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Does the Doctor Need a Boss?

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Executive Summary

The traditional model of medical delivery, in which the doctor is trained, respected, and compensated as an independent craftsman, is anachronistic. When a patient has multiple ailments, there is no longer a simple doctor-patient or doctor-patient-specialist relationship. Instead, there are multiple specialists who have an impact on the patient, each with a set of interdependencies and difficult coordination issues that increase exponentially with the number of ailments involved.

Patients with multiple diagnoses require someone who can organize the efforts of multiple medical professionals. It is not unreasonable to imagine that delivering health care effectively, particularly for complex patients, could require a corporate model of organization.

At least two forces stand in the way of robust competition from corporate health care providers. First is the regime of third-party fee-for-service payment, which is heavily entrenched by Medicare, Medicaid, and the regulatory and tax distortions that tilt private health insurance in the same direction. Consumers should control the money that purchases their health insurance, and should be free to choose their insurer and health care providers.

Second, state licensing regulations make it difficult for corporations to design optimal work flows for health care delivery. Under institutional licensing, regulators would instead evaluate how well a corporation treats its patients, not the credentials of the corporation's employees. Alternatively, states could recognize clinician licenses issued by other states. That would let corporations operate in multiple states under a single set of rules and put pressure on states to eliminate unnecessarily restrictive regulations.

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There is a lack of coordination of care in the United States, particularly for patients with multiple health problems.

Introduction

Reasonable people disagree about how best to finance health care. However, everyone agrees that health care delivery in America is highly inefficient. Patients do not see outcomes commensurate with our country's sharply rising health care expenditures. Credible estimates suggest that one-third of health care spending is wasted.[1] Measures show quality of care often falling short of best practices.[2] Estimates of medical error rates are alarmingly high.[3]

Those macro-level indicators of inefficiency are reinforced when one examines health care delivery from a process perspective. There is a lack of coordination of care, particularly for complex patients with chronic illnesses or multiple health problems. Late-stage care and treatment of chronic illness together account for perhaps three-fourths of all health care spending.[4] Fee-for-service payments are widely viewed as distorting medical treatment.[5] Existing fee-for-service systems discourage doctors from "wasting" time interviewing and examining patients, fail to reward prevention, and encourage doctors to overutilize certain types of equipment and procedures.[6] There is considerable friction between doctors and their remote "supervisors" from Medicare, Medicaid, and private insurance companies. The use of information technology, such as electronic medical records, appears to fall far short of its potential.[7]

The Times, They Are A-Changin'

Several trends have converged for which the current institutional framework for health care delivery is not well prepared.

Technological innovation and increases in specialized knowledge have dramatically altered everyday medical practice. The challenge of complex patients has increased, in part as a result of that progress: more conditions have become treatable, thus more patients have multiple diagnoses. As death rates resulting from preventable injuries, heart attacks, and communicable disease fall, more people live to reach a stage where multiple breakdowns occur at once.

Fifty years ago, the typical patient encountered one doctor and was treated for a single complaint. Today, the patients who use the most services are being seen by multiple specialists and treated for multiple ailments.

Americans have been shifting their priorities from other material goods to health care, as reflected in the fact that the share of health care spending in national income has roughly doubled over the past generation. Perhaps related to that, the share of health care expenses paid for out of pocket has plummeted over the past 50 years, while the share of expenses paid for by third parties has climbed to over 85 percent.[8]

All of America's health care financing mechanisms are under stress. The cost of providing insurance is rising in Medicare and Medicaid, as well as in the private sector. Company-provided health insurance is becoming a major proportion of employee compensation. Medicare and Medicaid face an increasingly bleak financial future.[9] This has led to increasingly frequent and often crude attempts to reduce physician compensation, even as the demand for care increases.

Delivery Lags Technology

Given all of these trends, it is not surprising that the traditional model of medical delivery, in which the doctor is trained, respected, and compensated as an independent craftsman, is anachronistic.

When a patient has multiple ailments, this traditional model breaks down. There is no longer a simple doctor-patient or doctor-patient-specialist relationship. Instead, there are multiple specialists who have an impact on the patient, each with a set of interdependencies and difficult coordination issues that increase exponentially with the number of ailments involved.

