Defining Educational Priorities in Managed Care

A Symposium Overview

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The need for cost containment and the movement toward managed care have restructured traditional roles among patients, physicians, and health care organizations. Nationally, nearly 80% of primary care physicians have at least one managed care contract.[1] Approximately 45% of primary care physicians and 40% of specialists are employees of health care organizations,[2] and about half of all primary care physicians and at least 20% of specialists receive at least part of their reimbursement through capitation.[1] Further, 65 million Americans are enrolled in health maintenance organizations, double the number from one decade ago.[3] In addition, a multitude of managed care organizations have evolved, with nearly as many acronyms, that take responsibility for coordinating and delivering care to a population of enrollees.

Managed care places new responsibilities on physicians, health care organizations, and patients. For primary care physicians, these responsibilities include independently treating patients with a greater variety of chronic and acute conditions in ambulatory settings, formally acting as "gatekeepers" for specialty services and tests, and practicing cost-effectively.[4–6] Specialists also have begun practicing in ambulatory settings with an emphasis on cost-effectiveness and are establishing new referral mechanisms as their traditional sources of referrals shift owing to preferred provider listings and HMO regulations.[7] Managed care organizations, which extend beyond the traditional health plan or group to organized delivery systems, independent practice associations, and physician-hospital organizations, among others,[8] have become responsible not only for delivering care but also for controlling utilization, maintaining and improving the health of their enrolled population, and monitoring quality.[9] In some cases, managed care organizations have subsumed responsibilities previously delegated to physicians. Patients have assumed the duties of making informed decisions about which plan to join, understanding in exacting detail what their insurance covers, and navigating the referral system when they need specialty care.

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RELATIONSHIPS AMONG PATIENTS, PHYSICIANS, AND ORGANIZATIONS

Many have strong emotions about the value of managed care strategies, but we have only begun to understand how these changes in the "rules" about seeking, receiving, and delivering medical services have actually influenced clinical care. For example, many of the changes may have positive influences on patient care and medical practice. The focus on care of a population has improved enrollees' access to preventive services.[10] Further, the emphasis on evidence-based medicine and cost-effectiveness, coupled with financial incentives that do not reward physicians for overutilization, may serve to decrease utilization of unnecessary tests,[5] and have decreased hospitalizations and patients' length of stay,[10] thus improving quality of care for many enrollees. In addition, managed care organizations have led the way in quality monitoring efforts such as the Health Plan Employer Data and Information Set (HEDIS)[9] and many plans use these monitoring results for continuous quality improvement activities. The results of monitoring are also being transferred to enrollees in the form of "report cards," with the hope that such information will improve informed decision making. Despite many potentially positive consequences, the change in rules has nonetheless led to tensions within the practice of medicine that are likely to influence relationships between physicians and organizations, specialists and primary care providers, and patients and physicians. Figure 1 is an overview of different managed care strategies that have the potential to influence relationships among managed care organizations, physicians, and patients. This article presents a broad overview of how these strategies influence medical care; each level will be further detailed by the other articles contained in this supplement.

The potential influence of managed care approaches on relationships among physicians, patients, and organizations needs to be understood within the context of current health care organization models. The delivery of managed care is no longer dominated by group and staff-model HMOs, but rather takes place predominantly in private physician offices and medical group practices.[8,11] In addition, organized delivery systems are emerging as a growing model for health care delivery.[12] Further, with the rapid growth of decentralized health plans, there is little clarity about the distribution of responsibilities—and attendant accountability—between physicians and plans. As more physicians join large groups that contract directly with purchasers or lead physician service organizations, the locus of accountability for quality improvement and utilization management is likely to become more rather than less ambiguous for individual practitioners

