

Modern managed care

Managed care in an age of covert rationing

If you were going to design from scratch a system for covertly rationing healthcare, you would need a central organizing concept like managed care, about which everybody could communicate using the same terminology, but while meaning entirely different things. **Defining Managed Care**

Managed care in its purest form simply refers to an administrative philosophy, under which certain management principles that have become standard in other industries are now applied to the healthcare industry.

A managed care organization is the bureaucratic entity that purports to apply the techniques of managed care to a population of actual patients. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs), for instance, are two types of managed care organizations. To keep things simple, in this chapter I will arbitrarily use the term "HMO" as a shorthand notation for all the various species of managed care organizations.

Since it is only an administrative philosophy - a technique, a tool - managed care is value-neutral. It is neither "good" nor "bad," any more than any other tool is good or bad. What is important is how the tool is used. "Pure" Managed Care

Managed care is a concept that has been around for decades, developed largely in academic and intellectual circles by healthcare policy experts, economists, governmental commissions and industrial management experts. In its purest form the idea behind managed care is a very simple and very useful one - it is to bring basic management principles that have been used successfully in other industries to the healthcare system, thereby injecting logic, organization and accountability to what traditionally has been a bastion of disorganization and inefficiency. Of course, there are many industry-derived principles that could be applied to healthcare. But the unifying idea behind most of them can be boiled down to one word: standardization.

Standardization of process is what defines the difference between a factory worker and an artisan. In fact, standardization can be considered a virtual synonym for industry. In industry, it is axiomatic that standardization is the primary means of optimizing the two essential factors in any industrial process: quality and cost.

This can be stated formally as the Axiom of Industry: The standardization of any industrial process will improve the outcome and reduce the cost of that process.

If you had a widget-making factory, you would break your manufacturing process down into discrete, reproducible and repetitive steps, and then optimize the procedures and processes necessary to accomplish each step. Later, if you wanted to further improve the quality of your finished product (or to reduce the cost of producing it), you would re-examine each step of the process, one by one, seeking opportunities for improvement. To find such opportunities, of course, you would need to understand the process very well, and you would also need to collect data about how well the process works. But with the right information, you would almost certainly identify a few minor changes, often involving only one or two steps, which would improve the manufacturing process. The beauty in such a system is that you have only to make one change - to the process itself - and every single widget that comes off the line after you make that change will be improved.

So: standardization is good. It leads to higher quality and lower cost. Conversely, variation is bad. It reduces quality and raises cost.

Proponents of managed care argue that there is no reason that standardization should not be just as useful in healthcare as it is in other industries. In fact, since medical care traditionally has been completely individualized, highly variable, and without any semblance of standardization, there must be a huge opportunity to improve the processes of care, and to make them both cheaper and more effective. Without a doubt, there is great merit in this idea. **Some Benefits of Managed Care Techniques**

A good illustration of how industry-derived principles have been successfully applied to clinical medicine is in the use of "critical pathways."

In practice, critical pathways are blueprints for delivering standardized care to patients with specific medical problems. Consider, for instance, a critical pathway for hip replacement surgery. A surgeon following such a critical pathway will have a blueprint of what services he or she is to provide for the patient, from the date of hospital admission until the date of discharge (which is, of course, predetermined). The surgeon will have a checklist telling him which laboratory tests to order and when, what medications to administer at which times, and what complications to watch for. The nurse and all other healthcare workers involved in the patient's care will have their own checklists. They will know from the moment of

a patient's hospital admission, for instance, when to take vital signs, when to get the patient out of bed, when to begin physical therapy, and when to provide standardized instructions to the patient before discharge. All this is pre-determined by the critical pathway.

All the while, the care each patient receives under the critical pathway is being monitored by a "case manager." The job of the case manager (usually a nurse), is to track how well the doctors, nurses and other healthcare workers involved in the patient's care are sticking to the prescribed pathway. Every deviation from the pathway (for instance, the patient with a hip replacement might begin physical therapy on Day 3 instead of Day 2), is tabulated as a "variance." The idea of tracking variances is not to mete out punishment, but to identify areas within the process of care that need improvement. If too many instances of a particular variance are seen within a critical pathway, then either medical personnel need to be "retrained" on following the pathway appropriately, or the pathway itself should be changed to reflect more realistic expectations.

The case manager is also responsible for tracking the medical outcomes of patients cared for under the critical pathway. If a pathway is seen to lead to suboptimal outcomes of care, it needs to be revised. It is said, therefore, that a critical pathway is never static. It is a "living" document, constantly being monitored and revised in order to produce an ever-improving process of care.

Thus, critical pathways can provide at least three benefits that improve the delivery of healthcare. First, the mere act of developing a pathway requires you to understand completely the care process being managed. Prior to managed care, such insights were rare. Often when first studying the process, one or more "routine" clinical practices are immediately identified as being obviously wasteful. So the very act of creating a critical pathway often leads to a rapid improvement in the efficiency of medical care.

Second, critical pathways provide a means of standardizing the processes of care. To the extent that healthcare is like other industries, the Axiom tells us that such standardization ought to be effective in improving outcomes and reducing cost - mainly by assuring that all patients enrolled in a critical pathway receive all necessary items of care at just the right time, and do not receive any unnecessary ones.

Third, critical pathways provide an organized means of defining, acquiring and tracking data related to the process of care. Such collection and analysis of data are the keys to improving any repeatable process.

In many cases critical pathways have helped hospitals and physicians to achieve the twin goals of managed care - improving outcomes and reducing costs. While critical pathways are only a small part of "managed care" itself, they can be seen as the embodiment of the main principles by which managed care aims to organize, coordinate and tame the healthcare system. It quickly becomes obvious to most individuals participating in the development of managed care procedures that there is often much to be gained by applying these principles. In fact, it is largely due to the success of critical pathways that many within the healthcare field have come to embrace managed care with at least some enthusiasm. Systematically reducing the cost of care while simultaneously improving the quality of care is indeed a very attractive proposition. Some Drawbacks of Managed Care Techniques

Unfortunately, there are at least two inherent limitations to the application of industrial management principles to the field of medicine. The first of these is a truth that, unfortunately, escapes many proponents of managed care techniques - namely, not all medical processes are suitable for standardization.

The standardization tools of managed care work only when you're dealing with a process that can be broken down into a predictable series of discrete, reproducible tasks that will generate reproducible results. In other words, industrial management tools work best when the process of care is similar to the process of making widgets.

Hip replacement surgery, for instance, tends to be reasonably widget-like. We know, for instance, that on Day 1 the hip replacement operation itself will take place. We also know that since hip replacement is usually an elective procedure, any other medical conditions the patient may have will have been stabilized prior to surgery (and prior to entrance to the critical pathway), and so should not present unexpected problems during the hospitalization. Thus the critical pathway can focus solely on steps to minimize the risk of complications of surgery, and to maximize rapid recovery. For hip replacement and many other elective surgical procedures, the use of critical pathways has resulted in reduced lengths of hospital stays, less cost, and more rapid (or at least, no worsening in the time of) recovery.

In contrast, developing critical pathways for many non-surgical hospital admissions has proven extremely problematic. For many medical illnesses, neither the diagnostic procedures nor the treatments that may be employed are possible to predict, or thus to standardize. For instance, consider what happens when we try to develop a critical pathway for congestive heart failure (CHF). Patients with CHF may have one or more of a variety of underlying conditions that caused their heart failure in the first place (such as coronary artery disease, valvular heart disease, viral infections of the heart muscle, and many others); they vary widely in their severity of illness (from mildly ill to moribund); and they often have related complicating disorders of one or more additional organ systems, such as kidney failure or peripheral vascular

disease. These factors, along with a multitude of others, ultimately determine what diagnostic and therapeutic maneuvers will be necessary. Knowing only that a patient has been admitted to the hospital with CHF tells you nothing about whether that patient will require cardiac catheterization, angioplasty, bypass surgery, valve replacement, a pacemaker, an implantable defibrillator, a mechanical ventilator, a prolonged and complicated stay in the intensive care unit, or just a couple of diuretic tablets and overnight observation. No two patients with CHF are alike; and there is no such thing as a "standardized" patient.

For medical conditions like this, in which every patient tends to be unique, managed care techniques tend not to be very useful. Unfortunately, the majority of non-surgical hospital admissions fall into this category.

The second inherent limitation in applying industrial management principles to healthcare, and the one that is more pertinent to our discussion of covert rationing, is that in healthcare the Axiom of Industry simply does not hold true. Standardization does not always improve outcomes and reduce cost.