Today, the typical patient is more like Arnold's late father. Prof. Merle Kling was

diagnosed at the age of 88 with esophageal cancer. A month later, he fell and broke his hip, and then found himself in eight different hospital units over the course of three weeks. As he was moved from floor to floor, each unit seemed to pick up on a problem that the previous unit had missed—or perhaps had caused. His greatest suffering was caused by infected bed sores that developed while he was in the hospital. He remained under hospital care for two more months, until he died.

Professor Kling likely received hundreds of thousands of dollars in health care services, almost all paid for by Medicare or additional insurance. During his father's illness, Arnold observed firsthand the lack of continuity and coordination of care, which squandered the sincere efforts of many individual doctors and nurses.

Complex patients require more than independent craftsmen. An independent craftsman can fix your sidewalk, but he cannot build a highway interchange. An independent craftsman can create a website for your soccer team, but he cannot build a computer system to support the operations of a financial services firm.

Organizational Competence

To serve the needs of complex patients, medical care delivery needs to include more than just the skills of doctors and nurses. Complex patients require *coordination*, *planning*, better *communication*, more attention to *process*, and *accountability*. The importance of planning, communication, accountability, and so forth suggests a need for *organizational competence* in addition to pure technical skills.

A Project Manager

Treating a complex patient is comparable to building a house. The work of a number of skilled craftsmen needs to be planned and managed. When unexpected problems occur, someone needs to revise and adapt the plan. In constructing a house, that role is played by a general contractor.

For complex patients, there should be one person who is aware of all aspects of the patient's needs and who acts as a project manager. Except in cases of dire emergency, the first person a complex patient sees upon diagnosis should be the project manager, who would formulate a plan to get the patient well. The project manager would anticipate problems and balance risks, adjusting the plan as needed.

It should be a project manager's job to anticipate risks such as bed sores, which afflicted Arnold's father. Under the existing approach, no one took responsibility for anticipating or dealing with that risk until it was too late.

The project manager should be responsible for ensuring adequate communication among all parties. That means ensuring that everyone involved in the patient's care, including the patient, is involved in making the plan and is kept informed of changes and other issues that require attention. The project manager should coordinate the work of medical specialists by bringing them together, if necessary, in order to go over the trade-offs and resolve issues.

A homebuyer typically does not oversee the day-to-day construction work. Instead, buyers may be involved in the initial planning process, and they may be consulted as different problems present themselves along the way. Likewise, medical care today is too sophisticated for complex patients to be their own project managers—though they should remain the project manager's boss.

The project manager may or may not be an M.D., but doctors would have to treat this person as the boss—just as in home building, where an electrician acknowledges that the general contractor is the boss.

Medical care typically lacks coordination, in part because payment systems such as Medicare have not kept pace with technology and patients' changing needs, and because many doctors are unwilling to cede authority to a boss. Medicare and other payers continue

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to pay doctors according to the independent-craftsman model. For example, Medicare's payment system generally does not reward coordination. Instead, Medicare and other fee-for-service payers tend to favor technologically intensive specialist services over those of general practitioners who might be best suited to play the role of project manager. The mismatch between payment systems and patients' needs can be seen in the fact that the supply of gerontologists is not increasing, in spite of the obvious demographic basis for greater demand and the value gerontologists can add as project managers for those who are least able to coordinate their own care.[10]

Physicians' resistance to managerial authority is legendary. According to one colorful account:

> While many physicians fall prey to an illusion of omnicompetence and believe that their medical training endowed them with superior management judgment, most are incapable of submitting to the authority of anyone, even a fellow physician. Many physicians selected their profession based upon their need for autonomy and individual achievement. As a consequence, many lack the interpersonal skills or civility to function as part of a larger enterprise . . . A few less-temperate administrators actually pop off in medical staff meetings about how different things will be "when all you bastards finally work for me."[11]

In the home-building analogy, it is as if the concrete contractor, the drywall contractor, the electrician, and the plumber all refuse to work under a general contractor. Instead, they each try to do their jobs independently, regardless of the impact on the rest of the project. No one craftsman is in a position to take responsibility for delivering the overall finished product, and quality suffers as a result.

