

# THE DOCTOR IS NOT IN

On the managed failure of  
managed health care

By Ronald J. Glasser, M.D.

**W**e are born, we live, and then we die, but these days we do so with less and less help from a medical profession paid to discount our suffering and ignore our pain. Proofs of the bitter joke implicit in the phrase "managed care" show up in every morning's newspaper, in casual conversations with relatives or friends recently returned from a hospital or from what was once thought of as a doctor's office instead of an insurance company's waiting room, and in a country generously supplied with competent and compassionate doctors, 160.3 million of us now find ourselves held captive to corporate health-care systems that earn \$952 billion a year but can't afford the luxury of a conscience or a heart.

Childless women in every city in America dread the simplest fertility workups because they know that the evaluation probably will serve as evidence denying them future payments for diseases of the vagina, uterus, or ovaries; the rest of us have had our co-payments increased, our use of prescription drugs curtailed or replaced by corporate-sanctioned medications, stays in the hospital reduced or eliminated, "pre-authorizations" required for necessary and routine tests. The broad removal of health-care benefits takes place at all points of the country's medical-industrial complex, and in line with the tone and temper of the times more than 2,300 Massachusetts physicians in December of last year signed a despairing manifesto in the *Journal of the American Medical Association*:

The time we are allowed to spend with the sick shrinks under the pressure to increase throughput, as though we were dealing with industrial commodities rather than afflicted human beings. . . . Physicians and nurses are being prodded by threats and bribes to abdicate allegiance to patients, and to shun the sickest, who may be unprofitable. Some of us risk being fired or "delisted" for giving, or even discussing, expensive services, and many are offered bonuses for minimizing care.

Such forced denial of care occurs at a time when new medical and surgical technologies allow physicians to treat and often cure any number of conditions that only a few years ago barely could be diagnosed; organs now can

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be digitally reconstructed in three dimensions to locate previously inoperable tumors; heart attacks can be stopped with injections of a compound known as tPA; blind people may wake up and see with implanted plastic lenses; one-and-a-half-pound premature babies, once given up for lost, routinely are nursed to health; a new generation of medical research brings us genetically engineered tests and one nearly miraculous drug after the next. At the same moment, presumably well-insured women diagnosed with disseminated breast cancer must hire lawyers to have their health plans pay for life-saving bone-marrow transplants and managed-care companies can deny powered wheelchairs to handicapped children who pass a "utilization review" showing them able to stagger twenty-five feet with the help of a walker.

But although a good many of us suspect that somehow we are being swindled, and those of us who have fallen seriously ill know for a fact that the purveyors of managed care often wish we would go away or die—as quietly and quickly as possible—we're reluctant to draw the commercial moral of the tale. The system wasn't meant to care for sick people; it was meant to make and manage money.

**T**he theory of "managed care" first attracted attention in the 1940s in the coal regions of Kentucky and West Virginia. Labor unions hired doctors, constructed clinics and hospitals, and supplied prepaid medical services at a fixed monthly rate to their members and their families. The fixed rate per patient was unrelated to the patient's use of the service. By the 1950s, a few large companies had taken a similarly paternalistic stance and were offering contract health care to their own employees. The arrangement was not designed to profit anyone other than those who received care, which was why it worked.

But in the 1970s, the government and large corporate employers began to seek ways to reduce health-care costs, and the concept of contract medicine was injected with the virus of the profit motive. Cadres of systems managers, some of whom had planned the failed technowar in Vietnam, brought forth new corporate structures meant to introduce market forces into the industry and named by the several acronyms (HMO, PPO, POS, etc.) for preferred or managed medicine.<sup>1</sup> Not only were a lot of people going to get well, but some of them were going to get rich. First promoted by what is known as InterStudy (a health-policy think tank organized in 1972), the proposition relied on the idea that an HMO could make money if it provided medical care only to people who enjoyed the prior benefits of perfect health and a full-time job. Thus the practice known as "cherry picking," which virtually removed the burden of insuring people who were seriously ill. You simply cannot be employed full time if you suffer from the effects of a crippling disability or disease.