It is instructive to consider just why this is so. What makes the Axiom of Industry apply to other businesses, but not to healthcare? The answer is: patients are not widgets. While this fact is obvious to everybody, its implications, apparently, are not.

If you're a widget maker, deciding between two manufacturing processes is purely a matter of economics. Nobody expects you to consider the widget itself. The outcome by which you are judged has nothing to do with how many individual widgets get discarded during the manufacturing process, or even, ultimately, the quality of the widgets that pass final inspection. Instead, it's the bottom line - it's how much profit you make in relation to whatever level of quality you put into the widget. So the quality of the widget is not necessarily maximized, instead it's optimized, tuned to the optimal quality/cost ratio as determined by the market forces of the day. This is why, for a widget maker, the Axiom holds: standardization, by rooting out variability, reduces the cost of making the widget (whatever the chosen quality level may be) - which automatically improves the outcome, since the outcome the manufacturer cares about is profit.

If instead of running a widget company you're running an HMO, the calculus is supposed to be quite different. You're supposed to be more interested in how things turn out for individual patients than you are in the bottom line. So an extremely expensive process of care that yields a significantly better clinical outcome is one most people (patients, at least) would expect you to use, even though it only gets you a healthier patient and doesn't make your money back for you. Furthermore, a process that increases patients' mortality rate by 5% is one you should disregard, even if it is substantially cheaper than the alternative. The clinical outcomes experienced by patients - the measure of "success" you're supposed to be concerned about - may move in the same direction as costs, or in opposite directions. But because you're dealing with patients the Axiom of Industry doesn't hold - outcomes and costs do not always move in the same direction.

In summary, "pure" managed care has given us some very useful ideas about how to make healthcare delivery more efficient without diminishing medical outcomes. The principles of managed care are being widely and profitably used in most large hospitals in America today, and without a doubt have the potential of even broader applicability. However, contrary to the dogma, these principles are not applicable in many cases, nor do they always yield favorable results.

The Two Faces of Managed Care

Managed care - two faced? Actually, it has many faces. By which I mean there are several variations in what the many entities within the healthcare system mean by the term "managed care." All the variations are based, more or less, on the "pure" ideas we have just considered, but none conceive of, promote, or apply managed care in its purest form. "Pure" managed care does not exist in the wild.

Fortunately, the most prominent variations in managed care fall into just two major schools of thought, which, as it turns out, happen to be those same schools we've already had the pleasure of meeting - the Wonkonians and the Gekkonians. Wonkonian managed care

As you will recall, the Wonkonians believe that the problems in our healthcare system can be traced to human weaknesses (most specifically, greed on the part of physicians, patients, and corporations). Thus, fixing these problems depends on setting public policy and promulgating governmental regulations. One can readily see how a theoretical construct like managed care might appeal to one holding to such an outlook, since managed care offers to remove some of the choices humans have to make in delivering healthcare (choices which are easily colored by greed), and to replace them with externally-generated processes and procedures. Philosophically, it's a good fit.

Because Wonkonians genuinely like and believe in the ideas behind managed care, the people who conceived of and developed those ideas - the academics, healthcare experts, government commissions, economists and editorialists -- tend to gravitate to the Wonkonian camp. Thus fortified, Wonkonians espousing the ideals of managed care tend to sound like very much like purists. They are proselytizers, who truly believe in applying continuous quality improvement,

critical pathways, information management, and other efficiencies of industrial management to healthcare. Because of their obvious sincerity, and because many of their ideas have considerable merit, it is easy for right-minded folks to fall in with this crowd.

What differentiates the Wonkonians from true managed care "purists" is in what they mean by the word "managed." In classic managed care, "manage" merely refers to the application of management principles such as standardization. To Wonkonians, manage means "regulate." Managed care is, to a large extent, simply a convenient tool for advancing their basic belief in policies and regulations to control human behavior. Invariably the specific recommendations put forth by Wonkonians have much more to do with establishing a centralized regulatory structure for healthcare than they do with classic managed care principles. To them, an envisioned system of strict regulations has become synonymous with managed care. Gekkonian managed care

The Gekkonians, on the other hand, find that the healthcare system is broken because it hasn't been treated like the business it is. Allow free-market forces (i.e., to force the point, greed) to reign, and the problems will take care of themselves.

Accordingly, Gekkonians come at managed care from an entirely different direction. Historically, they have little claim to the managed care peerage. In fact, Gekkonians spent decades decrying managed care as socialist heresy. Freedom and competition is their battle cry, and managed care smacks too much of social engineering.

Since the 1980s, however, the Gekkonians have co-opted the term "managed care" to their own ends, and in so doing have utterly changed its meaning. Their tie-in to managed care is quite tenuous; indeed, it is almost brazen. Since managed care techniques derive from industrial management principles, they hold, managed care is actually a child of the open marketplace. Thus, Gekkonians seem to be saying, what managed care is really all about is applying the principles of free enterprise to the business of healthcare.

Managed care to Gekkonians is dog-eat-dog, compete until you die, for-profit healthcare. Any actual relationship between Gekkonian managed care and classic managed care is purely incidental. (Sometimes standard managed care techniques can be useful, but only if they give you a competitive advantage).

Both faces of managed care, then, have co-opted the terminology of managed care in order to advance their own goals. Managed care is a means of establishing a stronger system of regulation on one hand, and a means of seeking profit on the other. Both schools of thought are prominent today, and both are actively and loudly advancing their respective points of view. A lot of the turmoil we have seen over the past decades, in fact, can be explained by the competition and interplay between these two schools of thought as they each try to advance their visions for American healthcare.

But for more than a decade, ever since the failure of the Clintons' audacious (or brave, depending on whether you hold with the Wonkonians or the Gekkonians) attempt to reformulate American healthcare, it has been the Gekkonians - armed with their chief weapon, the Gekkonian HMO - who have held center stage. Accordingly, it is the typical Gekkonian HMO, the despised beast with which most Americans are familiar, that we will now explore. The rise of the Gekkonians

The Clintons' reform plan, misguided as it was, was proposed in response to a true crisis in healthcare financing. And while the collapse of the Clintons' reform plan in 1994 caused a sudden deflation of expectations, the severe fiscal crisis remained. In fact, awareness of that crisis had been significantly heightened by the Clintons' campaign to reform healthcare, and nobody (except, of course, some of the doctors) entertained the delusion that we could simply go back to business as usual.

But as it turned out, a new group of saviors awaited. And here is what they said: "Citizens! We all - employers, patients, physicians, hospitals, manufacturers and insurers - have just dodged a bullet. Thanks to us, the frightening socialist reforms of the Clintons have been soundly defeated. But where does this leave us? We stand now between Scylla and Charybdis, between the specter of nationalized healthcare on one hand, and the continued profligacy of traditional fee-for-service medicine on the other. And we cannot countenance either. But here," the Gekkonians continued, "is a third way. A painless way, based on the sound principles of managed care, open markets and free enterprise. Let healthcare become a business like any other business, and the market forces will find ways not only to cut costs but also to improve quality, etc., etc., and with no government intervention."

The offer, in other words, was to turn healthcare over to the business professionals, and let them harness the efficiencies of the marketplace to solve our problems. Because we're Americans and we know the benefits of capitalism, and because the other choices we faced looked even worse, we all said: go for it.

The result, over the next few years, was perhaps the most rapid transformation our healthcare system has ever seen. While most of those changes were real, palpable and material, perhaps the biggest transformation of all was a

philosophical one.

For all their faults, the Wonkonians have always held to the age-old and endearing notion that the basic underlying purpose of healthcare is to maximize the public good. Indeed, they believe, this fact is what gives government the ultimate authority to regulate healthcare. Only the government can guarantee that the special interests will act in a manner appropriate to public benefit. (The flaw in this argument, for those of us who are suspicious of Wonkonians, is that regulatory bureaucracies often wind up behaving as the biggest, nastiest special interest of all.)

What the Gekkonians gave us in the 1990s was a brand new first premise. The primary purpose of healthcare, they said, is not to increase public benefit. How could it be, when healthcare is merely a business like any other business? What we should be striving for is to build a well-run business. Since well-run businesses are beneficial to the community, in the end we can expect plenty of benefits to go around. But the fact remains that healthcare is a business. And the primary purpose of business is to make money.

To see the effects these Gekkonian-style HMOs are having on doctors, patients, and on American culture, in the following vignette we'll trace the evolution of an imaginary, but typical, modern-day HMO called "For the Patient" (FTP).

A Vignette - Portrait of a Modern HMO. It's 1995; Clinton healthcare reform has just gone down in flames, and it's a new era for HMOs - HMOs like FTP. FTP, established in 1992, has already gained a foothold in eight cities along the eastern seaboard. Following the original business plan, FTP was taken public last year.

