Editorials

Medicine 1984: A profession, not a business

1983 was the year in which the impending great changes in the manner health care will be delivered in the future became manifest to almost everyone. It was the year in which this nation switched from a generation of emphasis on access to care, quality of care, and improved technology to cost limitation as the driving force in its attitude toward health. A decade of nibbling away at cost containment through the writing of only tangentially effective regulations limiting utilization and/or making various percentage reductions in the amounts of cost reimbursement for physician and hospital services was replaced by a total change in the underlying philosophy of paying for Medicare.

The wonderfully named Tax Equalization and Financial Responsibility Act (TEFRA) of 1982 effectively capped (or strangled) cost reimbursement to individual hospitals. The Social Security Amendments of 1983 then introduced a nationwide system (Diagnosis Related Groups [DRG]) which paid a fixed—except for several fudge factors—amount of money for a given disease diagnosis regardless of the amount of resources devoted to the care of that patient by the hospital. A price schedule has replaced the traditional method of full (or partial) repayment of the hospital's actual cost of care.

This federal action came at the same time at which industry began taking an aggressive approach toward limiting its own health costs. Earlier Health Care Financing Administration (HCFA) cost control efforts had resulted in large cost shifts from federally sponsored patients (Medicare and Medicaid) to those insured through employer (and often employee) financed plans. Industry has responded by increasing the amount of self-insurance, thus reducing its costs by eliminating the administrative expense of the third party. One form of this self-insurance has been contracting with hospitals and/or groups of physicians to deliver care at a discount for their employees. Whether this is done directly, or through Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Health Maintenance Organizations (HMOs), or any of a variety of other alphabetically identified mechanisms, the effect is to attempt to get an especially favorable financial arrangement for one's own people regardless of the effect this might have upon the general level of health care or upon costs borne by other groups in the community. This enables the business to shift costs from itself to other segments of the economy, just as the government has been doing and is attempting to continue doing with DRGs.

Industry has looked upon health as an unjustifiably large part of its overhead in the conduct of its normal business. However, it, or portions of it at least, also look upon health care as a golden opportunity to make money. This attitude, once pretty much limited to companies that made pharmaceuticals or hospital supplies, is now rampant. Chains of for-profit hospitals are not new, but they are now expanding rapidly, even into academia. Humana has acquired a university hospital in Louisville. Vanderbilt is working with American Medical International (AMI) on a joint psychiatric hospital. Massachusetts General and George Washington have entertained offers for cooperative ventures and/or sales to profit-making chains and other universities have been approached more or less informally with a variety of offers.

So far this may seem only to be an extension of previous trends by further intrusion of organizations already in the health care field more deeply into delivery mechanisms. However, there are other entrants now, for example, Sears. This company has always been considered to be in the retail and catalog merchandise business. However, it is now one of the country's largest insurance companies (Allstate), stock brokerage firms (Witter-Reynolds), and real estate brokers (Coldwell-Banker). It is already in the health field with its lens fitting operations. Now this industrial giant is

looking for methods of entering the health field in a wholesale manner. Those who did not believe that people would buy "stocks and socks" in the same store have had to face the success of the Sears in-store stock salesmen who are three times as effective as those in the traditional separate brokerage facilities.

There are many other examples but these should suffice. The question becomes: What will happen to the medical profession? Will it go the way of the small department store swallowed by the discounters? Of the Mom and Pop grocery stores pushed out by the supermarkets? Of the crossroad service station which also pumped gas? Of the tailor? The brokers of insurance, stocks, and real estate have thought of themselves as professionals who performed a service that could not be accomplished by a large, impersonal corporation in a wholesale manner. They have been proved wrong! Will it also happen to us?

The answer will depend upon our actions in the next couple of years. To the extent that the large number of young physicians entering practice each year makes it easier to hire medical expertise than at any time since the Great Depression, the new entrepreneurs will be able to employ doctors to man the Urgicenter, Emergicenter, etc. systems of distributing care. To the extent that they employ nonphysicians to deliver care, and even more importantly as far as they are themselves nonphysicians dedicated to the "bottom line" mentality, medical care will become less professional.

Therefore, physicians, if they wish medicine to remain a profession, will have to act as responsible professionals in the best sense of both words. This is not going to be easy. This country, along with others such as the United Kingdom, is in the grip of an antiprofessional wave. Physicians are described as "dangerous to your health." Media advocacy of self-treatment, the use of nonmedical practitioners in place of physicians (such as midwives for obstetricians), and of homes instead of hospitals for deliveries are indicators of this trend.

To be perceived by the public as true professionals we must redouble our efforts on the part of our constituency—our patients. It is not enough to decry the DRGs and various alternative health care systems as being unfair to hospitals and doctors. Few, except our families, care. We must be able to point out the adverse effects upon those people who most need us—the sick, the aged, and the disadvantaged. No one wants to include any of these people in his favored system—PPO, EPO, HMO, Blue Cross, Blue Shield or other private insurance plans. As the young, the well, and the working are signed up into groups with favorable rates, the organizing entrepreneurs will become wealthy, but those who most need care will be excluded from it. They will not be able to afford it themselves, and the government or whoever else is responsible for them will not be able, or will not be willing, to pay the increased rates for their coverage after the healthy part of the population is no longer part of the insurance pool.

We must therefore evaluate the effects of these changes that the new systems are bringing, both the good and the bad. We must make positive suggestions that will protect our patients, but at the same time be cost-effective. We must defend our position as the patient's best advocate by being just that.

No medical organizations are better suited to this task than the specialty societies. They have a long history of dedication to medicine as a profession. They have been leaders in the establishment of medicine as a science through their long support of research and education at all levels. They have for long taken on the task of protecting the quality of care through screening their members for their competency and their ethics.

1984 then must be a year of specialty society action. The American College of Physicians' proposal authored by its president, Dr. Richard Reitemeier, to monitor DRGs is one such progressive step. There must be others as well. The United States' system of health care is changing drastically and inexorably. It will never again be as it was. However, the profession can still direct these changes into beneficial channels by acting decisively. The Council of Medical Specialty Societies (CMSS) is available as a catalyst for the proactive measures to be taken by the different specialty societies and it is ready now.

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