The full story of how and why, over the short span of twenty years, the concept of the HMO came to dominate nearly every phase of American medicine (directing the distribution of every operation, wheelchair, test, and pill) would embrace all the arts of financial chicanery made popular in the 1980s: with appropriate reference to junk-bond financing, the prosperity of the drug companies, the general acceptance of the 401-K plan, the demographics of the baby boom, and probably a list of every fund-raiser attended by Presidents Ronald Reagan and George Bush. Here was but one scheme in an era of schemes, the HMO as a brilliant means of redistributing income from individual physicians to corporate executives and shareholders. The short-term profits were extraordinary: PacifiCare, for example, swelled from a \$168,911 enterprise in 1986 to a \$10 billion behemoth by 1997.

For corporations and small businesses burdened with rising medical costs

<sup>1</sup> Alain Enthoven, who served as a systems analyst under Defense Secretary Robert McNamara during the Vietnam War, devised the theory of managed competition and still serves as its principal apologist, both in his capacity as chairman of California's Managed Health Care Improvement Task Force and as a professor of health-care economics at Stanford University

the HMO appeared as a gift from heaven. As recently as 1980 company health plans enrolled only a small percentage of the eligible employees; last year the plans enrolled 85 percent, up from 48 percent in 1993. The percentage of doctors practicing outside the HMOs meanwhile has dwindled to the present 19.9 percent.<sup>2</sup>

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But the spectacular success of managed care proved to be the cause of its equally spectacular failures. Cherry picking is another name for a Ponzi scheme, and sooner or later it falls apart. Even a company blessed with tens of thousands of healthy subscribers eventually finds itself obliged to pay for the occasional premature birth at \$1,500 a day, or the occasional employee who develops a brain tumor or whose wife is diagnosed with ovarian cancer. There are car accidents and near drownings. There are the late complications of diabetes, the forty-year-old struck down with a heart attack, the previously undiagnosed melanoma, the complications of hypertension. The odd executive may need a hip replacement because of an old football injury, or a chief financial officer a heart transplant after what should have been a routine viral illness. If the HMO acquires 400,000 or half a million new members (as it must if its stock price is to keep rising), the costs mount at an exponential rate. Now there may be as many as 20,000 claims a month—a metastasis of paperwork, a hemorrhage of cash. The co-payments coming in from new enrollees can no longer keep up with the money going out. New restrictions must be implemented, new administrators hired to guarantee compliance, more controls, more advertisements to attract new members. The whole operation begins to unravel.<sup>3</sup>



When a company finds itself hard-pressed for profit, then behind the closed doors of the executive suite what has been left unsaid becomes the loud and forthright voice of reason: *Yes, we are a company that cares about the well-being of the American people, but the free market is the free market, and so . . .* And so, among the middle managers and accountants of the nation's health plans the talk these days turns to ways of lowering what Wall Street calls an HMO's "medical-loss ratio"—i.e., that percentage of yearly revenues allotted to patient care. The term, in and of itself, repudiates every principle that undergirds the profession of medicine and flatly contradicts the Hippocratic oath, which pledges a physician's first responsibility to the care of his or her patient. But banks don't accept pay-

<sup>2</sup> The wealthier American zip codes continue to support a troupe of expensive physicians whose skills (at unclogging befeater hearts or smoothing the wrinkles in a woman's neck) are so renowned, or whose clients are so prosperous, that they do not accept any form of insurance. Such practices are, in effect, boutiques, and the practitioner is able to lavish time and attention on his patients, who may in turn congratulate themselves on the quality of the care they have received.

<sup>3</sup> Last fall, Oxford Health Plans, Inc., a "model" HMO that aggressively marketed its friendliness toward consumers, reported losses of \$125 million, citing higher medical costs than expected. Not surprisingly, the stock price of Oxford lost 80 percent of its value over the span of four months. Shortly thereafter, investors accused Oxford executives of withholding information about the company's balance sheet while they sold large blocks of shares. The Securities and Exchange Commission and the New York Attorney General's Office are investigating the complaint.