But FTP is in trouble. Earnings, and consequently stock prices, have been stagnant. Enrollments have not grown to expectations; the physicians on FTP's panel (most of whom are new to managed care) have been resistant to changing their inefficient patterns of practice; and it's been difficult to get hospitals in the FTP system (some of which have been rivals for decades) to cooperate with one another. The shareholders are restless, and in response the board has just fired the old CEO (a physician and one of the FTP's founders) to bring in a hard-nosed businessman who will know how to put things right.

That man is Gregory Gekko (distant cousin to Gordon). He doesn't know much about healthcare, but he's not in the least intimidated. The last CEO knew plenty about healthcare, and look where it got him. Besides, Gekko didn't know anything about greeting cards either before he developed a tiny greeting card company called Greetings-Schmeetings into a multibillion dollar corporation that's giving Hallmark a run for its money. What Gekko does know is business.

Gekko immediately begins with the two fundamental steps that must always be taken when building a business: First, define your customers. Second, define the scope of your business (i.e., decide what it is you do to make your customers happy). Only then, knowing both your customer base and your scope of business, can you decide how best to maximize your profits. Who are FTP's customers? To Gekko, making money is everything - but not because conservative Republicans have recently swept Congress, or because it's the new paradigm for healthcare. Making money is everything to Gekko because that's what the stockholders of FTP have put him on this earth to do. Above all, Gekko is acutely aware that when all is said and done, and it is time for him to receive his final judgment, those who will do the judging can only be the shareholders of FTP. He knows from his past business experience that he will have some latitude and flexibility regarding the tactics he uses to make that money, but ultimately, his overriding strategy must be pleasing to those shareholders. Keeping clearly in mind who his own personal customers are, Gekko carefully considers who might be the customers of his company - of FTP.

Gekko knows this is where the last CEO made his big mistake. He'd talked about his primary customers being the patients enrolled in FTP and their doctors. It wasn't until his final shareholders' meeting that he'd finally gotten it. Of course, it was too late for him by then.

Obviously the primary customers of any business are the people who decide to purchase whatever product the business is selling. In this case, those would be the individuals who decide whether or not to use FTP as their health plan. Gekko knows that patients don't really purchase health insurance, nor do their doctors significantly influence those purchasing decisions. Patients and doctors are important on the spending side of the equation, since they determine how much of FTP's money will be frittered away on delivering healthcare. So they will have to be dealt with. But they don't buy insurance premiums.

The people who actually make the purchasing decisions are the human resource executives and benefits officers in companies that provide health insurance for their employees. To FTP, these purchasing agents are all-important; they will determine Gekko's success or failure. All stops must be pulled out, at whatever the expense, to make these individuals feel very favorably toward FTP. Gekko is confident in this regard, since he knows many techniques, subtle and otherwise, that can be usefully employed to that end. What is FTP's scope of business? This is also pretty straightforward for Gekko. FTP's main business is to take in lots of money in the form of health insurance premiums, and then try to keep as much of that money as possible. The rest of the insurance premium money, the money FTP doesn't get to keep, must be held on to (and invested), for as long as possible. The best part of course is that, unlike a bank, during the time FTP is holding massive quantities of other people's cash, it doesn't have to pay any interest.

In return for this opportunity, FTP must arrange for the provision of healthcare to the individuals for whom the insurance is paid. But providing healthcare is not how FTP will make its money - it's merely one of the costs of doing business. It's the price FTP must pay for access to all those insurance premiums. So, how FTP should actually go about providing the necessary healthcare to its enrollees is a completely open question for Gekko. There are a lot of ways to do it, and he's not married to any one of them. The only firm bounds he sets for his executives are that whatever methods FTP uses to dispense healthcare must be legally defensible, must minimize or mitigate any opportunity for negative publicity, and

must be sufficiently acceptable to its customers - i.e., to those benefits officers.

Since his ultimate goal is to make money for the shareholders, Gekko also understands that he needs to be alert to any low-risk investment opportunities - aside from high-grade government and corporate securities, of course - for turning all that cash flow into profit.

The bottom line is that to be successful, Gekko must maximize the inward flow of cash (health insurance premiums,) and minimize the outward flow of cash (healthcare payments). Much of his effort will have to be targeted toward these two goals. Maximizing the inward flow of cash To maximize the amount of money flowing into FTP in the form of insurance premiums, Gekko must do several things. He needs to grow and expand FTP into as many localities as possible as rapidly as possible, in order to increase the number of businesses to which FTP can reasonably sell its insurance products. He needs to create a strong and aggressive cadre of sales representatives who can market, enlighten, persuade, cajole, schmooze, entice, bribe, seduce, blackmail or threaten the benefits officers of those companies to offer FTP as a health insurance option to their employees (and as the sole option, whenever possible.) And he needs to charge as much for his insurance products as the market will bear. Keeping premiums high. Optimizing the cost of his health insurance premiums is pretty simple. Gekko must lower his premiums just enough to induce employers to switch to FTP, but not a penny lower. Since high-priced indemnity insurance plans are still active in all the cities in which FTP operates, all he has to do is to beat their prices by a little bit. So Gekko sets his rates to a fixed proportion - 90%, in fact - of the indemnity rates, and he's in business. The beauty of this methodology is that, since FTP's rates are fixed to the highest rates in the market, whenever the indemnities are forced to increase their rates, FTP automatically gets a raise, too.

Gekko understands, of course, that the reason everybody's pushing HMOs in the first place is that they're supposed to reduce the cost of healthcare. And most people assume that what HMOs charge for their premiums are tied somehow to that lower cost of delivering care. Gekko just shakes his head. Why would people assume that? Why would anyone expect Gekko, a businessperson, to pass his savings on to the consumer (unless doing so results in a clear-cut competitive advantage)? Businesses are supposed to make as much profit as they can. That's how it works. To do anything else would be unfair to FTP's shareholders, and fatal to Gekko's career.

With all the promises from Gekkonians in the mid-1990s about how their HMOs would save money for the healthcare system, this last point deserves some emphasis. Despite the aggressive cost-cutting measures taken by HMOs (which now enroll over 80% of insured Americans), the health insurance premiums paid by employers haven't fallen. In fact, except for a few years during the mid-1990s when the inflation rate for insurance premiums dropped to below 5%, premiums are still increasing by double digit amounts in most years. But with the drastic cuts in services being made by HMOs and the resultant lowered costs, shouldn't we have seen at least a rather sizeable one-time savings in healthcare spending? Where did it go?

Gekko has already answered our question. The dollars that HMOs squeeze out of the system are not returned to the payer in the form of reduced premiums; nor are they plowed back into the healthcare system in the form of improved or widened services; rather, they are invested for maximum returns, which are then pocketed by the HMOs in the form of administrative costs, bonuses for top executives, and profit for the shareholders.

Typical HMOs end up spending around 85% of their collected premiums on actual healthcare, a proportion shareholders and analysts refer to as the "medical loss ratio." That "medical loss" had better not climb. In 2002, when Aetna was found to be spending as much as 90.5% of its money delivering healthcare, the Wall Street analysts and shareholders went ballistic, and inside of Aetna heads rolled. Keeping premium dollars out of the actual medical arena is critically important for HMOs. Growing FTP: acquiring community assets. Growth is required in order to maximize the inflow of cash. Gekko decides that the fastest way to grow FTP is to acquire major healthcare facilities (hospitals and nursing homes) in all its key cities of operation, and he begins doing so. Along the way, Gekko stumbles upon a gold mine. It is a gold mine not directly related to FTP's scope of business, but it's close enough, and the shareholders love it.

The first time Gekko acquires a community hospital for FTP, he notices that within a week of the transaction the price of FTP's stock rises by 5%. What he has just done, he realizes, is to cash in on a publicly-owned asset. So Gekko tries it again, and this time the stock rises by 7%. Gekko's head spins. This scheme threatens to become such a windfall that Gekko momentarily worries that it might overwhelm the presumed actual business of FTP. The payoff promises to be so astounding, however, that he decides not to worry about it.

Gekko is right. It's a great scam, and completely legal to boot.

Non-profit hospitals existed in the first place because their communities decided they were needed for the public good. Accordingly, these hospitals were established under the nonprofit laws, which required them to function primarily under a charitable philosophy. Over the decades and in return for their service to the community, these hospitals operated under the public largesse, in the form of their blanket tax-free status, their ability to raise tax-free bonds, and their ability to raise tax-free charitable contributions. Their boards of trustees, made up of prominent members of the community, were charged with guarding the accumulated public value represented by those institutions.

