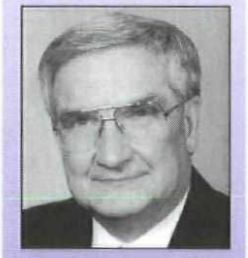
We Need a Realistic Approach to Healthcare Financing

BY HAROLD RAY, MD



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Emily Friedman, in her usual style, has presented a provocative view of HMOs. To counter all of her points with which I take issue would require a longer article than I wish to write. However, she makes several good points, and her idea to "unbraid the rope" is a good one.

Managed care has controlled the cost of healthcare, but the easy savings opportunities are now gone. Providers' revenues and, thus, bottom lines have gone down in many regions of the country, particularly in urban areas. I am concerned that the quality of healthcare is now declining due to continuing pressures to reduce costs.

I agree with Friedman that managed care is not going away soon, and that we will not return to fee-for-service, even though many areas of this country still have fee-for-service and indemnity insurance. A single-payer system is not in the future of this country, in my opinion, but there must be significant changes in managed care as it exists today. Let's start by reducing exorbitant salaries for HMO executives, controlling drug costs, and improving access and quality of care.

Friedman alludes to one root cause: too many hospitals, physicians, and services. I agree that we need to find a way to reduce the number of hospital beds, realign physician distribution, and decrease medically unnecessary services. However, we need to balance that approach with proper access and quality of care.

I disagree with Friedman's negative opinions about providers. Most providers I have associated with have been professional, caring, and compassionate caregivers. They did not enter their profession just for the financial incentives.

On page 24 she writes, "It also goes without saying that ethical providers do not accept equity positions, stock, or partnership in organizations with which they contract," but in the very next paragraph she encourages providers to form their own managed care company. Are they to start the companies and take the financial risks, but not contract with them? You can't have it both ways.

The Balanced Budget Act of 1997 gave providers the opportunity to form provider-sponsored organizations (PSOs). However, many large third-party payers and most providers are not assuming Medicare risk in the face of low government reimbursement and significant financial risk. HMO and PSO management is not usually a core competency of healthcare providers, and I do not see it as a viable option for most providers. Kaiser Permanente, to which Friedman refers, had net losses of $266 million in 1997 and $288 million in 1998.

Providers are concerned about reduced revenues, but, more important, they are concerned with the intrusion of healthcare plans into the practice of medicine, the quality of healthcare services, and the well-being of patients. Health plans' decisions to withhold payments, delay appropriate medical care, or prevent it altogether are the most disturbing aspects of managed care. Managed care plans need to be accountable when their decisions result in harm to the consumer.

Friedman expresses strong opinions about the business side of managed care plans. It is unfortunate that she cannot actually manage an HMO and see firsthand how difficult it is to provide all the services she wants to provide, reduce costs, and keep providers involved. Some of her ideas are good but many are unrealistic in today's economy.

Managed care has problems that need to be solved, and their solution will require the cooperation of all. Let's "unbraid the rope" and find a realistic approach to healthcare financing in this country. Managed care faces a true challenge if it is to deliver high-quality care, continue saving costs, and satisfy consumers.