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ment in oaths, as was made plain by an analyst from Nutmeg Securities, Ira Zuckerman, who reminded his prospective investors last November that the attractiveness of managed-care companies as investments changes when health plans sign up members who will actually have to see a doctor. The rule of thumb holds that a managed-care business is in trouble if more than 65 percent of its enrollees submit a significant claim in any one-year period. Little wonder then that rehabilitation for stroke victims or occupational therapy for spinal-cord injuries no longer make the list of benefits. Managed-care companies actually seek to hide their competencies; no HMO wishes to advertise its successes with cystic fibrosis or multiple sclerosis, or, ~~or, the skill of its subspecialists who treat AIDS.~~ Were a company to become known for treating complicated or expensive diseases, it would run the real risk of attracting the attention of the very sick. The blurring of priorities becomes embarrassingly obvious in the newspaper ads that promote the virtues of the country's prepaid health plans. As, for instance, last December in the Minneapolis Star Tribune

We offer an extensive and unique program of reporting quality, accessibility and satisfaction data to consumers at the clinic and physician level—through the internet and other mechanisms.

We developed a doctor-led organization, called the Institute for Clinical Systems Integration, that develops nationally recognized medical best practices using the best medical minds in our community.

We have received numerous national awards for our community health improvement initiatives.

We created the nation's first comprehensive program to encourage reading and brain stimulation for infants and young children.

In less than five years, managed care has managed to eliminate from the public-policy debate any and all words that describe suffering and disease, and together with the good news about "reporting quality," and "satisfaction data," the industry defends itself against past, present, and future criticism by explaining the symptoms that afflict the country's health-care system with at least five warm and welcome fairy tales that the public apparently still chooses to believe:



ALL DOCTORS ARE RICH AND OMNIPOTENT: The stereotyped image of the aloof and wealthy physician driving a Mercedes or wandering over a golf course allows the proponents of managed care to imply, usually with a good deal of success, that any doctor who speaks ill of corporatized medicine is, by definition, a greedy and callous fellow who thinks only about his fees.

As a percentage of all medical costs, the money allotted to physicians' services has remained constant over the last thirty years. Between 1993 and 1995, what the American Medical Association calls "median physician net income (after expenses, before taxes)" declined, in real terms, by 1.4 percent. Surgeons and radiologists, among them the most highly paid practitioners in any of the medical professions, earned, on average in 1995, roughly \$250,000. The sums dwindle into pittances when compared with the earnings of the executives of publicly traded managed-care companies, which, on average in 1996, approached the handsome sum of \$10 million. What inflates the price

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of medicine in the United States is the cost of corporate vice presidents, not the cost of doctors.

Which possibly explains why the number of practicing physicians in the United States has increased by no more than 20 percent in the last six years, while since 1983 the number of health-care managers has increased by 683 percent. The comparative percentages speak to the loss of authority on the part of doctors who no longer have much to say about the schedules they keep, the fees they charge, the treatments and protocols they prescribe. As often as not, they possess as little power of decision as the custodians of a hospital's linen supply.

**THE OPERATION IS UNNECESSARY:** The rich doctor requires the unnecessary operation (as well as the superfluous test, the costly prescription, the frivolous C-section or coronary bypass) not for any sound medical reason but in order to become even more rich. Thus the nation's hospitals and operating rooms supposedly overflow with patients who have no cause for serious complaint, healthy, happy people, who, were it not for the avarice of their physicians, would be baking pies or running relay races.

Once again, actual practice contradicts the heartwarming cant. The numbers of C-sections performed in the country have more to do with the availability of fetal-monitoring equipment and the fear of malpractice suits than with the will to profit on the part of the attending obstetrician. Recent reviews of coronary-bypass operations have shown that the number of inappropriate procedures varies from 0 percent to 2.4 percent, while the number deemed "equivocal" never has exceeded 7 percent. The number of inappropriate coronary angiographies in a 1994 study conducted in New York State was 5 percent. In 1992, a Medicare pre-authorization program was discontinued when, following a review of Medicare requests for coronary-bypass procedures in the state of Texas, a negligible number were found to be inappropriate.

