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Managed care

Continued from page 1.

Schopp, executive director of the Catholic Managed Care Consortium. The St. Louis-based consortium provides consultation services for nine health-care systems with more than 160 members in 39 states, including St. Mary's Hospital in Rochester.

In addition, Schopp noted, "Originally, when HMOs were formed they really had the orientations of improving the health care of the people they were servicing."

"We are a health care system," agreed Dr. Mary Dombovy, vice president for managed care integrated services at Unity Health System, an affiliation of St. Mary's and Park Ridge hospitals. "It is our job to take care of the health of the people in our system."

The focus, Dombovy added, is on preventative medicine.

"What you're trying to do is take care of a problem when it's a minor one rather than a larger one," she said.

The result, she acknowledged: better overall health care at lower cost.

Although managed care plans have been around in some form or another for nearly a century, industry observers note, such health plans began to grow rapidly in the 1970s, prompted in part by the financial problems faced by Medicare, the federal government's health program for seniors, and by spiralling health-care costs.

The traditional method of payment had been "fee-for-service." The patient – and/or the patient's insurance company – paid for each service rendered.

But often people who had little money and who were uninsured or underinsured could not afford services. On the other hand, if the individuals had money or adequate insurance, their doctors sometimes ordered unnecessary treatments.

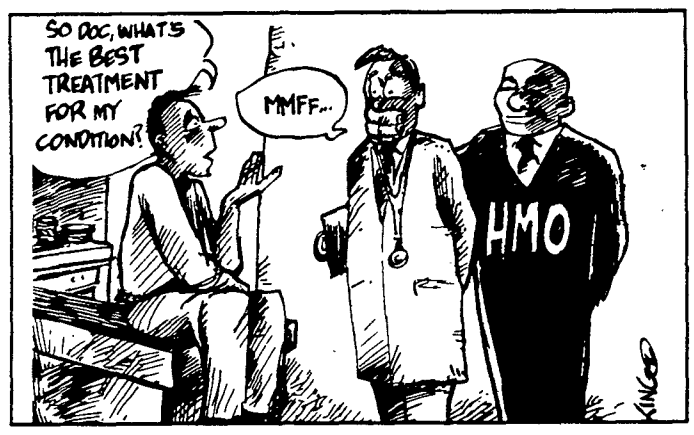
The consequence of the old system, observers note, was that the poor sometimes did not receive adequate care, and health insurance companies were losing money.

Managed care, on the other hand, is supposed to ensure that basic services are provided. Under the most common plans, doctors are be paid a set amount no matter how much work they do. Because of the limits ("capitation") – and because they do not profit from providing added services – doctors are less likely to recommend unnecessary treatments. Meanwhile, patients are more likely to see their doctors on a regular basis because they are charged only a co-payment. And they are thus more likely to receive preventative care, rather than waiting until serious illness strikes.

In terms of managed care, Dombovy said, "capitation presupposes you're operating under some ethical code and making sure the patient gets the best possible care."

She further noted out that neither health care system is inherently bad.

In a 1996 address to the International Association of Catholic Medical Schools, the late Cardinal Joseph Bernardin highlighted strengths and problems of both systems.



"For those with adequate insurance or sufficient personal resources," he noted, the strengths of the fee-for-service system "include maximizing the choice of providers for patients, and clinical freedom for physicians."

"The traditional system," he continued, "also was characterized by pluralism in the delivery system and a commitment to the highest quality medicine through public and private support for research and education. The view of healthcare as a service – as opposed to a commodity – was widespread among physicians and not-for-profit hospitals that provided charity care."

On the other hand, the traditional system was also marked by "the absence of a right to healthcare for all and the lack of a strong commitment to public health," the cardinal said. "It may be argued that the relentlessly rising costs of traditional care acted as a brake on expanding healthcare services to the poor and elderly under existing services as well as efforts to achieve universal coverage as a matter of right."

Meanwhile, managed care, he noted, "By restraining costs, offers the possibility of including more persons under public and private insurance. By explicitly addressing the appropriateness of care through practice guidelines and other means, it offers the possibility of improving the quality of healthcare and eliminating unnecessary care. By focusing on prevention, it offers the possibility of avoiding or mitigating many serious and disabling conditions."

On the other hand, he observed, "the market forces and economic disciplines that are the engines of managed care can be socially insensitive and ethically blind."