The widespread transfer of not-for-profit public assets (such as a community hospital) to for-profit corporations (such as

an HMO) was perhaps the major unnoticed healthcare story of the 1990s. It was fueled by the Gekkonian notion that for-profits are inherently more efficient in providing healthcare than mere charities. Such transfers only occurred at the urging of the community hospital's board of trustees, and had to be overseen, depending on local regulations, by either the state insurance commissioner or the state Attorney General. That state official, if he or she approved the conversion, was expected to assign a formal dollar value to the hospital. The HMO then had to reimburse the community for that amount, usually by establishing a charitable foundation.

It is a procedure that might be acceptable in theory. In practice, however, all too often the hospital's board of trustees permitted, or even encouraged, a low valuation for their hospital. Also, state insurance commissioners seemed congenitally unable to establish an accurate value for non-profit hospitals. In doing those valuations, for instance, they considered only tangible property values. They ignored (and neither the hospital's board nor the HMO insisted on pointing out to them) the value of many of the assets owned by the hospital such as trademarks, reputation, name recognition, provider contracts and subscriber lists. The commissioners didn't insist on going through a competitive bidding process or conducting a formal market valuation. In fact, only the hospital's value as a charity, and not as a business, was considered. And for some reason insurance commissioners often also seemed quite happy to do the negotiations behind closed doors, and with no public disclosure. Within a year Gekko has established a routine for acquiring community hospitals, and it works like this. First, the hospital's board of directors see fit (when necessary, induced by stock options or offers of directorships within FTP) to severely under-represent the value of their institution to the insurance commissioner. The insurance commissioner then approves the transfer to FTP at a low valuation rate. Then, after the hospital becomes a hard asset of FTP, its true value is established by the open market as reflected in the price of FTP's stock. Almost invariably, that value is orders of magnitude greater than the value set by the insurance commissioner. So, without doing a thing to improve the quality of care or to reduce the cost of care, FTP's market value soars - and all at the expense of the public.

It's a win-win. During Gekko's first 2 years at the helm of FTP, not only does the company's stock go through the roof, but also Gekko acquires key medical facilities in all his cities of operation (which he's now expanded to 15). He finds he is able to begin significantly influencing the healthcare markets in most of those cities, and consequently controlling the behavior of even the most recalcitrant of physicians and benefits officers (who suddenly find they have to deal with FTP whether they want to or not). The health insurance premiums, always optimally priced, are pouring in to FTP at a 25% annual rate of growth.

Minimizing the outward flow of cash

Having lots of health insurance premiums flowing in the front door is nice, but it will be of relatively limited value to FTP if that money just ends up flowing out the back door to buy healthcare for subscribers. Gekko has to find ways of minimizing the amount of money it costs him to administer actual healthcare. He knows this will be a challenge, since the reason HMOs have been given a mandate to run healthcare in the first place is that no other method of reducing costs has worked. But he is confident. The key element that was missing from those prior efforts has now been supplied - the profit motive. What a wonderful way to concentrate the mind! He is sure he can find ways to cut costs.

Furthermore, the healthcare crisis itself will be very helpful to him, in that it provides him with some very useful cover.

The need to trim the cost of healthcare gives him an acceptable reason to make cuts that might otherwise be unacceptable. And the mandate not to reduce the quality of care gives him an excuse to keep his premiums as high as he can. (If we cut our premiums too much, he will say, quality will suffer.) Confident that he has a lot of latitude, Gekko develops strategies for minimizing his cost of doing business. Cost-minimizing strategy # 1 - Use economies of scale.

Making FTP a very big HMO has benefits in addition to merely increasing the inflow of dollars. It gives Gekko opportunities to capitalize on the economies of scale. He negotiates favorable purchasing agreements with all the major vendors. He works to reduce pharmacy costs by having the major pharmaceutical houses "bid" to have their drugs included on the limited FTP drug formulary (i.e., a list of drugs approved by FTP). And he quickly acts to streamline the management of each of his new hospitals as they come on line, firing layers of old-fashioned administrators, and replacing them with streamlined management teams made up of his own people, using standard FTP operating policies and procedures. Cost-minimizing strategy # 2 - Avoiding unnecessary risk. A glance at the dynamics of the HMO industry is enough to convince Gekko that the biggest risk he faces is sick patients. They are extremely expensive these days. The sickest 10% of the population, in fact, account for over 70% of all healthcare spending, and one really sick subscriber can wipe out the potential profit from twenty, thirty, or even fifty healthy subscribers. Sick patients are to be avoided like the plague.

There are two obvious ways of avoiding the sick. First, don't sign them up. Second, if you do have to sign them up, make it unpleasant for them to stay with you.

Fortunately, the system Gekko has inherited helps immensely. Since FTP's insurance products are only available through employers, only employed people can sign up for FTP. And employed people are, on average, far healthier than unemployed people. There are good reasons for this. In most of the cities in which FTP operates, a substantial proportion of the unemployed do not have jobs precisely because of some chronic illness, disability, or addiction. And because employers are loath to employ the obviously ill, there's an invaluable screening process that takes place before anyone even becomes eligible for FTP. You can't buy prescreening like that at any price, and Gekko's getting it for free. Not all of Gekko's options in this regard are purely passive. He notes that several of FTP's new hospitals run specialty centers that are clearly counterproductive - two hospitals, for instance have Congestive Heart Failure Centers, and five have Cancer Centers. Why should he support clinical programs that go out of their way to attract patients with chronic (and therefore expensive) illnesses? Gekko orders his Medical Directors to figure out how to make these programs

profitable within 6 months, or shut them down.

In addition, FTP's new size gives Gekko some clout where it counts. When he learns that Congress is considering legislation that would require insurers to make health insurance available to people who are "between" jobs, he directs FTP's high-paid lobbyists to keep any such bill from having teeth.

Despite his best efforts, Gekko realizes, FTP will get its share of patients with chronic illnesses. He'll deal with these simply by allowing layers of obstacles to form between those patients and the care they need. Gekko realizes he doesn't have to ask anyone to create such barriers - they'll form naturally within any bureaucracy. What he needs to do is to let the system bog down in red tape for the ill, while, at the same time, to work hard to keep the system squeaky clean for healthy subscribers.

It won't be long before the chronically ill begin switching to other plans out of sheer frustration - preferably back to indemnity plans so their premium rates (and thus FTP's) will keep rising. Even better, the healthy (who are receiving benefits like free memberships to health clubs) won't know what the malcontents are complaining about - FTP seems pretty good to them. And as a result, when FTP does its periodic consumer surveys, at least 70% or 80% of its subscribers (i.e., a proportion representing a large majority of its healthy subscribers), will rate its service as good to excellent.

A survey in 2000 by the Kaiser Family Foundation and Consumer Reports showed that while 64% of Americans gave their health plans an A or B grade, the sickest 20% reported having major problems getting the care they need. The most common complaints were denials of care, difficulty getting in to see a doctor, and billing problems. "These results are not good news for consumers," said Peter Lee, President and CEO of the Pacific Group on Health. On the other hand, these results are "good news for consumers," said Susan Pisano, spokesperson for the American Association of Health Plans (AAHP). I guess it all depends on whether the consumers you're talking about are the ones who are healthy or the ones who are sick. It is perhaps not surprising that the AAHP naturally identifies with the needs of the former.

In any case, to the greatest extent possible, health plans seek to attract only healthy patients. The practice of attracting only healthy patients is called "skimming" or "cherry-picking," and it's a true art form. HMOs make a lot of money by enrolling healthy young families and avoiding the old or chronically ill. In the mid-1990s when indemnity insurance plans were still common, skimming actually made money for the HMOs twice - once by enrolling only patients who probably will not need medical care; and again by driving the sick into traditional indemnity plans, thus causing the premiums of those plans to rise, and pulling up the HMO's premiums automatically.

Nowhere was the practice of skimming more profitable for HMOs than in the government's push in the mid-1990s to get Medicare patients into HMOs. A Medicare HMO during that era got paid a flat amount per enrollee. If it spent less in delivering healthcare than it took in, the HMO kept the difference. The amount Medicare HMOs received was set at 95% of what it costs to care for a Medicare patient on a fee-for-service basis, which at the time was about \$5000 per year.

HMOs were plenty smart enough to figure out what Congress apparently couldn't - cherry-picking is especially profitable with Medicare patients. If HMOs could recruit from the healthiest 75% of Medicare patients (who use only 9% of the Medicare health dollar), the sickest 25% of patients then would continue using fee-for-service plans, thus driving cost for those plans through the roof. The HMOs continued to receive 95% of those higher premiums.