Health-care executives like to say that doctors get away with performing needless operations because their monopoly of the standard surgical repertoire excuses them from having to explain or justify their actions. The canard ignores the fierce but societally beneficial struggle between different medical specialties, a struggle that constantly forces the argument about what is necessary and what is not. Internists develop drugs to reduce the need for the cardiovascular surgeons' bypass procedure; neonatalists use chemicals to get premature infants off respirators quicker and keep them out of the hands of pulmonologists; infectious-disease specialists develop oral regimens and home antibiotic therapies as alternatives to orthopedic surgery or in-hospital IV medications.

**THE DOCTOR IS A MECHANICAL DEVICE:** The systems planners at the Pentagon construed the Vietnam War as a manufacturing problem—victory a product, death a means of production, soldiers listed in the inventories like truck tires or boxes of ammunition. A similar habit of mind inclines our health-care managers to classify doctors as interchangeable pieces of hospital equipment. As with light bulbs and bottles of saline solution, so also with heart specialists and neurosurgeons. Every doctor serves as well as every other doctor. The proposition is patently false, but it allows the HMOs to limit their patients' choice of physician. Like nineteenth-century coal miners obliged to buy their necessities from a company store, subscribers to late-twentieth-century health plans must go to the doctors named on a company list. A number of HMOs improve the policy with a further refinement of cost-saving simplification. Not content with the assignment of absolute equality to doctors in all degrees of specialty, they suggest that the only physician whom any patient ever needs to see is the primary-care physician—i.e., the doctor who knows a little of this and a little of that, who is so well rounded that he points in no direction at all, a compliant soul content to follow a memo or a guideline because he isn't sure when

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an MRI is really appropriate or whether, in the attempt to rule out Lyme disease, it is best to do the expensive Western Blot test or the cheaper ELISA essay.

THE PATIENT LOVES GOING TO THE HOSPITAL: As corollary to the story of the rich doctor, the health-care companies tell the story of the patient as spend-thrift fool, who, if left to his or her own devices, will bankrupt the country with an "infinite demand" for heart transplants, kidney dialysis, and liposuction. But as with the health-care industry's other probings of imaginary symptoms, the diagnosis has been proven false. Most people check into hospitals only when they have no choice in the matter, and the nonexistent phenomenon of infinite demand doesn't lead to the unproven result of infinite cost. New medical treatments and surgical procedures, no matter how expensive when first introduced, retain their original costly forms for astonishingly short periods. Less expensive and less complicated therapies invariably replace the early experiments.

The evolving art of kidney dialysis offers the textbook case in point. Long before the advent of managed care, kidney specialists looking for an alternative to hemodialysis—with its inconvenience, risks of infection, clotting, and blood loss, as well as its complicated machinery—pursued the development of the less demanding peritoneal dialysis. So also with balloon angioplasty, which today has become the preferred alternative to the expensive coronary bypass. So also with every other specialty that anybody but an insurance agent cares to name.

An axiom of economics holds that nothing can be rationed that is itself not scarce, and, absent evidence of infinite demand and infinite cost, you can't ration health care when there are more than enough doctors, hospitals, and high-tech equipment distributed through the country to do everything and anything that needs to be done. American health care is an unsaturated demand market, and in such markets "rationing" is simply a code word for not spending the money to take care of the poor, the uninsured, the underinsured, and the high-risk patient.