Government interference holds at bay the market forces that would otherwise improve coordination of care.

Physicians have been more successful than other professionals in resisting managerial authority. Their success comes not from any inherent aspect of medical practice but from government protection.[12] Licensing of medical professionals, state health insurance regulations, corporate-practice-of-medicine laws, and policies that encourage fee-for-service payment (i.e., Medicare, Medicaid, and the federal tax code) hold at bay the market forces that would improve coordination of care by subjecting physicians to managerial authority.

Senior Management

Coordinated health care teams in turn would benefit from senior-level management that constantly examines how well their plans are working, retains those that deliver positive outcomes, and discards those that do not. When bottlenecks or errors arise, management must brainstorm solutions, test them, and implement those that work. In other words, senior management must be accountable for overseeing processes that lead to the best possible outcomes for patients.

Such organizational advances are not entirely foreign to medicine. Some hospitals rely on "intensivists" to coordinate treatment in intensive care units, though this innovation has yet to be widely adopted. Gerontologists coordinate care for elderly patients, yet remain a relative anomaly, despite the obvious value they could provide to the growing number of adults who struggle to care for their children and their aging parents at the same time. Intensivists employ checklists of standard procedures to reduce errors in intensive-care units.[13] These advances illustrate how management techniques borrowed from industrial settings can be used to improve health care. Yet prevailing payment and workforce policies have inhibited these and similar innovations.

A Role for Corporations

The challenge of developing organizational competence is the chief focus of the modern corporation.[14] The very purpose of corporations is to reduce transaction costs

between parties.[15] It would be very costly for a wealthy individual or large firm to contract with several highly specialized but independent lawyers and accountants. Thus the markets for legal and accounting services are dominated by corporate providers that can hire, coordinate, and monitor the services of those specialists.

In medicine, transaction costs include the costs of soliciting input, sharing information, and coordinating treatment among multiple clinicians, often across space and time. Thus it is not unreasonable to think that delivering health care effectively, particularly for complex patients, could require a corporate model of organization. Just as most homes today are built by large regional companies, the typical health care provider might turn out to be a corporate entity.

Perhaps large national corporations would dominate the health care industry. However, it would seem more likely that, as with home building, no major dominant national firm would emerge. Small firms would compete alongside large regional companies. Solo practitioners could continue to serve consumers with less complicated needs, as with legal and accounting services.

Health care companies could straighten out lines of accountability and provide coordinated care. For complex patients, the corporation would assign a project manager. The project manager would bring to bear whatever resources are appropriate for meeting the patient's needs.

A patient-focused corporate provider would not waste skilled craftsmen through failure to coordinate their work. If the patient's needs are best served by a team, then the corporation would train its personnel to work in teams.

A corporation would develop compensation systems that align the incentives of its employees with the interests of its customers, the patients. If team behavior is valuable to the patient, then the compensation system would reward team behavior. If hands-on evaluation of the patient is more helpful than sending the patient for an MRI, then the corporation would reward hands-on evaluation.

A corporate model of health care would set standards for its employees. Rather than leave the quality of care to the whim of the individual doctor, the corporation would try to make sure that all of its employees use state-of-the-art methods and share best practices.

A corporation would standardize procedures and treatment plans, such as intensivists' use of checklists, using corporate guidelines. With procedures that are standardized and rationalized, it would pay to deploy information technology to support those procedures, thus reducing costs and preventing errors.

In a corporate setting, a doctor would not have a business or administrative function. The doctor would not worry about what is billable and what is not. Instead, the doctor's job would be to serve patients according to corporate standards. The doctor would be paid a salary, with increases, bonuses, and other incentives that take into account direct observation of the doctor as well as patient satisfaction and peer evaluations.

A corporate compensation system would be administered by onsite managers, rather than by remote control. Doctors and other employees would be paid on the basis of how well they execute corporate policy and meet the needs of patients, not on the basis of how well they fill out forms to game the system of fee-for-service medicine as administered by insurance companies or government bureaucrats.

