MANAGED CARE, RATIONING AND TRUST IN MEDICAL CARE

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With emerging knowledge and technological advances, demographic changes, and growing population expectations, medical care will have to be rationed more strictly.[1] While most people accept the abstract idea that care should be distributed in a cost-effective way, this principle seems less relevant when their own health or the health of loved ones is involved. If we are to minimize inevitable conflicts over the rationing of health care in the future, we will require a great deal of trust in those who make such decisions. In the past decade, trust in medicine, as for most other social institutions, has fallen significantly.[2] Trust is basic to how we resolve such long-term issues as Social Security, Medicare, and the balance between markets and regulation.

Changes in the organization of medical care make trust more problematic. Many characteristics contributing to trust in medical institutions and to processes of medical care, such as patient choice, continuity of care, and encounter time, have been reduced as employers more commonly select health plans for their employees and seek to reduce health benefit costs. Market changes such as limiting referrals to specialists, increased use of gatekeepers, and the privatization and changing ownership of many health care plans also contribute to increased concern. The larger social and cultural contexts further complicate health affairs; significant restructuring of the economy, erosion of community solidarity, skepticism about the reliability of experts, increased media attention to failures to provide appropriate health care, and violations of public trust more generally, all play their part in the erosion of trust.

Managed care is often seen as the solution to our health care problems because of its seeming ability to reduce the growth of health care expenditures. Managed care includes a variety of structures, strategies, and approaches to organize care, pay providers, and prescribe processes of care. It typically is defined to include

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group and staff health maintenance organizations, independent practice associations and networks, and utilization management organizations. Capitated practice has been growing rapidly, and utilization management now affects the care of most Americans in some fashion. With growing private centralization of managed care, managed-care companies have become a convenient target to blame for medical errors and public dissatisfaction with care processes.[3] While the industry has contributed to its problems by many poor practices and inept public relations, the problems faced by managed-care providers transcend their own policies and practices.

Politicians now find that attacking managed care gains considerable public support and incurs few political risks. The political gains in attacking and legislating against "gag rules," "drive-through deliveries," "mastectomies on the run," and related managed-care practices are sufficiently enticing to enlist the participation of critics and regulators, from the President of the United States to local legislators. In 1996, more than 1,000 bills were introduced in Congress and state legislatures to constrain managed-care practices, and bills continue to be introduced in large numbers. There is an obvious need for an intelligent framework of managed-care regulation, but it is unlikely to emerge from legislatures practicing medicine.

Two features of health care organization draw particular attention to managed care. The first, already noted, is the fact that, as managed care becomes more centralized, the public can more easily blame it for the millions of untoward events that occur annually in the practice of medicine. Mistakes increasingly are seen as systematic and not simply as individual errors or misdeeds. Thus, they help impugn the entire industry. Even more unnoticed is that new types of managed care increasingly shift medical care rationing from an individual process shaped by health professionals making medical decisions under capitated arrangements (implicit rationing) to an organizational and explicit form of rationing by which third parties intervene in care decisions, prescribe networks of referral, and deny care.[4] Medical care has always been subject to some rationing, but medical rationing has never before been so explicit or so extensively involved decision makers other than the physician.

Recognizing the inevitable need for rationing, some health analysts argue that fairness requires that the rules for medical allocation of resources should be derived publicly and should be administered consistently; that is, that rationing of health care should be explicit.[5] I agree that, at the governmental level, or level of health care plans, certain explicit decisions are needed, such as spending levels, the types of services that should be covered, the extent and type of new technological developments, and the development and location of new facilities. Administrative decisions also are necessary about required cost sharing (if any),

the number and mix of providers that will be available, the extent of direct access versus gatekeeping, and the like. But, these analysts go much beyond these types of financial and planning functions. They seek to make rationing at the bedside explicit, so that all persons in like circumstances will be treated identically. In support of this view, they advocate processes to establish public norms and preferences, such as town meetings, community surveys, focus groups, and approaches such as clinical pathways, practice guidelines, and the application of cost-effectiveness analysis. These are all useful tools and have much to contribute to improving care, but, as I explain below, seeking to make rationing explicit at the bedside is misguided[6] and is the source of much dissatisfaction with current managed-care approaches.