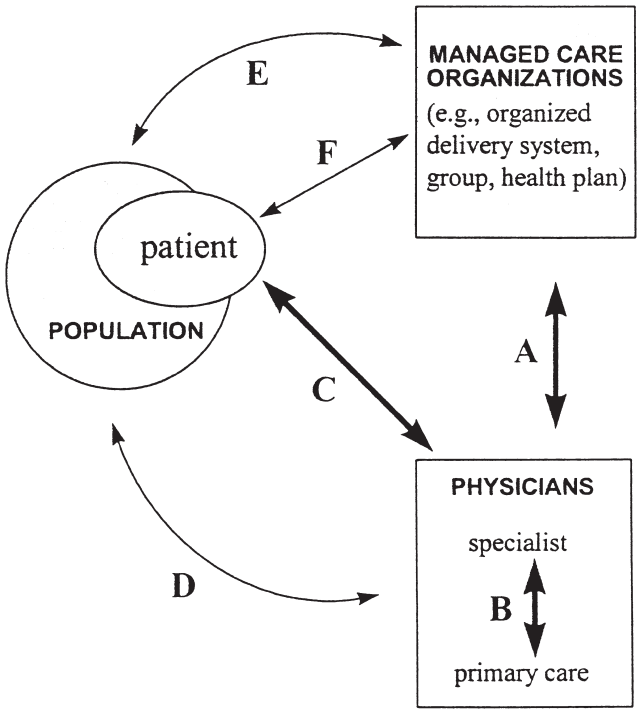

FIGURE 1. A framework for understanding the influence of managed care strategies on relationships among patients, physicians, and organizations. (A) Reimbursement levels; financial incentives; utilization review; disclosure rules; paperwork requirements; clinical rules/guidelines; threat of deselection; profiling. (B) Gatekeeping and referral mechanisms; clinical guidelines; financial incentives; level of reimbursement. (C) Financial incentives and conflict of interest; disclosure rules; gatekeeping and referral mechanisms; visits times; coverage rules. (D) Financial incentives (capitation rates and global budgets); quality monitoring. (E) Quality monitoring; coverage rules; profit versus nonprofit status; disclosure rules. (F) Coverage rules; utilization review; precertification; choice of providers.

and their patients. In fact, some researchers have found that the clear lines that previously separated insurers, groups, and physicians have recently become blurry.[4,12]

Consequently, the "managed care organization" is not an easily defined entity, and both physicians and patients may thus need to interact with managed care organizations on more than one level. For example, depending on the level of integration, a physician treating a patient with cancer may need to think about coverage policies of the plan, utilization review policies of the group, and precertification requirements of the hospital. It follows that physicians may have to approach more than one organization if they are dissatisfied with their contracts, reimbursement formula, or a patient coverage decision. The framework in Figure 1 specifies the managed care organization as a single entity; we recognize, however, that physicians and patients may interact with different organizations on different levels, and that in fact these organizations have relationships with themselves.

In a managed care delivery system, physicians have relationships with managed care organizations, other physicians, patients, and the enrolled population. Contracting arrangements, financial incentives and reimbursement schemes, the threat of deselection, and regulations established by health plans and physician groups regarding the appropriate delivery of health care can influence relationships between physicians and managed care organizations[13] (see Fig. 1, A). Organizations that foster "a culture of practice characterized by practitioners who equate good patient care with cost-effective care"[14] minimize tensions by promoting physician autonomy and directing utilization management at the macroscopic level. Conversely, organizations that focus on micro-management of physician decisions and excessive financial incentives for limiting utilization position themselves as possible adversaries to physicians. Both physicians and managed care organizations should have the same overall goal in mind: providing high-quality care within a fixed budget, with responsibility both to individual patients and to the enrolled population. When their missions are not aligned, patient care may suffer.