HMOs had to work a little harder to cherry-pick Medicare patients (since employers didn't do the dirty work for them), but they were more than up to the task, and it was especially worth the effort. The public recruiting of Medicare patients at the time was telling. We saw HMOs advertising enrollment drives in affluent suburbs, or at country clubs, or on the third floor of a building without elevators. Medicare HMOs assiduously avoided the less affluent parts of town. They not only avoided recruiting patients in such locations, they (and non-Medicare HMOs for that matter) also avoided contracting with doctors whose offices were located within a couple of bus transfers of those areas. (So as an added benefit - if you're trying to covertly ration healthcare - this practice punished doctors who chose to work in such economically deprived areas.)

The Medicare HMO scheme worked very well (for the HMOs) until the late 1990s, when the government finally noticed that the for-profits were skimming all the healthy patients and leaving the sick ones for standard Medicare. They changed the rules to remedy this practice - and within three years virtually every for-profit HMO had abandoned the Medicare program.

If you can't cherry-pick the healthy patients any more, you can still try to frustrate the sick. The practice of discouraging usage of expensive services, and thus making healthcare particularly inconvenient for the ill, has been openly discussed as a legitimate technique among healthcare managers. A 1994 article in the Journal of Health Care Marketing is particularly interesting in this regard. This article praises several useful techniques that HMOs have developed for discouraging the use of (or "demarketing") costly healthcare services. To quote:

"Decreasing accessibility to services . . . can be accomplished by "managing" the information distributed to patients regarding services available and how to access them. For example, an organization might excessively promote less-costly preventive procedures . . . and repress information about other elective and/or expensive services. In addition,

providers can strategically locate and number specific services to make them easy (e.g., primary care) or difficult (e.g., specialists) to utilize. Furthermore, lag periods . . . also serve as containment strategies. Lags may be affected by the need for referrals, limited number of contracted specialists, restricted or inconvenient appointment availability, and increased office-visit waiting periods."

So we see once again that institutionalized waste and red tape are an essential part of covert rationing. While Gekko is willing to streamline the internal processes that impact the efficiency of FTP itself, and is not against improving the convenience factor for healthy subscribers, he will, at best, simply let processes that impact services for sick patients bog down in bureaucratic inefficiencies, and at worst, actively establish road blocks to adequate services.

Cost minimizing strategy # 3 - controlling the physicians' behavior. One night shortly after becoming CEO, Gekko has a nightmare. A doctor and a patient are sitting together in the privacy of the doctor's office, and the two of them are deciding how much of Gekko's money to spend. And as they ponder their options, all they talk about is what the patient wants or needs. Then, the decision at last made, the doctor takes out his pen and with a few strokes bends the will of the vast medical-industrial complex - and mobilizes Gekko's money - to suit his patient's needs.

Gekko awakens in a sweat, and considers his dream. He realizes that all you had to do was to multiply the one encounter he'd dreamed about by the 1.5 million of similar encounters that take place every day, and you'd know why healthcare is so expensive. It frightens Gekko to think that this is how his money is being spent. But the fear motivates him powerfully, and focuses him on what he has to do to control his expenses.

Simply, he has to control the behavior of his physicians. There is no way he can allow them to carry on as if the patient is their only concern. When FTP physicians are counseling their patients, deciding how much of FTP's money to spend, they've got to consider something other than just the patient. They've got to consider the needs of FTP.

Gekko knows there are many, many ways to accomplish this. Some involve making the physicians loyal to FTP; others making physicians frightened of FTP. Some involve subtle intimidation; others heavy-handedness. Gekko can pull no punches on this one. This, he knows, is where the money is. He decides to use every means at his disposal to become an unseen presence in that office with that doctor and that patient. He's got to become the doctor's primary customer; keeping Gekko happy must become the doctor's number one concern.

Controlling the flow of patients. Physicians are nothing without their patients. So the first thing Gekko must do is wrest the "control" of patients away from the doctors in each of his cities of operation. Purchasing key community hospitals is a major step toward this goal, but Gekko leaves nothing to chance.

So he mixes himself a martini, puts his feet up, and dictates a first draft of an "18 Month Plan," aimed at nothing short of bringing the physicians to heel:

THE FTP 18 MONTH PLAN

Phase 1 (Months 1- 6): Open the gates. Allow any willing licensed physician in the area to join FTP's physician panel. Actively and aggressively recruit all the largest and best known physician practices. Purchase a few key practices, if necessary, to break any physician resistance to joining FTP.

Phase 2 (Months 7 - 12): Get control of the patients. Armed with an impressive physician panel that promises not to limit the choice of any patient, aggressively market FTP to all large and moderate-sized businesses in the area. By the end of month 12, FTP should be offered to every employee of every company in each area of operation employing 250 or more. Undercut prices of every other insurer in the market, if necessary, to achieve this goal. On Day 1 of month 13, FTP should control at least 30% of all insured patients in key medical practices.

Phase 3 (Months 13 - 18): Collect the data, begin making the cuts. Track how much of FTP's money is being spent by every FTP physician. Then, with fanfare, drop from the FTP panel at least several prominent and highly-visible physicians who are deemed to be spending "too much" on patient care. (Note: The letter sent to the dropped physicians should not give cause for termination. It should simply thank them for their services, and say those services will no longer be required.) (Note: This step will be most effective if those physicians dropped from the panel are not only well-known to their colleagues, but also lose a substantial proportion of their long-time patients as a result of their being dropped.)

It's a good plan. It is designed to rapidly and efficiently assume control of the physicians' very means of livelihood - their patients - and in practice Gekko is pleased to find that it most often accomplishes this goal before the doctors even realize what is going on. The plan is vital to the mission of FTP, and fortunately, it works well (although in three cities it takes up to 24 months to complete).

Once the 18 month plan has achieved its goals, Gekko institutes Phase 4. Phase 4 lasts forever.

Phase 4 (Month 19 and beyond): Turn the screws. Let the FTP physicians know what is expected of them. A) Revise the terms of their contracts with FTP. New contracts will lay out terms of capitation and associated incentives and disincentives, and will add nondisclosure language. B) Begin a quarterly "review" of each practice, showing physicians in detail where they are spending dollars, and comparing their expenditures both to target values and to the expenditures of their peers. C) It will be necessary to continuously reinforce who is in charge. Periodic issuance of without-cause termination notices to selected physicians will be important. Handing out occasional but highly-visible performance awards will also be helpful in this regard.

In other words, now that Gekko "owns" the physicians, it's time to let them know what their new boss wants.

Controlling the flow of dollars. Before Phase 4 of his 18 Month Plan begins, Gekko continues paying his physicians on a discounted fee-for-service basis (i.e., they get paid for every service they provide, at a somewhat lower fee schedule than for Medicare). But for any HMO during the 1990s, the pot of gold at the end of the rainbow is capitation. And Gekko institutes capitation with great relish during Phase 4.

Under his capitation plan, FTP primary care physicians (PCPs) get paid a fixed amount per month for every FTP patient they follow in their practice. No matter how much or how little medical care they provide for that patient, the PCPs get paid only the capitated amount. But Gekko doesn't actually pay them the full capitated rate up front - they get only 90%. He keeps the last 10% as a "withhold," which he fashions as an additional incentive.

Thus, at the end of the year, if FTP meets its financial goals and the PCP meets certain performance requirements, Gekko distributes the last 10%. If not, FTP keeps the money. It is possible, of course (if FTP's financial goals are exceeded and the physician's performance is rated "excellent"), for the PCP to receive a bonus in addition to the 10% withhold. And Gekko sees to it that at least a few PCPs get such a bonus each year, just to let his physicians know that such a thing is within the realm of possibility. Capitation fee schedules are renegotiated each year with each PCP, based on how "well" the PCP has done in the previous year.

It's a shame Gekko's number crunchers can't yet figure out a way to capitate specialists as well, but so far it's too complicated. The accountants cannot guarantee him that he'd make money capitating specialists. Some day they'll have sufficient data to pull it off, but for now he continues paying his specialists on a modified fee-for-service basis. Gekko knows he needs alternative measures to control the behavior of the specialists.

The performance measures that determine whether a PCP does or does not get his 10% withhold at the end of the year are a vital part of Gekko's plan. There are a few token "quality performance measures," of course, that monitor whether the doctors are aggressively treating hypertension and screening for high cholesterol and the like. But Gekko wants to make sure his doctors know what he really means by performance, so he doesn't try to disguise the fact that the bulk of FTP's performance measures have to do with fiscal performance.