Medicine as an activity transcends its technical aspects. Medical care is, in many instances, a fundamental cultural activity that builds on the deepest concerns and emotions of individuals. Its mission is caring, as well as curing; such activity cannot be easily contained within a set of explicit and unalterable rules. Relationships between doctors and patients often remain uncertain, develop iteratively, and are governed more by experience and judgment than by science. Explicit standards are not only difficult to develop, but once developed, are difficult to change because constituencies develop to preserve rules in their interests. Building strong professionalism and responsibility is far better than expending efforts to micromanage what, in essence, cannot effectively be managed explicitly.

Patients also have different needs, tastes, and preferences. Methodological techniques can be used to arrive at average preferences, but there is large variation around such averages; persons seeking care when ill want treatment responsive to them and not some hypothetical average. Patients in comparable medical circumstances do not necessarily want to be treated in the same way and, indeed, may have strongly differing views about the aggressiveness of treatment, the tradeoffs between quantity and quality of life, and how they weigh the value of medical certainty against maintaining functional abilities and other considerations. Persons often refuse effective therapies because they are unwilling to suffer the side effects.

Medical care is by its very character a process of discovery and negotiation and needs to retain a high level of flexibility. There are innumerable contingencies relating to family circumstances, comorbidities, and other life situations that cannot be captured appropriately by inflexible rules. Rules that may be perfectly reasonable in the abstract may have perverse consequences in individual instances, as has been illustrated repeatedly.[7]

One important motive for those seeking more explicit rules is to avoid physician decisions that give preference to some individuals because of their position,

influence, attractiveness, ethnicity, or whatever. Seeking fair and equitable treatment is, of course, a highly important and attractive value, but the advocates deceive themselves if they believe they can build a fairer and more decent society by regulation. Explicit efforts to ration publicize conflicting needs and preferences and lead interest groups to mobilize. Such mobilization often not only destabilizes and politicizes health care, but subjects it to even greater political manipulation than one might observe under more implicit processes.[4] Once medical decisions are removed from a dialogue between doctor and patient, such decisions become a source of social, moral, and political battles. There is little in our experience with interest group politics to suggest that such politicalization will result in increased fairness.

Implicit rationing is particularly suitable for responding to complexity, diversity, and changing information in a sensitive, responsive, and timely way. Its advantage is its capacity to build on physician trust, which remains strong, and the meaningfulness of doctor-patient communication. Physicians and other health professionals are better attuned to the range of needs and preferences of patients and their varying life circumstances than regulators. Implicit rationing must, however, be embodied in a context of open and vigorous discussion that begins in medical education and continues in postgraduate education and throughout the doctor's career. Implicit rationing must also be constrained in some ways to insure the maintenance of trust. Such regulation would include honest marketing, appropriate disclosure, easy and timely appeals processes, and other interventions that protect communication and patient autonomy.[8]

We are in a process of tumultuous change, and it may take time for our system of care to come to a more even keel. In all likelihood, the kinds of explicit utilization review that so antagonize doctors and trouble patients will give way to greater transfer of financial risk to providers. In this context, utilization review can be transformed into a more collegial peer-review process, guided by intelligent use of practice standards and patient pathways and an orientation to patient care that is based more on evidence. Transferring risk, of course, opens other issues, and it is essential that such changes take place with due consideration to the level of transfer that produces the most thoughtful practice decisions without providing inducements to withhold necessary and efficacious care. Over the long run, the future of medicine depends on retaining trust in medical institutions and especially in physicians. Measures to preserve and build trust are a good investment for the future.

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