# PHYSICIANS, PAYERS, AND POWER

## *The United States Is Witnessing A Struggle for Control of Healthcare*

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**Summary** From its earliest days, healthcare in the United States has been controlled by providers, that is, by physicians and by hospitals (which, in turn, were also usually controlled by physicians). But this situation is changing.

In the 1920s and 1930s, providers created health insurance companies like Blue Cross and Blue Shield to help patients pay for healthcare—to pay, in other words, for those services offered by providers. After World War II, the Hill-Burton program covered the nation with new hospitals. In the 1960s, Medicare and Medicaid eased the healthcare burden of older Americans—and also recapitalized hospitals. Thus providers called the shots in the creation of both the delivery and the payment systems.

But in the 1970s, payers began to become more powerful. Now, in the 1990s, they have joined employers in acting to contain rapidly escalating healthcare costs.

But even those long disturbed by the arrogance of some healthcare providers are now asking themselves: Is this really what we wanted? Payers are governed by the market; they may well seek, not the best, but the cheapest healthcare available. This is not in the interest of either patients or physicians. A middle ground—a new power alignment—will have to be worked out by patients, physicians, payers, and government.

As the healthcare system is restructured (regrettably, at least so far, without a national commitment to universal coverage), one hears a great deal about the goals of the various movers and shakers. Some speak of containing the admittedly egregious annual increases in healthcare spending; others believe that the creation of more organized healthcare systems will improve patient care; still others see a chance to make a quick buck (or several million quick bucks); and yet others cling to the idea that access to care can be made a reality for all Americans.

To which I say: Baloney. It's about power.

The crux of the reform debate is neither access, nor cost, nor quality, but rather the simple question: Who is going to control a sector of the economy that consumes more than $1 trillion annually and employs as many as 10 percent of working Americans? What we are calling reform is, in many ways, really an attempt to shift power.

### Control by Providers

As has been documented by several historians,[1] healthcare in the United States has been, from the beginning, the providers' fiefdom.

In the early public hospitals, which were philosophically only a step or two away from the almshouse, control was held by the physicians-in-training who lived in them (hence the contemporary medical education term "resident").[2] As the system developed, clinicians had the power, whether they were medical educators, fully trained physicians, residents, interns, or even (very occasionally) nurses. Institutionally speaking, in acute care, hospitals were dominant (as were the doctors who worked in them); nursing homes were the same in long-term care (although the rise of the modern nursing home was largely a result of the 1965 enactment of Medicare and especially Medicaid, which paid for long-term care when virtually no private insurers did).

When patients' ability to pay out of pocket for hospital care eroded to the point of crisis in the

1920s and 1930s, the result was Blue Cross, then (and until fairly recently) a creature of the hospitals. Blue Shield, created by physicians, soon emerged to cover the doctor side of the bill. Thus providers were able to ensure stable payment from entities they controlled.

When there arose an outcry after World War II about problems of access for rural Americans, the Hill-Burton program papered the nation with hospitals (and paid for a good bit of urban hospital building as well). When elderly Americans' inability to pay for care came to the attention of the Johnson administration in the 1960s, the response was Medicare (and, as an afterthought, Medicaid for low-income populations). Medicare and Medicaid were designed as much to recapitalize American hospitals with generous reimbursement as to ease the healthcare burden of older Americans. The American Hospital Association (AHA), to be sure, helped write the bill; but the American Medical Association (AMA), in its worst political miscalculation of this century, fought the enactment of Medicare tooth and nail. Nonetheless, physicians were also promised generous reimbursement under the program.

Thus providers were the controlling players in the creation of both the delivery and third-party payment systems. They ended up in charge of both provision and payment. Whether this was the brightest of ideas is certainly open to question; but few people were examining the organization of healthcare 40 or 50 years ago. One dissenter was the brilliant and prescient health economist Rufus Rorem, PhD,[3] who warned about the unintended consquences of fee-for-service payment and fragmented delivery of care; however, his voice was muffled by the providers' chorus.

There were exceptions to provider domination of the system, of course. One of the most notable was the Kaiser Foundation Health Plan, created in the 1930s and 1940s by physician Sidney Garfield and industrialists Henry and Edgar Kaiser. Their innovations led to what became known as health maintenance organizations (HMOs): physicians in group practice, salaried or with exclusive contracts; hospitals owned by the same organization; and capitated premiums paid directly to the provider. The same organizational thinking had earlier led another industrialist, Henry Ford, to found a hospital whose entire medical staff was salaried. He did not, however, add an insurance arm; that would come decades later.

Provider organizations bitterly denounced these systems as everything from communistic to anti-patient. And mainstream healthcare and health insurance continued to be based on the model of individual providers working separately for payment per service, with reimbursement coming from entities (like Blue Cross) that often were separated from the providers only by a thin and highly permeable membrane.