Each quarter, a dark-suited FTP representative (a "Practice Consultant") visits each PCP with a "Performance Report." The Performance Report accounts for every dollar that FTP has had to spend during the past quarter on patients enrolled in the PCP's practice.

"Your patients cost us an average of \$439 apiece during the past quarter, Dr. Smith," the Practice Consultant might say. "That compares unfavorably with the mean of \$348 achieved by your peer PCPs, and even less favorably with the target of \$294 that would be required for you to receive your portion of the year-end withhold. Now, Dr. Smith, let's examine this report in more detail to see if we can figure out where all that money is going."

So Dr. Smith and the helpful Practice Consultant look things over. They notice that Dr. Smith referred ten patients to cardiology practices during the past quarter. The Valley View Cardiology practice ended up spending an average of \$6247 on the five patients Smith sent them, but the Cormatic cardiologists only spent \$4593 taking care of the other five. They both agree that substantial savings could have been realized by referring more patients to Cormatic, and fewer to Valley View.

"Of course," the Practice Consultant says, "we would never tell you how to practice medicine."

"Of course," Dr. Smith replies.

It is a thing of beauty. Look what Gekko has accomplished here. By rapidly gaining control of physicians' means of livelihood (i.e., their access to patients), he is able essentially to dictate the terms of their surrender.

Those terms put fiscal pressure on doctors at several levels.

Since they are paid a capitated rate, there is financial pressure on the PCPs to keep patients out of their offices. Office overhead is often figured on an hourly basis, so the more time a patient spends in the office (i.e., the more office overhead that patient consumes) the less profit (or the more loss) the physician realizes on that patient. Under many capitation rate schedules, more than two office visits per patient per year will result in a net loss for the PCP. This is why many doctors now take great pains to head off office visits by requiring patients to go through a screening process before letting them in the door. (All too often, it seems, that screening consists of a telephone interview with thick headed, thin skinned, minimally trained "assistant." If you've ever wondered why doctors would ever want to employ such obviously off-putting personnel, now you know.)

Of course, HMOs themselves sometimes pitch in to discourage patients from visiting doctors' offices, humanely relieving their doctors of some of the burden. In 2002, for instance, Kaiser Permanente was called out (by a disgruntled nurses' union) for paying bonuses to clerks in three northern California call centers, for limiting the medical services provided to patients who called in with medical problems. Specifically, Kaiser had set up a quota system that paid these minimally trained clerks bonuses equal to 2 - 4% of their salaries, in return for not making doctors' appointments, for not transferring calls to a registered nurse for further evaluation, and for keeping the average call time under four minutes. When the story made the news Kaiser admitted the story was true, but said that now they had stopped. (Leaving one to wonder whether, instead of paying bonuses to the clerks to get them to do their jobs well, the company might have

reverted to more traditional and less humane incentives such as threats, terminations and arbitrary scheduling practices.)

HMOs do not directly control patients' visits to medical specialists - patients are referred to specialists by their PCPs. So to control expenditures by specialists, the pressure needs to be applied to the PCP. This is done by ultimately holding the PCP personally accountable for whatever money the specialist ends up spending on a referred patient. These specialist-ordered expenditures will affect the PCP's end-of-year "bonus," and will impact on the next year's capitation rates.

Since doctors really do want to take good care of their patients, most PCPs will refer when they really think it's necessary. But to whom do they refer? In the old days, they referred to the specialists they thought gave the best care, or who were the most congenial, or who invited them to the best golf outings, or who were their brothers-in-law. The new fiscal incentives are so powerful that they tend to override any of these considerations.

This is how HMOs control specialists indirectly: A cardiologist whose referrals have fallen drastically is all ears when the friendly FTP Practice Consultant shows up in her office with facts and figures. Learning that she is spending a lot more money than her peers in providing patient care (and that her referring PCPs also have been provided with the same data), leaves her with two choices. Either cut out some of the services she is providing, or go out of business.

Gekko's operational plan has at least one other major benefit. Visualize what happens, if you will, when a patient with a chronic illness shows up for the first time in the office of a PCP. Most likely the PCP immediately has visions of \$100 bills flying out the window. He gets paid no more for delivering care to that sick patient (who may require office visits at least on a monthly basis), than he does for a healthy 18 year old he will not see at all. And, odds are he'll end up having to refer the patient to at least a couple of specialists during the course of the year. The PCP has already seen his income fall by more than 10% each of the last two years, and has had to lay off office personnel to boot. He just can't afford to absorb any more cuts.

So, is he happy to see that patient? Or is he frustrated, and maybe even angry (at the patient, at the system, and at himself)? Under such circumstances, it would only be human nature to begin sending the patient subtle messages that indicate she's not really welcome. During office visits the physician is more likely to seem disinterested, distracted, or rushed - off-putting. He may be a little less accommodating when she needs to schedule an appointment; he may drag his feet when she sends him a stack of disability applications to fill out. He may be a little slower than necessary to return her calls. And after a while, the patient is likely to get the message and switch PCPs, or better yet, to switch health plans altogether.

By appropriately incenting his physicians, Gekko has thus established a highly effective adjunct to his cherry-picking program. His physicians want just as badly as he does to avoid the sick, and by their words, actions and deeds are able to directly discourage the more expensive patients from staying with FTP.

Making the destruction of the doctor-patient relationship legally binding. Gekko is happy with the results of his 18 month plan, but wishes to reinforce and formalize the message he has successfully delivered to FTP's physicians. He wishes to make that message legally binding. When it is time for him to rework his physician contracts, Gekko asks his attorneys to come up with language that does just that, and they are happy to accommodate him:

"The physician agrees not to take any action or make any communication with patients or patients' families, potential patients or potential patients' families, employers, unions, the media or the public that would tend to undermine, disparage, or otherwise criticize FTP or FTP's healthcare coverage. The physician further agrees to keep all proprietary information such as payment rates, reimbursement procedures, utilization-review procedures, etc., strictly confidential." Gekko likes the language. It is plain and straightforward. His physicians, completely without choice, sign the new contracts with nary a peep of complaint. Gekko has made an assertion to his doctors. He has said, "You work for me, and me alone. You're all mine." His doctors, by their legally-affixed signatures, have acknowledged that assertion. Gekko has sought a place at the table with FTP doctors and their patients, and now he has it. In fact, he is at the head of the table.

What Gekko has just done is to add a classic "gag clause" to his physician contracts. The final insult to a doctor's professional integrity, a gag clause prohibits the doctor from disclosing certain types of information to his or her patients. The forbidden information is likely to be material to the patient's ability to accurately assess the doctor's medical advice, and therefore the lack of that information may impact on the patient's health. So from a purely practical standpoint, gag clauses are a threat to patients.

But from a more philosophical standpoint, what the gag clause represents - by the fact that HMOs used them with impunity and physicians signed them with little more than a whimper - is a formal death certificate for the physician-patient relationship. It officially and legally certifies that the doctor's first loyalty is to the integrity and reputation of the HMO, which supersedes any loyalty or duty that might exist toward the patient.

Gag clauses attracted a fair amount of criticism in the late 1990s, but essentially only from the standpoint of it's not being nice to "gag" physicians from telling their patients what they need to know. Little has been said about the implications of

HMOs having had the audacity to include gag clauses in physician contracts in the first place, and of physicians quietly and timidly signing them by the tens of thousands.

In response to the voiced concerns over gag clauses, the General Accounting Office more recently conducted a study to assess their continued prevalence in HMO contracts. The report concluded that gag clauses are no longer a problem, and for the most part they don't even exist any more.

The reason "gag clauses" don't exist anymore is that the HMOs, feeling the heat, have converted them to "business clauses." Generically, business clauses require the signer (usually an employee) to agree not to disparage the business, not to encourage clients to use some other business instead, and not to break confidentiality with the business. In other words, business clauses are merely gag clauses somewhat reworded, and then relabeled.

In this manner, HMOs have asserted that, since they are a business, they have a right to the same protections as any other business. And if assertion of those business rights require the business' contractors (i.e., doctors) to forego previous arrangements and understandings (i.e., the doctor-patient relationship), well, that's business. The GAO, apparently, was swayed by this argument.

Various proposed Patients Bills of Rights require striking gag clauses from HMO-physician contracts. Presumably (now that they are just business clauses), that has already been accomplished. But even if all such clauses - whatever they are called - are struck from every contract this very day, the damage has been done.

For, when HMOs asked physicians for a declaration of loyalty that superseded all other loyalties, physicians gave it. Removing gag clauses from contracts at this point doesn't change the fact that, when asked, physicians signed. Once a dog learns to heel, you can get rid of the leash - the dog still heels just fine. The HMOs have more than made their point.