The bottom line

Dr. Linda Peeno has seen this "insensitive" side of managed care firsthand. She was a medical director with a Louisville, Ky., managed care organization, but quit in disgust in 1991.

"Even if you were a non-profit and even if you had a vision to do the right thing, you couldn't because of system factors," said Peeno, now chair of the ethics committee at the University of Louisville Hospital, and an expert witness in managed care litigation cases. She spoke with the *Catholic Courier* from the University of Texas Law School in Austin, where she was speaking at a conference on suing and defending managed care organizations.

Peeno said that she has testified in cases in which managed care institutions have delayed expensive treatments so long that the patients died.

"I think they are just focussed too much on cost cutting, cost saving, particularly in the for-profits," she said.

Moreover, there are questions about where the savings from all that cost-cutting go, argued Father Kevin O'Rourke, OP, former director of the Center for Health Care Ethics at St. Louis University.

"Part of the difficulty of managed care is the money saved doesn't go into the care of the people," Father O'Rourke said. "I did a study. Often the salaries of managed care executives was exorbitant. That's an introduction of a new cost into health care."

Schopp, however, argued that the salaries were simply an extension of what the health insurance industry executives were receiving, not a new cost.

"As individuals have left the insurance companies and gone to managed care, I don't know if the administrative component has increased significantly," he said. "Right now, we typically see out of one premium dollar, 15 percent goes to managed care organizations' administrative activities, and that includes profits."

But Father O'Rourke noted that efficiently run managed-care based Medicaid programs have administrative costs of around just 5 percent.

And Peeno pointed out that her experience in the industry presented a different picture than that Schopp painted.

"My last corporate job, I made $156,000 in 1990 for a 30-hour-a-week commitment," she said. "I would sit at my desk sometimes and think, 'What am I doing here that justifies my salary?' I would think of pediatricians working 100 hours a week and bringing home $80,000 a year."

Moreover, the managed care institutions she has examined have been creating new, well-paid administrative positions – most of them non-medical in nature.

"We have the highest administrative cost of any health system in the world," she said.

Sense of mission

Peeno acknowledged that not all managed care systems are necessarily bad. She said, for example, that many of the Catholic ones serve their patients well because of "a strong sense of mission."

One system with such a sense of mission is currently growing in New York state.

The state's bishops created Fidelis Care as a means to support Catholic health care and to serve the poor, explained Jack Balinsky, director of Catholic Charities of the Diocese of Rochester, and Bishop Matthew H. Clark's representative on Fidelis' board.

Launched Jan. 1, 1997, Fidelis currently serves approximately 65,000 people on Medicaid, and 15,000 previously uninsured children in low-income families through Child Health Plus.

Unfortunately, Balinsky noted, Fidelis is not available in the Diocese of Rochester, although current discussions could soon bring it to Monroe and Wayne counties.

"Fidelis has developed its managed care program consistent with the church's ethical and religious directives," Balinsky observed. Those directives, he noted, include a belief in the "primacy of the client" in health-care decisions.

With some managed care systems apparently working, the question arises whether managed care in general can be similarly reformed.

Schopp sees room for improvement.

"We have a huge issue with the uninsured that needs to be addressed somehow," Schopp said.

Schopp also described the issue of a patient's right to sue a managed care provider as "sticky," but one that must be addressed.

"I think the question becomes, 'Is there sufficient accountability for health plans in the current system?'" he said. "What concerns me is maybe pushing over too much in the other direction. What are limits on awards?"

"Probably the most important thing to be done would be with the liability issue," Peeno said. "Everybody who makes a health-care decision should be liable."

Thus, she contended, industry executives should be accountable for decisions based on cost factors.

She would also like to see managed care providers better inform patients concerning the reasons for decisions, and for patients to have more say in those decisions.

The CHA echoed her views, issuing a position paper in 1998 calling for a number of reforms, including: making more information available for consumers, enacting "prudent layperson" protections on a federal level and creating a "meaningful" system for review, appeals and grievances.

One option voiced by some health-care observers is scrapping managed care for universal health care coverage of all people. Father O'Rourke supports that approach, saying that one of the great evils of managed care is that it is keeping attention away from creating a universal care system.

"The health-care system in the United States is poorly administered and poorly financed," he declared. "When you talk about managed health care, there's a lot of bad medicine practiced."

But Schopp is optimistic about managed care's future.

"I think there will be some evolving it and refinement of (managed care)," he said. "But the core of it we're going to have for the foreseeable future."