**Some power shifts are subtle. Such was the case in American healthcare as power shifted from the providers of care to those who pay for it.**

### The Payers Rebel

Provider control remained quite solid until the 1970s, when three changes took place.

First, a growing desire to contain healthcare costs led a host of analysts, politicians, and employers to ask if it was such a great idea to have the providers so dominant on the payment side of things.

As a result, the growing separation between Blue Cross and the hospitals accelerated. The AHA, which once owned the plans' national organization, turned its symbol over to the Blue Cross and Blue Shield Association at the beginning of the 1970s. And a rash of state and federal legislation opened up the field to HMOs and other entities that were led, not by providers, but by insurers and entrepreneurs. The traditional provider-payer bond was broken.

Second, managed care and capitation, which had been around for decades, by the 1990s were being touted as the magic bullet that would contain costs, broaden access, make healthcare more efficient, and (according to some advocates) cure the common cold. The rush toward capitated payment meant that incentives went all topsy-turvy, and providers were faced with a new and often unwelcome world in which the less you did, the more money you made.

Third, employers, who had placidly been paying increasingly high bills for years, went on the offensive—cutting benefits, increasing copayments and deductibles, demanding data on provider performance, embracing selective contracting, and shifting to managed care and capitation. They also moved aggressively into utilization review and access management. They decided to take charge, basing their demands on the not unreasonable argument that they had a right to some say about what they were buying and how much they were paying for it.

Shifts in power occur in all kinds of ways. Some occur overnight, as in a military coup. Some occur on schedule, as in regularly held

elections in democratic nations. Some are agonizingly slow, as in efforts by minority groups and women to achieve equality in their societies.

And some power shifts are subtle. Such was the case in American healthcare as power shifted from the providers of care to those who pay for it. This change had been coming for years, but few noticed; and then one day the providers woke up and realized that they no longer called the shots.

### A New Arrangement

What we face now is control of healthcare by those who pay for it—an arrangement that is in keeping with America's reliance on its beloved market. This revolution was born, in large measure, from the fact that the provider-controlled healthcare system came to cost more and yet exclude more people than at any time in the history of this or any other nation. Another contributing factor was the rise of health services research, a discipline that, for the first time, started to analyze the processes, structures, and economics of healthcare—especially the latter. Its conclusions were often that healthcare, as it was organized, was among the most wasteful of systems.

Furthermore, the healthcare system had become emblematic of the ancient proverb that pride goeth before a fall. Healthcare providers, especially hospitals and physicians, were arrogant. They were above the law and they knew it. They fought every government attempt (except in rare cases such as in Maryland) to moderate prices or set even minimal standards of accountability. They made enormous amounts of money. They overbuilt. They went into huge debt. And they reduced every public policy debate in healthcare to the issue of how much they would get paid.

Physicians and hospitals were their own worst enemies. They were big, fat targets, many with high margins and high incomes and a whole lot of money in the bank. They were asking for trouble—and they got it.

It is said that when the private sector fails, the public sector must act. It is said less often, though it is just as true, that when the public sector fails, the private sector acts. This happened in healthcare. When providers rejected spending caps, global budgets, and all-payer systems, when the so-called competitive approaches of the go-go 1980s did not work, insurers, employers, and consultants said, "So be it."

**Do we want physicians' clinical decision making controlled by nonphysicians? Should the incentive to do less (or nothing) control physicians' decisions when there are no outcomes data to direct those decisions?**

And they stripped hospitals and especially physicians of their power over healthcare. If your prices were too high, you would not get a contract. If you wanted to retain your patients, you would have to offer discounts of 25 percent, 50 percent, even 75 percent. If you were involved in medical education or indigent care, that was your problem. And, in some cases, if you could not produce data demonstrating that your quality was as competitive as your prices, you were at risk. It is no accident that mental health services, which have lagged behind other forms of care in terms of producing reliable data on outcomes, are the services most often cited by employers as being candidates for termination of coverage.[4]

It is interesting to note that physicians have been involved in every phase of this takeover. They advise insurers. They own and invest in utilization review firms. They own and invest in HMOs. They are deeply involved in corporate quality measurement programs. Nonetheless, they are still helping to divest other physicians of power.

### The Struggle Goes On

The argument has often been made—usually covertly—that healthcare providers, especially physicians, are motivated only by money, and that if you want them to change their ways, just change their economic incentives and everything will be fine. This theory is being tested in a great many places right now. Of course, with a rather significant physician oversupply (of perhaps 40 percent), a massive physician maldistribution, and a mismatch of 70 percent specialists to 30 percent generalists, there is no way any kind of market mechanism could possibly be expected to work, except brutally. But in health policy, we always seem to need to learn the hard way.