Just a second. What about outcomes? What about quality?

Well, what about them?

The fact is, nobody in our FTP vignette has any incentive to really want to know about outcomes - except as they may be incidentally useful as a marketing tool.

Gekko for one doesn't have any reason to care about clinical outcomes. His outcome is measured by his profit. So as long as he's making money, his outcome is good - and data on clinical outcomes would only serve to threaten what is now a nice, clean picture. Unless pushed, he sees no reason to invest his resources in collecting such data.

What about Dr. Smith - the PCP who has to decide whether to refer his patients with heart problems to cardiologists in the more expensive Valley View group or those in the less expensive Cormatic Group? Wouldn't he want to know which group has the better clinical results? Certainly he would, on a professional level. But subconsciously, he realizes that if he had that data, it might give him the wrong answer - there's at least a good chance that the more expensive group might turn out to achieve better results. That would certainly complicate his referral decisions.

And what about the cardiologists of the thrifty Cormatic Group? Do they really want outcomes data? Well, why should they? They're already getting the referrals.

Doctors in the profligate Valley View Group are the only ones who really have a good reason to care about clinical outcomes since, if they turn out to have more favorable outcomes, it might help to exonerate their expensive ways. But even if they take the time and expense to examine the outcomes they achieve in their own practices, there is no way for them to get the comparative data from competitive groups.

So, while there is plenty of talk about outcomes in the Gekkonian HMO world, when you analyze the mechanics, it is difficult to find anyone slogging away in the trenches who really wants to know about them.

But surely, you might be thinking, somebody wants to know about quality. What about the patients? What about the employers who are paying the bills?

Gekko knows about patients. When patients are faced with a choice between an HMO that's "free" or an indemnity plan that might cost them an extra \$50 or \$100 a month, he just knows they're going to pick the HMO. And while they're picking it, they want to feel good about it. They deeply, sincerely, and desperately want to hear that they're making a good choice. They want to hear what a high quality HMO they're being forced to join. And that's where quality and marketing come together. To Gekko, quality is marketing.

This is why HMOs over the past few years have gotten away from advertising (and implying ready access to) their fancy, state-of-the-art, high-tech services. Instead, they've gone all fluffy, emphasizing warmth, concern, and caring, through

filtered lenses and soft music. When you join our HMO, it's like joining a family. What a good choice you've made.

Okay, you might reply, but what about employers? Don't they want to offer high-quality healthcare to their employees? Well, sort of. What most of them really want is to offer adequate healthcare without losing their shirts on it.

My own eyes were opened on this issue several years ago when I attended a retreat, sponsored by my hospital, that featured a panel discussion by a group of prominent local employers. When asked how they go about assuring themselves that the health coverage they buy for their employees provides high-quality care, the captains of industry responded thusly: "We make widgets, we don't assess healthcare quality. We don't know how, and we don't want to know how. So we've got to be practical about it. To us, quality means quiet. As long as we don't hear more than the average number of complaints from our employees, the health coverage we provide is, by definition, good enough."

Men and women like Gekko long ago figured out what their paying customers (i.e., the businesses that purchase health insurance for their employees) want. And because of what his customers want, Gekko can define quality simply as keeping the volume of complaints down to an acceptable level (and, of course, keeping FTP out of the newspaper).

Now, to be sure, efforts are being made on several fronts to actually measure quality in healthcare, and some of these efforts are having an impact. But in general these efforts are not originating with Gekkonian-style HMOs, or even from healthcare providers. FTP - 12 years later The end game is near for Gekko, and none too soon, because running FTP for 12 years has aged him. Continuing to grow his company throughout this time has been a real challenge. The vast preponderance of FTP's growth once came from expansion into new cities, and especially from the acquisition of public assets. But it's long since become impossible to find new areas in which to expand, and worthwhile community hospitals ripe for takeover are no longer growing on trees.

For the last 5 years Gekko has been able to continue FTP's growth cycle by acquiring smaller HMOs every 18 months or so, and in doing so he eventually developed a national presence for FTP. He's even become a regular on CNBC. But even that means of growth is now drying up. Smaller HMOs that would be suitable acquisition targets have become very hard to find.

The time has finally arrived when, for the first time, Gekko has to try growing FTP's revenues solely by providing healthcare to patients. This has turned out to be harder than Gekko ever thought it would be. Despite the fact that he continues to turn up the heat on his physicians - cutting their reimbursement schedule every year and raising the bar for getting their end-of-year payouts - FTP's revenue is stagnant, and even shows signs of dropping.

HMOs have long since penetrated the healthcare market so thoroughly that, in most of FTP's cities of operation, the indemnity insurance plans are no longer players. This means FTP isn't competing against indemnity plans any more; instead it's competing against other HMOs. Consequently it has become very difficult for Gekko to keep his premiums as high as he'd like. In a couple of cities, FTP has actually gotten into some very nasty bidding wars.

And now that the large majority of Americans are already enrolled in HMOs, cherry-picking the healthy enrollees has become virtually impossible. Even making the chronically ill feel unwelcome is no longer effective, since most sick people have finally realized that one HMO is pretty much like another. There's no point in their changing health plans any more. Patients in general are becoming more vocal, as are the Congress and the state legislatures, about HMOs conducting themselves dishonorably. Gekko fears that one or more of the various proposals on a Patients Bill of Rights may eventually end up taking away even more of his prerogatives for making money.

Then there are the rumblings Gekko is hearing in high places about how for-profit healthcare is robbing society of its precious healthcare premiums. It may still be a ways off, but Gekko now thinks it's increasingly likely that, some day, for-profits will be outlawed and the government will take over the whole shebang. That wouldn't be fair, of course but Gekko's a realist. He doesn't insist on providing fairness, nor does he insist on receiving it. This is business, after all. His run as CEO of FTP has already lasted far longer than he had ever thought it would. He has set himself up for a platinum parachute for when the time comes for him to "retire," of course, but even now he is imagining grander exit strategies. For instance, perhaps he will be able to engineer an acquisition of FTP by one of the two or three even larger HMOs. Gekko would no doubt do quite well under such a scenario. But sometimes, if he's really thinking expansively, he can see himself playing a key role in negotiating the final buyout of FTP (and all the other remaining for-profit HMOs) by an even more massive and even more affluent entity - that is, by the feds.

HMOs - the end of the line?

No, not really. But I personally wouldn't buy any stock in FTP.

I believe that HMOs will be around for a long time. But I also believe that the heyday of the for-profit, Gekkonian-style HMO is coming to an end.

Just considering the demographic facts of life outlined in Chapter 2, it is inevitable that, sooner or later, society will find it unconscionable for these organizations to continue siphoning off large proportions of the healthcare dollar for profit - especially when it is debatable whether they are contributing anything substantial to the actual delivery of healthcare. Sooner or later, we will become very indignant about the for-profits.

But my guess is that the for-profit HMOs will fade from the scene on their own accord, well before the rest of us get exercised enough to do the job ourselves. Gekko has shown us why.

It is looking more and more as if there is a natural life cycle to for-profit HMOs. In their early years, their meteoric rise was not attributable to their efficient management of healthcare, but instead to their rapid growth and subsequent consolidation, and to the acquisition and privatization of public assets. As the opportunities for rapid growth dry up, as the opportunities to select the most desirable enrollees fades, and as public officials, government agencies, and the general public become wise to their ways, Gekkonian HMOs are finding their traditional methods for making money no longer feasible.

As is the case for FTP, very few for-profit HMOs have ever done well financially by managing the healthcare of their subscribers. My prediction is that they will ultimately find it so difficult to make a profit in this way - at least enough profit to keep their shareholders happy - that that they'll eventually get out of managed care on their own.

This is especially likely, in my view, when you consider that the Wonkonians have never gone away - they're still there, still as active as they can be while waiting for their chance to assume their rightful, regulatory control of the healthcare system. Imagine, if you will, the for-profits - seeing that their days are numbered - whispering in just the right places that, for the right price, they would be willing to consider selling their business to the government. It wouldn't be the first time the government assumed control of a formerly powerful industry, nor would it be the first time the owners of that fading industry would get one, final, huge windfall for their troubles. Remember the railroads?

So, if I'm right, we the taxpayers will get one last chance to contribute to the welfare of Gekko and his brethren. If so, perhaps we should consider it a reasonable price to pay for bringing the era of the for-profit Gekkonian HMOs to a close. The meaning of the Gekkonian era

While acknowledging that the demise I've just predicted for the Gekkonians may be a bit premature, let's still conduct a postmortem. The positives - incremental efficiencies

On the positive side, the Gekkonians have focused the attention of everyone within the healthcare system squarely on the issue of costs. Today, in any healthcare organization, no purchase of any sizeable item is made without first carefully considering how badly the item is needed, calculating the full cost of ownership, and defining clearly who will pay for the expanded services made possible by the new item. This is a fairly radical departure from just a few years ago, when hospitals often purchased high-cost equipment of marginal value just to keep up with their rivals across town.

