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## Review of: Erin Dominique Williams & Leo van der Reis, *Health Care at the Abyss: Managed Care vs. The Goals of Medicine* (1997)

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## Book Review

Erin Dominique Williams & Leo van der Reis, *Health Care at the Abyss: Managed Care vs. The Goals of Medicine* (William S. Hein 1997). About the authors, acknowledgments, figures, index, preface, references, table of abbreviations. ISBN 1-57588-201-9 [242 pp. Paper.]

Health care reform is shifting decision-making toward a dynamic of shared responsibility. Four major groups are involved: individuals, underwriters, payers and providers. Business, government, the health care industry, and participants all agree that the ultimate issues posed by health care reform are access, cost and quality.

Yet, the authors' underlying perspective seem to be that of physicians, and its premise that medical providers should build consensus to regain control of health care and return economic incentives to physicians. The title "Managed Care vs. the Goals of Medicine" goes far toward depicting this adversarial theme.

At the outset, the authors identify eleven goals: (1) access, (2) affordability (3) appropriateness of care, (4) comfortable provider-participant relationships; (5) efficient administration; (6) a user-friendly system; (7) appropriate resource distribution; (8) responsiveness to technological growth; (9) participant privacy and confidentiality; (10) appropriate incentives; and (11) group consensus building.

They then provide a useful basic primer of managed care models and definitions. The authors briefly compare and contrast various types of Health Maintenance Organizations (HMOs), including staff, network, group, and direct contract models; Preferred Provider Organizations (PPOs); Individual Practice Associations (IPAs); Physician-Hospital Organizations (PHOs) and Medical Savings Accounts (MSAs). Using the eleven "goals of medicine" as an evaluation model, various managed care models are critiqued with regard to each.

Cursory overview of these models concludes with an assessment that managed care may increase access but do not enhance progress toward the other goals of medicine. The exception in the authors' view is the IPA, the one model predominantly under physician control.

The authors state that their "mission is to facilitate... ready access to a system of high-quality medical care for all Americans." While most

of their eleven goals fall within the access-cost-quality paradigm, their mission statement conspicuously avoids cost. To understand this and the basic premise of this book, the conclusions asserted must be analyzed with regard to the authors' perspective, economic motivation, desire for control, and aim of group consensus building.

This book asserts that managed care organizations (MCOs) do not give participants what they expect from their health care system. However, the authors seem to presume that their expectations are shared by participants. This is not often true. Providers traditionally operate from an illness model, focusing on participants during the more resource-intensive period. Participants' goals have become more focused on preventing illness and making cost-conscious care decisions.

Problems purported to be related to MCOs is supported with a few media anecdotes of medical complications. Although longitudinal research is limited, MCOs appear to have more positive effects on health outcomes than a fee-for-service, illness-oriented system. Yet, the authors consistently conclude what they perceive to be weaknesses in MCO models without acknowledging advancements made over similar weaknesses that existed in the previous physician-dominated system.

Two of the eleven goals of medicine, resource distribution and incentives, involve economic motivation. The authors admit that the primary incentive for providers is financial. It is claimed that MCOs provide the wrong incentives, i.e., none for physicians to provide, e.g., lab tests, more frequent office visits or specialist referrals. Such an assumption is misplaced because the focus under managed care is on increased access and decreased cost. Incentive is not related to how much physicians can bill participants, but to the market share of MCOs and participants that providers can win competitively.

The authors believe that appropriate incentives are those which reward providers for delivering maximum (the most) care, not necessarily optimal (efficient, cost-avoiding, risk-assuming) care. They state that "[a]n increase in physician compensation may facilitate access to care." However, since prices are market-sensitive, in a fee-for-service type system without competition, costs (and thus resources) cannot be managed effectively. Contrary to the authors' conclusion, managed care has decreased the cost of health care. The rate of growth of health

care as a percentage of the gross domestic product has decreased due to the “deregulation” resulting from competition.

The authors argue that cost-containment is inconsistent with quality care. Yet, MCOs work to achieve fiscal goals as well as differentiate between providers in terms of quality. Providers ability to participate in revenue decision-making depends on how well they, e.g., understand costs and use a management model that reduces treatment variations.

A focus on financial incentives shows a desire for control of health care. The authors demonstrate their view of competition by asserting that MCOs, described as “holders of the purse strings,” play providers against each other, frequently to divide and conquer physicians (and hospitals), gaining effective control over both. They further claim that under managed care a decreasing number of “provider positions” may undermine appropriate care. Advocating physicians to exert more control fails to recognize that other groups of providers, e.g., physical therapists, nurse practitioners, psychologists and dieticians deliver “appropriate” care. Other providers using medical management tools, also help to assure reliable health care quality.

Arguing that financially based control of medical decision-making can be detrimental to quality medical practice posits the underlying premise of the book: physicians desire control of the health care system. To rally support for this position, the authors suggest that “if all of the groups have an opportunity to affect the delivery of health care, the system should naturally begin to support the other goals of medicine as well.” In the context of the book’s theme, this conclusion means that if physicians had more control of the health care system, physicians’ goals would gain more support.

The authors continue to encourage group consensus-building among provider stakeholders (coalitions among physicians to oppose MCOs) because “providers are disenfranchised” by highly organized MCOs. They state that group consensus-building is about “leveling the playing field” between providers and holders of the purse strings. This approach would fall short of the kind of consensus necessary to achieve real health care access, cost, and quality goals because all stakeholders are not considered. The group consensus building goal omits three of the four major groups: insurance companies and MCOs; business and

industry; and participants. The authors contend that “[d]iscordant forces are currently battling each other at the expense of patients.” They state that the goal of group consensus is likely unobtainable because interests of providers and payers are adverse. To clearly mark their position, the authors assert that “[t]he elimination of the third party payer [MCOs] is a sine qua non for genuine health care reform....”

Finally, the authors propose the “Quincy Model for the Delivery of Health Care” as their formulation of a strategy to achieve the goals of medicine.<sup>1</sup> This model envisions creation of the “American Health Care Trust” (AHCT), an autonomous public corporation which would provide: (1) universal access, voluntary participation; (2) funding through payroll and income taxes; (3) a standardized national computer network for billing/reimbursement management, quality control, health care technical support, and epidemiological research; (4) choice of provider; (5) physician salaries augmented with bonuses; (6) medical education completely funded in exchange for service payback in needed areas; (7) full funding of participating hospitals by a prospective payment or annual budgetary system; (8) coverage for formulary medications, monitored and approved via the computer network; (9) inclusion of all workers’ compensation needs; and (10) allowing commercial insurance companies to significantly downsize and continue to cover non-AHCT or elective services.

The authors declare that the goals of medicine can only be accomplished after consensus is reached by investigating differences in assumptions, and coming to an understanding by recognizing the validity of others’ perspectives. How can the “Quincy Model” achieve these goals when presented from one narrow perspective?

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