So we are now disempowering physicians (sometimes with lay hospital executives leading the charge), using the generous physician supply, selective contracting, the growth in managed care, and the old (now conveniently remodeled) idea of integrated delivery systems as means to that end. Although hospital-based integrated systems are, in fact, a way for hospitals to try to regain their power, such systems are usually controlled by nonclinicial administrators, not physicians. Even within healthcare organizations, power is passing from physician to lay administrator and trustee.

The question for the future: Is this what we

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## COOPETITION

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citizens throughout the area.

• In conjunction with 130 physicians who serve both hospitals, the two facilities are forming a physician hospital-organization. The hospitals are also creating a complementary management service organization to support physicians' desire to lower overhead costs in preparation for managed care participation.

### COOPETITION

These initiatives are geared toward creating an integrated delivery network that allows the missions of both hospitals to be fulfilled. These integration efforts provide a route to maintain a Catholic healthcare presence in central/southeastern Ohio. Some have coined the phrase "coopetition" to describe this new effort, which acknowledges the history of competition while embracing cooperation as the wave of the future. This shift in emphasis has not eliminated competition but rather highlighted the opportunity for institutions to work together to lower the cost of care while improving access.

As a prescription for the remainder of the 1990s, coopetition symbolizes the manner in which Catholic-sponsored healthcare organizations can and will thrive and survive. It is essential that the heritage established by religious congregations continue. By developing new and better relationships with other providers, Catholic sponsors can preserve the opportunity to serve.

### RESPONDING TO COMMUNITY NEED

Upholding the mission may not save an institution. Local market conditions will determine the number of providers a community can support and the services they offer. Healthcare reform will help rewrite mission statements to focus on community health instead of institutional survival.

The definition of Catholic-sponsored healthcare need not change, only the application. Success will be measured by how well we respond to community needs—the same standard established when the founding sisters began their healthcare ministry. □

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wanted? Do we want physicians' clinical decision making controlled by nonphysicians? Should the incentive to do less (or nothing) control physicians' decisions when there are no outcomes data to direct those decisions? Should the availability of physicians to patients be based solely on the ability or willingness of the doctor to discount? Just how inconvenient should we make it for physicians, or payers, to put the patient first? It is curious that—insofar as I have been able to learn—few of those policymakers and payers who advocate plans with tight capitated payments and stringent utilization controls belong to such plans themselves.

Yes, too often physicians have seemed to put their own incomes first—and the devil take the hindmost, even if the hindmost includes their own patients. Most have rejected salaried practice, which may well be the only sane solution to their current dilemma. They have alienated many of us. But is their clinical autonomy too high a price to pay for our vengeance?

Perhaps it is. Certainly, many physicians think so—even those who could make a handsome profit by undertreating patients whose insurance is capitated. Many policymakers think so as well, even those who have not been historically known as friends of doctors.

Sen. Paul Wellstone, D-MN, certainly the most liberal member of the U.S. Senate, in the last session sponsored the AMA's Patient Protection Act, which limits HMOs' ability to control physician contracting and practice. The "any willing provider" legislation being considered in at least 20 states requires managed care plans to contract with any provider who agrees to abide by the plan's payment rules. This is often a desperate attempt by physicians and other providers to avoid being shut out of contracts. (But what does that say about providers' willingness to stand up to unacceptable contract demands?)

Physicians in Alaska, California, and other states are warming to proposals for single-payer systems; even if such systems threaten lower payment rates, these physicians say, they would allow them and their patients the kind of freedom they feel they are losing. This may be the dawn of the strangest of bedfellows, as liberals who worry about access, quality of care, and profiteering team up with conservative physicians who see in managed care and selective contracts the potential doom of their profession.

This is bare-knuckles power politics, as payers (many of whom were once controlled by providers) seek to make physicians dance to their tune, and physicians seek to reclaim ground long lost. It is an economic battle, to be sure; but it is also a moral battle.

There are strong values on both sides, and great sins as well. But there is also a middle ground, which is where we will likely want to end up. That middle ground must be defined by physicians, government, outcomes researchers, patients, and payers together, in the interest of efficient, effective, affordable healthcare. Sadly, I fear that by the time we get to that middle ground, the path to it will be soaked in blood. □

*The author would also like to congratulate* Health Progress *on 75 years of contributions to healthcare.*

### NOTES

1. Charles Rosenberg, *The Care of Strangers*, Basic Books, New York City, 1987; Rosemary Stevens, *In Sickness and in Wealth*, Basic Books, New York City, 1989; Paul Starr, *The Social Transformation of American Medicine*, Basic Books, New York City, 1982.
2. Rosenberg.
3. Rufus Rorem, *A Quest for Certainty*, Health Administration Press, Ann Arbor, MI, 1982.
4. Northwestern National Life Insurance Co., *Employee Benefits in the Year 2000*, Minneapolis, 1989.