Further, changing traditional methods of referral and patient management[7,15] affects relationships between primary care physicians and specialists (see Fig. 1, B). The shift to primary managed care has been based, at least in part, on decreasing expenditures by high-cost specialists.[15] Reliance on managed care has the potential to improve continuity and communication[16] and to decrease overutilization.[5] Some researchers have demonstrated, however, that reliance on primary care is not always cost-effective[17] or compatible with the highest-quality care.[18] Providing high-quality, cost-effective managed care is therefore dependent on the development of collaborative relationships between primary care providers and specialists that are based on finding the optimal balance for each patient of primary and specialty services.[19]

The changing nature of physicians' relationships with one another and with health care organizations has been a topic of some discourse, but the changing nature of the patient–physician relationship has been the primary focus of community concern.[20–22] Emanuel and Neveloff-Dubler have summarized the ideal patient–physician relationship by the six C's: choice, competence, communication, compassion, continuity, and (no) conflict of interest.[22] They stress that some elements of managed care have the potential to strengthen the patient–physician relationship. For example, increasing the use of primary care providers may improve communication. Other elements, however, have the potential to compromise the patient–physician relationship (see Fig. 1, C). For example, utilization review by the plan or group could limit both patient access to desired care and trust in the physician.[21] Shorter office visits might restrict communication and compassion on the part of the physician.[22] High patient expectations despite coverage limitations and limits on physician autonomy could result in decreased trust in physicians and lower

satisfaction levels of both patients and physicians. In fact, patients in managed care settings report lower satisfaction than those in more traditional settings,[23] and primary care physicians have been shown to be less satisfied with the quality of care for capitated patients.[24] Finally, financial incentives that promote limiting utilization of services could lead to physician conflict of interest, thus decreasing both the perception of competence and patient trust in the relationship.[21] Although both negative and positive consequences of managed care approaches have been hypothesized, there has been little empirical work that increases our understanding of how managed care strategies actually influence the relationship between patients and physicians.

Many patients form loyalties more to individual physicians than to insurers or organizations. Some, however, have long-standing relationships with specific health plans (e.g., group/staff-model HMOs) or physician groups (e.g., those in academic medical centers).[13] Stringent utilization review, restrictions on choice, limits on physician disclosure, and coverage limitations could signal to patients that a managed care organization is not to be trusted (see Fig. 1, F). Decrease in this form of social trust weakens patient loyalty,[21] and has implications for stability of covered populations and continuity of care.

Finally, both managed care organizations and physicians also have relationships with and responsibility for an enrolled population (see Fig. 1, D and E). For a managed care organization, the responsibility to its enrolled patient population is rather direct: premiums must cover necessary services for the entire enrolled population, and coverage limits to individuals are justified by meeting global budgets for the whole (as well as overhead and profit, when applicable). For physicians, however, balancing their responsibility to individuals with their responsibility to a population is perhaps the most difficult challenge of practicing in managed care environments. Although it is relatively straightforward to teach and practice evidence-based medicine, it is yet another matter for physicians to confront their role in resource allocation and "bedside rationing."[25] Mechanic has observed that physicians are moving "from advocacy to allocation."[26] This transition is not a simple one, however, because physicians now need both to advocate for individual patient care *and* to allocate for the benefit of the population. Learning how to come to terms with this transition is critical to promoting effective clinical care, preserving physician job satisfaction, and safeguarding the patient–physician relationship.

EDUCATING PHYSICIANS ABOUT MANAGED CARE

Despite the rapidly changing health care environment under managed care and the potential for alterations in relationships among patients, physicians, and organizations, there is little empirical information on how different aspects of managed care influence how physicians practice and how patients perceive the care they receive. Nonetheless, physicians need to understand the benefits, challenges, and responsibilities of working in a managed care environment if they are to adopt constructive approaches to maintaining and improving quality of care for their patients and promoting strong patient–physician relationships. Hence, there is a clear need for educating current and future physicians on working effectively under the new and evolving rules.

For physicians, the benefits of working in a managed care environment include knowing that their patients are covered for all necessary services including preventive care, and being able to improve coordination of care. The challenges include balancing the needs of the individual with those of the population, limiting the influence of perverse financial incentives, and practicing cost-effectively while maintaining quality of care. While physicians' responsibilities under managed care include preserving the health of the population, their basic obligations to individual patients have not changed. These include confidentiality, advocacy, and provision of beneficial services.[27] Physicians now have the added responsibility of trying to define which services are truly beneficial for individual patients, taking into account individual patient circumstances (including patient preferences) as well as the costs of the services.