SICKNESS IS THE PATIENT'S FAULT, AND DEATH IS A PREVENTABLE DISEASE: Because we live in a society that equates youth and wellness with intelligence and superior moral character, the health-care industry can pretend that it really isn't supposed to do anything at all. If the patient hadn't been so careless—if he or she had given up smoking and drinking, read the complete works of Andrew Weil, cut down on the day's fat intake, checked the blood pressure, ridden the stationary bicycle, ingested the correct amounts of garlic and zinc, gotten in touch with the inner child—then the patient wouldn't be making so many awful noises, wouldn't be conspiring to harm the "medical-loss ratio," wouldn't be bothering doctors (busy and important people, albeit overpaid) with the miserable proofs of their weakness and stupidity.

No health plan advertises the fact that a good many patients admitted to the hospital with a diagnosis of a myocardial infarct have few or none of the so-called risk factors for a heart attack: they are not smokers; they are not overweight; they are not hypertensive; they exercised; they have normal cholesterol. No plan sends out notices or memos that one in twenty-five births will have a congenital defect, or that a third of patients with diabetes run the risk of going blind.

In truth, it is a dangerous world out there. Slip through the ice, get hit on the freeway, wake up with blood in your urine, have trouble breathing, stumble about after a splitting headache, lose the ability to feel, have trouble remembering things, experience ringing in your ears, find mucus in your stools, start gasping at night, and garlic pills will be of little help. But wellness is the panacea of the 1990s, and the health plans promote the wonders of aerobic exercise and fat-free diets in order to obscure the real purpose of medicine, which is the treatment of illness and the relief of suffering. To the extent that the plans can shift the burden of health care

to the private sectors of personal hygiene and morality, they excuse themselves from the tedious and increasingly expensive chores of providing a public service or addressing the common good.

For the last twenty years the theory and practice of managed care has enjoyed the protection of the political and financial interests—insurance companies, the pharmaceutical industry, large business corporations, suppliers of hospital equipment, members of Congress—eager to keep the Ponzi scheme profitably in place. Assured of the approval of the best people that money can buy, the HMOs have gone calmly about the business of eliminating one treatment after another and adding one doctor after the next to their rosters. For the time being they probably can count on their formularies of false diagnosis to preserve the illusions of compassion and competence. But every month another 315,000 Americans reach the age of fifty, a figure that will rise over the next fifteen years. Of the money spent on medical care during the course of an average American's lifetime, the bulk of it is spent during the last two or three years of that life, and by the year 2010, people over the age of sixty-five will constitute the most rapidly multiplying sector of the population. They will want, expect, and need medical care, but who will pay the bill? The government has been steadily depleting the funds intended to meet the future costs of Social Security and Medicare, and the working children of what promises to be the most long-lived generation in the country's history can't be counted on to come up with either the money or the will to support a pyramid scheme.

Because Americans as they grow older tend to become more political, the demographics also imply the likelihood of active protests on the part of large numbers of people (surprisingly vigorous, remarkably well informed) bent on redressing what they will come to perceive, not without reason, as a balance of wrongs. The reaction already has begun. A few months ago the Massachusetts physicians published their manifesto, and the American College of Rheumatology recently recommended that chronic arthritis patients should be seen at least once by a rheumatologist both for confirmation of the diagnosis and the development of an adequate treatment plan. The American College of Cardiology has compiled its own guidelines for heart disease and posted them on the Internet in the hope that Americans might learn from a computer what they never will learn from a doctor sworn to silence by an HMO.

All the symptoms of protest confirm the same diagnosis—a health-care industry sickened with the virus of "medical-loss ratio" and unlikely to recover until cured of its addiction to the profit motive. A physician is not by nature a commodities broker, a clinic is not a meat-packing plant, and unless the health-care industry quits caring for money instead of people, its chronic pathology almost certainly will be referred to the consulting rooms of government. Not that the politicians will want to take the case, but let enough people make strong enough complaint, and the therapeutics committees in the country's legislatures might be forced to write a new and not so mean-spirited set of guidelines.

BECAUSE THE BABY BOOMERS ARE HITTING FIFTY NOW, AND AMERICANS BECOME MORE POLITICAL AS THEY AGE, DOES TROUBLE AWAIT MANAGED CARE?

