Treating populations rather than individuals: the subtle danger of managed care

Will managed care improve the quality of health care for populations at the expense of care for individuals?

MANAGED CARE is here to stay, and it is having significant impact on the quality of medical care delivered to both individuals and populations. But will managed care improve the quality of health care for populations at the expense of care for individuals? I fear the answer is yes.

In an effort to control health care costs, managed care organizations present themselves as being dedicated to prevention of disease and improvement of the health of the populations they serve. But as managed care systems increase their emphasis on treating populations, this approach creates ethical problems for physicians who must treat individual patients. These ethical dilemmas come not only from the tools managed care employs to control costs (downward negotiations of fees, utilization management, and a "realignment" of providers' incentives) but from the rethinking of the goals of the health care system, which places emphasis on measuring health care outcomes in terms of populations and cost-effectiveness.[1,2]

WHO IS THE "CUSTOMER"

Over the last several decades, health insurers and other third-party payers (especially government and employers) have grown in importance in the health care system, preempting the importance of patients. Thus, the traditional relationships between physician, patient, and payer have been blurred. Physicians end up asking themselves who is the real customer (the payer or the patient) and what does the customer want (aggressive treatment or cost-effective care)? Increasingly the third-party payers have asserted their primacy in the health care system, although they state they want costs to be reduced without any harm being done to patients in the process.

Clearly, there can be economic strength in a population's numbers. The clout of the payers to negotiate better deals with physicians and other health care providers increased as they gained the ability to deliver ever larger groups of potential patients—all with just a single signature on a contract. In reaction to this growing power of payers, providers banded together into large "integrated" systems, encompassing providers of various types (hospitals, long-term care facilities, physicians, pharmacies, etc.) over a broad geographic area.

The goal of such organizations is to contract exclusively for all aspects of a given population's care. For such large integrated systems, the "patient" is the population, rather than the individual. And the objective is to obtain the greatest good for the greatest number.[3] There can be an upside to this, shifting the focus of the American health care system from episodic "illness care," to a more equitable system that emphasizes public health.

THE DOWNSIDE OF POPULATION MEDICINE

But there is a downside as well. Dr. David Eddy has given an extreme example of the dangers of population medicine when cost-containment makes it necessary to ration care.[4]

Suppose a patient of Dr. Jones has an ailment which if untreated is 100% fatal, but for which there are two alternative treatments. Treatment A costs $10 000, and treatment B costs $2000. The mortality rate with treatment A is 20%, and the mortality rate with treatment B is 50%. The total budget for treatment of this ailment is $200 000, and the actuarial probability of the number of patients with this ailment in the population is 100 cases. Should Dr. Jones use treatment A or treatment B for his patient?

Under the old system this would be a "no-brainer;" the likelihood of success with treatment A is more than twice that of treatment B. But with the budget of $200 000 under population medicine, the whole population would be better off with treatment B, which would save 50 of the 100 patients before the money ran out, while the more expensive treatment A could treat only 20 and save only 16 (at least 6 of whom would have died with treatment B).

This troubling dilemma lies at the heart of health care rationing,[5,6] whether it is done in the context of managed care or the old fee-for-service system. However, managed care's more carefully controlled integrated systems make it possible to bring more precision into the rationing decision because it deals with closed populations.

But such population vs individual decisions disrupt the doctor-patient relationship in a way that has not been resolved by the medical profession.[7]

THE CORROSIVE EFFECTS OF COST MANAGEMENT

The emergence of cost management as a priority of the health care delivery system, preempting the traditional importance of care of the individual patient, is contributing to the deprofessionalization and "commoditization" of American medicine. In this frame of reference, population medicine becomes a euphemism for getting the best overall outcome for the population at a given cost level deemed to be reasonable (by someone other than the patient or the physician).

However, the physician is the only effective advocate for the individual patient remaining in the health care system. When what is good for the individual patient is in economic conflict with what is good for the population, the physician has no moral choice but to opt for the good of the individual patient. In a society that believes otherwise, cost-saving strategies such as eugenics[8-10] and readily available euthanasia[11,12] become thinkable—even desirable. These reprehensible doctrines are good for no one, and physicians must not sell out to expediency.

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