Because many patients present unique challenges, however, doctors likely would have discretion to deviate from guidelines based on their judgment about a particular patient. Management could take the outcomes of such cases into account when deciding on compensation. A doctor whose deviations help to improve outcomes could receive a higher bonus than a doctor who simply follows guidelines or a doctor whose deviations produce inferior results.

The Veterans Administration and Kaiser Permanente, both of which have been praised by observers,[16] exhibit some components of

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what we call the corporate model of health care. Both pay physicians on salary, rather than on a fee-for-service basis. In effect, both receive a set amount of money per customer to keep their patients well. Both have been leaders in deploying electronic medical records, which enable coordination of care. Kaiser Permanente offers bonuses to its clinicians to ensure that patients receive recommended services.[17]

Yet a corporate model does not necessarily mean an integrated HMO model, which combines the functions of health care provider and insurance company. The company providing health care need not be the same as the insurance company.

Consumers must control the money that purchases their health insurance and must be free to choose their insurer.

Putting Patients ahead of Providers

If you ask doctors, you will find that they want more autonomy, more reward for ideas that work, less severe penalties for mistakes, and less competition. That is what every worker in every profession wants. What matters in health care, however, is the interest of the patient.

Some doctors practicing today would be unhappy in a corporate environment. They may value their autonomy and resent having to answer to a boss who is not as technically skilled as they are (an issue familiar to engineers, among others). On the other hand, a corporation might be able to offer doctors better work-life balance, more relief from administrative hassles, better information technology systems, and a day-to-day environment that operates more smoothly. Most doctors want to see their patients treated well, and if a corporation better serves the interests of a complex patient, doctors will be happier working in that environment than in an environment where the patients suffer because of flaws in the system.

The health care delivery system will probably include doctors who work in a corporate environment and doctors who work in smaller practices. Complex patients will tend to be handled by corporate medical care, but the majority of patients can be handled by either a corporation or a small practice.

Opening Markets to Corporate Competition

There is nothing magical about a corporation as an organization. Corporate bureaucracies are inherently inflexible, imperfect, and unimaginative. Competitive market pressures force corporations to overcome those limitations and are therefore essential to improving medical care. If corporations risk losing customers when they fail to keep pace with market standards for excellence, they will find a way to improve—or go out of business.[18]

At least two forces stand in the way of robust competition from corporate models of health care delivery. First, there is the regime of third-party fee-for-service reimbursement, heavily entrenched by Medicare, Medicaid, and the regulatory and tax distortions that tilt employer-provided health care in the same direction. Second, there are medical practice regulations that make it difficult for corporations to design optimal work flows for health care delivery.

Let the Patient Control the Money

Most doctors want to serve patients. But there is a conflict: the patient is not the one who pays the bills. Instead, the customer that health care providers must learn to serve is the private insurance company or the government program. If doctors want to get paid in today's environment, they have to play by rigid third-party rules imposed by employers and government, not patients' choices.

Reducing our reliance on third-party payments will not be easy. Our moral instinct tells us not to take advantage of someone in distress. That translates into a reluctance to have individual patients pay for their own health care services. Unfortunately, insulating consumers from the cost of what they buy is incompatible with efficiency. In health care, third-party payments force providers to serve two masters—the patient and the bureaucrat.

In order to put patients first, we will need to see innovation in insurance. One possibility is *fixed-dollar benefits* that go to patients on the basis of the diagnosis. Another possibility would be insurance with *higher cost-sharing* through copayments and deductibles. A third possibility would be for corporations to receive *a fixed amount from each customer* to provide medical care to that population.

The fixed-dollar-benefit approach has yet to succeed in health insurance. Given the tremendous uncertainty in medicine, and the fact that a lot of health care spending goes for diagnostic procedures, that approach may have only limited applicability. However, to the extent that it could be employed, it would give patients the incentive to shop carefully for treatment and to choose the most cost-effective procedures.

Higher cost-sharing would also give patients more responsibility for paying for more of their health care directly. That would likewise reduce the temptation for doctors to recommend procedures with high costs and low benefits.

