micromanagement of clinical decisions, or denial of beneficial but expensive care to some patients. Hyde plans may compromise a physician's advocacy function by imposing perverse financial incentives that penalize providers who fail to stay within certain utilization and expenditure targets, and then prohibit doctors from informing patients about these arrangements. These plans tend to have lower medical loss ratios because profits are paid out to investors.

THE FUTURE

HMOs can, and do, control costs[24] while providing high quality medical care.[25] A recent study by the accounting firm of Peat Marwick found that increases in health care premiums have fallen below the rate of inflation for the first time in 10 years, largely because of the growth of managed care programs.[26] It is unclear whether these savings will continue in the future or whether they represent a one-time savings from the move away from fee-for-service plans into HMOs. What is clear is that investor-owned profit-oriented plans are rapidly entering the HMO industry. Competition is fierce. Looking forward, we must search for ways to foster the development of Jekyll plans, and perhaps even find ways to transform Hyde plans into Jekyll plans.[23] Our schools of optometry have a role to play in preparing tomorrow's optometrists for population-based clinical practice.[21] Externships and residency programs in Jekyll-style HMOs can expose students to the culture of practice that successfully blends advocacy and allocation roles. For the public to be well served by the ongoing transformation of the American health care system, managed care organizations must do more than save money, they must also preserve the physician's advocacy function.[2]

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