remarks

Physician Re-Empowerment

As businesses shy away from providing health-care coverage, new windows of opportunity may open for physicians to retake control of patient care, projects one health-care consultant.

BY BRIAN R. KLEPPER, PhD

"The dream of reason did not take power into account—modern medicine is one of those extraordinary works of reason—but medicine is also a world of power."

—Paul Starr
The Social Transformation of American Medicine, 1984

A couple of years ago, I addressed a group of new physician-MBAs and urged them to develop collaborative business models for physicians. I suggested that by working together, physicians could regain competitive control over the care process from large organizations such as insurance companies and hospitals.

I received a number of responses to that speech, both for and against my position. One particularly provocative letter came from a Los Angeles physician who asserted that, other than my willingness to have physicians deal with insurance companies at all, I seemed like a reasonable person. But didn't I get the fact that all intermediaries standing between the patient and the physician corrupted the process? What physicians really need to do, he said, is rid themselves of all managed-care contracts, urge patients to open Medical Savings Accounts, find ways to contract directly with patients, give them their best price for cash, and use data and technology to hold each other accountable for quality.

I'm abashed to tell you that my first instinct was to treat this individual, now my friend, as a crackpot. There are many problems with this model, and I told him so. But while at the time I recognized the core control issues between physicians and insurance companies, I don't think I fathomed the degree of chaffing and abuse that doctors feel perpetrated against them by insurers.

In the last year I've watched as small groups of physicians all over the country have followed this path. But I see another, maybe more important, trend that may shift power back to physicians in a way that has been unimaginable for years. It is the flight of business away from a defined health benefit to a defined health contribution.

Last fall, there was an article in the *LA Times* that detailed how decision makers at Xerox were contemplating a major policy switch on health benefits. Three issues were driving them crazy. After a four-year period of relative price stability, premiums around the country have shot up dramatically, in some markets as much as 30 to 40 percent, significantly higher than general inflation. Second, the company is spending inordinate amounts of money simply administering these programs for their employees. Finally, components of the Patient Bill-of-Rights legislation pending in Congress threaten to extend liability for health-plan decisions to employers, which might dramatically elevate their own financial risk.

Employee health coverage is not a benefit mandated by law—it is a business decision. With these other factors at work, it's not hard to conclude

Continued from previous page

that perhaps the same advantages employee health coverage provides for the business—helping to recruit good employees, for example—can be obtained through other mechanisms.

Xerox has been careful to say that they haven't made a final decision yet, but they've clearly been thinking about it, and so have a lot of other people. Prior to the release of that article, I had a conversation with a good friend who sells reinsurance. He said that in the last month benefits managers of four good-sized firms had called to ask about individual coverage programs they could use for their employees.

A third indicator that employer-sponsored health benefits may be on its way out was a survey released in January by the benefits consulting firm Hewitt. The survey found that if new legislation translates to employer liability for health-plan decisions, 40 percent of employers would consider dropping employee coverage in favor of a voucher system or some other form of compensation.

In the U.S. system, where employers voluntarily sponsor the coverage of nearly 100 million people, the potential impact of a market change like this can't be overestimated. Given the opportunity, many people might take health-care benefits funds and simply spend them elsewhere—at the grocery store or on the lottery—and then join the ranks of the uninsured. More alarming, others would find that pre-existing conditions would drive the cost of individual coverage up far higher than their allocation, and they'd be unable to afford it.

The employer-sponsored coverage issue also could take a different but equally ominous turn. Let's say that employers hang in there with the present coverage model, maybe with a little tweaking, and swallow double-digit premium increases for a few years more. Even so, what happens when this greatest economic boom in the history of the planet takes a little downturn, as nearly all forecasters suppose it will at some indeterminate point? When that occurs, business will respond on the health-coverage front in two ways. They'll lay off employees, and they'll cut back on their contributions to the benefits packages to those remaining, and both will result in more uninsured people.

Keep in mind that this overnight spike in the numbers of people without coverage will be on top of the 44 million uninsured Americans today, who are mostly faceless and out-of-sight because they tend to be at the lower (although not the lowest) economic regions of our society. That group has grown by 11 million people over the last decade, disproportionately faster than the growth in our general population.

Imagine what would happen if, within a year, the numbers of the uninsured were to swell by 40 million people and if people who live in middle class neighborhoods were suddenly without health coverage. Our existing indigent care infrastructure would be rendered all but useless by the demand, the viability of our entire health system would be called back into question, and a hue and cry would arise throughout the land for a new national health system.

While some people see that as a straightforward solution, it is not an altogether happy or uncomplicated prospect. If Medicare is the model, we can look forward to a national health budget that will literally break the bank. A HCFA study of Medicare contributions and costs through 1994 showed that, during the period of enrollment, the average American senior went through 16 times his lifetime contributions to the program. It's doubtful that number has changed much in recent years. Our Medicaid programs tend to the poor and the infirm elderly. But each state's effort takes a different form, each is meager, and each is in a different stage of enlightenment. And the military and VA systems are boondoggles of entitlement, spending twice to triple what the private sector spends on each patient's care. It's difficult to imagine that any program that uses any of the existing governmental programs as a template can provide a positive result.

The shift away from employer-sponsored coverage would mean dramatic changes in the traditional industry mechanics associated with coverage, care, and reimbursement. Individual purchasing coalitions would spring up. So would the availability of new forms of risk financing vehicles, like Medical Savings Accounts. We'd see a resurgence of Major Medical insurance programs. Hospitals and doctor groups would find ways to directly contract with patients, perhaps on a payroll deduction basis. And in this laissez-faire, all-approaches-go environment, many people would receive care without any third party medical oversight, which, if history is any teacher, would likely translate to significant over-utilization and quality abuses. In many ways, a decline in employer-sponsored coverage would blow the current system apart.

This wouldn't be all bad. The move toward individual coverage would have some upsides too, clearing the way for entirely new restructuring. All of us would develop a far greater interest in our coverage and in the care we receive because we'd be far more familiar with the payment for those services. With tremendous oversupplies of physicians, nurse practitioners, physician assistants and, "alternative" medical caregivers, competition for patients would almost certainly intensify, driving pricing down farther than before.

However these coverage changes come about, we may be in for a new era that

Continued from previous page

will disrupt existing relationships between patients and physicians, replacing them with new ones that are potentially far more direct and satisfying. The old relationships between physicians and institutions will be disrupted also. The new linkages that form to replace them will depend on whether physicians find ways to work together to common advantage.

The sum of my professional experience over the last decade, working in every sector of health care, is that no amount of money or planning can compensate for the disenfranchisement of a key constituency. Our three most important constituents are the people who make the decisions to pay for the care (the government, employers, or employees), the people who provide the care (doctors and other caregivers), and the people who are cared for (patients). Ventures that have forgotten the interests of the first will find that new mechanisms spring up to circumvent them. Ventures that have forgotten the interests of the caregiver will find the same thing.

The changing dynamics of who makes the decision to buy the coverage and how that decision is carried out, along with how the physicians relate to one another and to outside institutions, will drive the shape of our new health-care system.

What medicine needs most now are capable business people who understand that the best and most effective health-care enterprises will be those which aspire to a democracy of business by seeking scale, investing in management capabilities, and being sensitive to the interests of all constituents, including payers, doctors, and patients. ■

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