In response to the growth of managed care and new challenges faced by physicians, more medical schools are requiring at least some education in managed care settings.[28] Both medical schools and training programs are beginning to incorporate into their curricula an emphasis on evidenced-based medicine,[6,29] and some are educating residents about such managed care strategies as utilization review and effective gatekeeping (see Ramsbottom-Lucier et al., this edition).[30] These additions to medical education come at a time when funding for graduate medical education is decreasing.[6] Although a good understanding of evidenced-based medicine and managed care strategies is fundamental to the current practice of medicine, it is not sufficient. Some medical schools have begun to be more explicit in teaching the value of the relationship between patients and physicians, physicians' roles as patient advocates, and the ethics of managed care (S.D. Goold, personal communication). The next challenge for teachers of medical students, residents, and practicing physicians is to help physicians understand how the emerging practice environment may influence relationships among physicians and patients, other physicians, and organizations, and ultimately how these fluxes in relationships can be used to improve patient care.

SYMPOSIUM GOALS AND STRUCTURE

The Society of General Internal Medicine (SGIM) Task Force on Managed Care, in collaboration with the Society of Teachers of Family Medicine (STFM), the American Academy on Physician and Patient (AAPP), and the Association

of Subspecialty Professors (ASP), conducted a 1-day symposium on defining educational priorities in managed care on May 1, 1997, in Washington, D.C. The symposium focused on developing principles for practice and teaching that would inform constructive relationships between physicians and patients, primary care physicians and specialists, and physicians and managed care organizations (Fig. 1, A, B, and C). The overall goal of the conference was to generate principles and teaching strategies that would enhance generalists' roles as managers and advocates for patient care, to interface with the public about issues related to doctor-patient relationships and expectations for specialty care, and to further enhance and disseminate teaching models that are effective and appropriate for managed care environments.

FUTURE CHALLENGES AND POLICY

No single symposium can identify and address all of the challenges facing the education of primary care physicians in a changing health care environment. Rather, we hope that the products of this symposium, including the publication of its results, will elevate the intensity of dialogue for SGIM members and others, and begin a critically important process of working with other professional organizations, health plans, and policy makers to ensure that future physicians are equipped to serve their patients effectively. Part of the educational goals should focus on ways to decrease the tensions currently felt in different parts of the health care delivery system. In fact, it is essential to find ways to align the interests of health care organizations, physicians, and patients. Providing care in a collaborative fashion, with a sharing of expertise, responsibility, accountability, and financial risk, may in the end create health care systems that deliver high-quality care within health care constraints.[31] Although often advocated as a remedy for current health care inefficiencies, the institution of such a "team approach" to delivering care (with organizations and facilities, generalists, specialists, ancillary staff, and patients as parts of the team) should be tested empirically, lest we replace a fragmented, inefficient system with a more organized but still inefficient one.

Educational strategies and principles by themselves will probably be insufficient to address all challenges confronting providers and patients. A secondary objective of this conference was to identify public and practice policy issues that must be clarified to ensure that the quality of care, in terms of both technical and interpersonal excellence, is maintained or improved. Following the principles developed through the symposium, we anticipate that the Managed Care Task Force of SGIM, together with representatives of the other participating specialty societies, will work to develop models for the enhancement of managed care quality that cover availability of appropriate specialty consultation, continuity of primary care, disclosure of financial incentives to patients and physician colleagues, and contractual arrangements of providers and organizations. These prototypes could then be used prospectively to help physicians and managed care organizations structure their practices in a way that maximizes the patient-provider relationship, and to guide future evaluations that will allow the research, policy, and managed care communities to identify opportunities for quality improvement.

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