In order for patients to be able to exercise better judgment, the whole process for billing patients probably should be changed. From the patient's point of view, an itemized bill, delivered days or weeks after a hospital stay took place, is not particularly helpful. It may be preferable for the corporation to present to the patient, as soon as possible, a complete plan for getting the patient well. This plan should include a fixed, all-inclusive price, which can be evaluated by both the patient and the patient's insurer. If the plan—including the price—is not satisfactory, then either the corporation modifies the plan or the patient goes elsewhere. Over time, if the plan needs revision, the parties may revisit the price, as in homebuilding.

Corporations could also offer patients an all-inclusive price for whatever ailments might befall them over the course of a year or multiple years. This is known as prepayment, and appears to work best when the health insurer and the delivery system are part of the same corporate entity, as with organizations such as Group Health Cooperative and Kaiser Permanente. Such corporations would compete with other financing structures to improve quality and reduce the cost of care.

For this process to work, consumers must control the money that purchases their health insurance, must be free to choose their insurer and health care providers, and must have information about how different corporations deliver health care. One consumer may prefer a low-cost corporate provider, while another prefers a high-end firm. The quality of the market will depend on the emergence of a good set of consumer information and rating services that allow consumers to see how well various corporations are performing at meeting patient needs. All corporations would then be under pressure to deliver good value for the consumer's money.

Deregulate the Medical Workforce

In order for health care corporations to function effectively, regulation of health care would have to change. Regulators could evaluate how well a corporation treats its patients, not the credentials of the corporation's employees. The current model, in which government licenses and (supposedly) regulates each individual practitioner, could be replaced by a model in which the government regulates at a corporate level. Government should ask whether a corporation is operating in a manner that is consistent with the promises that it makes to customers. The government should not have to ask whether the corporate employee administering a test for strep throat has a particular credential.[19]

In Maryland, where one of us lives, new physical therapists must have a doctorate in order to practice. The other lives in Virginia, which does not require a doctorate. While these sorts of education requirements supposedly exist to protect patients, the reality is that they are used by professionals to restrict supply and suppress competition.[20]

As patients, we do not care whether we receive care from someone with an advanced degree or someone who has completed a company apprenticeship. If a corporate provider

Government licensing of individual practitioners could be replaced by a model in which the government regulates at a corporate level.

Another alternative would be for states to recognize clinician licenses issued by other states.

develops a less expensive method of delivering superior outcomes and is willing to stake its reputation on it, that corporation should have the opportunity to compete. We will take *quality* care from anyone.

Corporations providing health care would be evaluated by consumers, both informally through word of mouth and formally on websites, in magazines, and by consumer groups. Just as in any other market, corporations would have an incentive to attain good reputations.

The market regulates quality by driving inferior firms out of business. If that process is insufficient, then government regulators could be empowered to license and revoke licenses of corporate health care providers.

Note that with any regulatory system, the regulated entities will attempt to "capture" the regulator and to use regulations to restrict competition. Under our current system of regulating individual practitioners, the revocation of licenses is a step rarely taken. Economist Shirley Svorny writes that "state boards have a poor record of disciplining errant physicians" and that "one might conclude that licensure offers more protection to malfeasant clinicians than to consumers."[21] This is another way in which our current regulatory structure favors the provider, not the patient. The net benefits (or costs) of institutional licensing would have to be weighed against the net costs of the current system of licensing individual medical professionals.

Another alternative would be for states to recognize clinician licenses issued by other states.[22] That would let health care corporations operate in multiple states under a single set of licensing regulations, and would put pressure on states to eliminate regulations that are unnecessarily restrictive. Each state could take that step on its own, or Congress could require states to recognize each other's licenses.

Conclusion

America needs real reform in health care. The fiscal outlook for our government health care programs is worse than that in other countries, even where populations are aging more dramatically. In many countries, budgetary limits force health care spending to stay within a fixed target. Under Medicare, with fee-for-service reimbursement, we have no effective spending control mechanism. The Congressional Budget Office has pointed out that our health care sector's excess cost growth, in which spending continues to grow faster than the GDP, is unsustainable.

Better ways of delivering medical care are available. But without entrepreneurial mechanisms, market incentives, and vigorous competition, these approaches tend to remain isolated exceptions, rather than general practice.

Eventually, we will have to consider radical new ways to organize health care delivery. To improve health care quality and to reduce its cost, we need to eliminate barriers to competition by corporations.

Notes

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