Similarly, the fiscal pressures brought to bear on doctors and hospitals by the Gekkonians have resulted in many true improvements in efficiency. This is because when the providers are squeezed by the payers, not all the cutbacks they make are in useful or worthwhile services. A lot of wasteful endeavors are cut too. In fact (despite perceptions to the contrary), when providers are forced to cut back, they usually try preferentially to eliminate the inefficiencies.

So the Gekkonians have driven our healthcare system to become leaner, meaner, and more in fighting trim than it was before. We may have made the same changes eventually even without the Gekkonians, but it probably would have taken longer. The negatives - facilitating covert rationing

On the negative side, the Gekkonians have greatly expanded our capacity for covertly rationing healthcare. HMOs are supposed to ration.

That HMOs ration healthcare, of course, is beyond question. Indeed, in 2000, the U.S. Supreme Court ruled that HMOs are supposed to ration healthcare.

The case in point was *Pegram et al v. Herdrich*, in which the Court heard the complaint of a Ms. Herdrich, whose appendix ruptured after her HMO doctor - who was under financial incentives to spend less money - delayed the diagnostic tests she clearly needed. Justice Souter wrote the Court's unanimous opinion in favor of the HMO, declaring that rationing healthcare was the very point of HMOs, and that Congress had a 27 year history of passing legislation encouraging HMOs to do just that. If Herdrich (or anybody else) doesn't like that fact, Souter said, they need to petition Congress, not the federal courts.

Souter invoked the GUT-HC in all but name in writing this opinion. He especially stressed what we've called Corollary One: When HMOs can take in only a fixed amount of money from premiums (thus creating a centralized pool of funds), but are at risk for having to spend unlimited amounts of money on their subscribers' healthcare, there must be a system of rationing in place. It's just math.

Justice Souter further implied that patients themselves have not been entirely innocent casualties of "secret" rationing by HMOs. Patients who abandoned their more expensive fee-for-service insurance for cheaper HMOs should have known what they were getting into, and should not think of themselves as blameless victims. (Ms. Herdrich learned this the hard way.) As healthcare expert David Mechanic has said,

"Enrollment in an HMO is really an agreement between the enrollee and the plan to accept a situation of "constructive rationing". . . .For a lower premium, more comprehensive benefits, or both, the consumer implicitly agrees to accept the plan's judgment as to what services are necessary."

Patients may not consciously realize that they've made this agreement, but it's pretty certain that the healthcare economists, academics, HMO directors - and the Supreme Court - realize it. And accordingly, patients and their health have become fair game.

So, faced with the mathematically necessary, Congressionally legislated, Supreme Court sanctioned, patient-acquiesced-to, but socially unacceptable mandate to ration healthcare, what is Gekko to do? He's got to ration covertly.

Whether or not Gekko really understood (or cared) that he was advancing the cause of covert rationing is actually quite irrelevant. Whatever he did or didn't think about it, that's clearly what he was doing. His most blatant covert rationing endeavors, perhaps, were the extensive efforts he made to exclude "expensive" patients from the healthcare system. More subtle were the pains he took to pry all those not-for-profit healthcare institutions out of their fundamentally charitable charters, and launch them into the wild, wooly world of for-profit healthcare. But the most far reaching was his utterly overwhelming campaign to destroy the doctor-patient relationship.

Destroying the doctor-patient relationship.

Destroying that relationship was a requirement for Gekkonian managed care, and the Gekkonians accomplished it to devastating effect. Their efforts have left the medical profession in complete disarray, and physicians' formerly clear-cut ethical mandates in tatters. As a result, the behavior of individual doctors and of their professional organizations as they try desperately to reassert old values, or establish new ones, or simply explain what the heck they are doing, have been bizarre and often schizophrenic. Such behaviors would be almost comical if their implications were not so profound.

Item 1. In a survey conducted by the American Medical Association's Institute for Ethics and published in the April 12, 2000 issue of the Journal of the American Medical Association, 39% of American doctors admitted that they sometimes or very often manipulated reports to their patients' health plans so their patients might gain coverage for needed medical care. These manipulations included exaggerating the severity of the patients' condition, changing the billing diagnosis, or reporting symptoms the patient did not have. And 72% admitted using one of these tactics at least once in the past year. More than a quarter said that gaming the system was necessary in order to provide high quality care to their patients, and 15% asserted that it was ethical.

This survey elicited a firestorm of criticism against the cheating doctors. Ethicists called for doctors to stop applying "insular" ethical norms and to begin using the norms that professional ethicists have long established against cheating health plans. Similarly, the AMA and the American College of Physicians have published strongly worded statements opposing the manipulation of reimbursement rules. And the federal government has made such "misstatements" to health plans a federal crime, punishable by huge fines, jail terms, and loss of license.

Item 2. Another survey, published in the July/August, 2003 issue of Health Affairs, reported that nearly one third of American doctors admit that they routinely withhold from their patients pertinent information about optimal medical treatments, because they suspect the patients' health plans won't cover those treatments. The always amazing Susan Pisano, spokesperson of the AAHP (the group representing the very health plans that are pulling out all the stops to make sure that doctors do exactly what this study confirms they are doing), told the AMANews at the time that AAHP officials "actually find it difficult to believe that that's going on." Meanwhile, the authors of the study, pointing out that "gag clauses" no longer exist, could only conclude (with seeming surprise) that doctors are "rationing by omission" on their own volition.

These two surveys reveal just some of the confusion and frustration being felt by doctors as a result of both HMO "rules," and the "guidance" they're getting from their professional organizations as to what to do about those rules. How, exactly, are they to square those rules and that guidance with their obligation to always do what's best for their patients? What's a doctor to do, for instance, when a patient needs a treatment, but they're pretty sure the health plan won't pay for it? There are only three choices:

1. Tell the health plan whatever you must in order to get the needed treatment for the patient;
2. Don't tell the patient about the treatment since they can't get it anyway; or
3. Tell the patient about the treatment they need, and then tell them they can't have it.

Clearly the most straightforward thing for doctors to do is choose Door Number 3 - just tell the truth. After all, a patient has a right to know what medical treatment he needs, whether or not he's allowed to have it. Informing a patient that the health plan won't pay for the needed treatment gives him useful information - it lets him know that his health plan is not adequate to his needs, and gives him an opportunity to respond appropriately to that information. For instance, a patient might appeal to the health plan directly, seek intervention by his local Congressperson, or ask his employer (who is the HMO's true customer), to intervene on his behalf. He can even raise the funds to pay for the therapy himself.

What patients actually do when doctors choose Door Number 3, however, is to beg, demand, threaten, implore, and plead (often with tearful spouses and children in tow, in scenes right out of Uncle Tom's Cabin), for the doctor to do something to fix things, since after all, it is the doctor who started the problem in the first place by insisting that this forbidden therapy is the only one that will do. So, the moment doctors choose Door 3, they are placed under incredible pressure to go back and choose again - Door Number 1, their patients are communicating to them, is actually the correct choice. This reason, plus wanting to avoid all the anguish and drama that follows telling the truth, leads doctors who are inclined to lie to health plans (and thus risk angering the entities that determine their ability to make a living, not to mention committing a federal crime), to choose Door Number 1 in the first place. If doctors are not inclined to risk their livelihoods and freedom by deceiving health plans, they will probably simply default to Door Number 2 - rationing by omission.

So the above two items merely reflect the proportion of doctors willing to admit which group they routinely lie to - health plans or patients. Most of the other doctors, one suspects, would just rather not say.

Item 3. In 2000, the AMA filed an amicus brief with the Illinois Supreme Court on behalf of a Dr. Portes, asserting that doctors have no duty to inform their patients when HMOs have given them financial incentives to withhold medical care. Apparently a patient of Dr. Portes died of a heart attack shortly after the doctor allegedly refused to refer him to a cardiologist. As it turned out, the patient's health plan apparently had agreed to pay the doctor's medical group 60% of any funds not used on referrals to specialists. A lower court in Illinois had found that Portes had a duty to disclose this financial relationship to patients, since it might clearly impact their interpretation of his medical recommendations, and Portes appealed. In this appeal, the AMA sided with the doctor.

The AMA said in its amicus brief that the obligation imposed on doctors by the lower court amounted to an "insurmountable burden," since it was hard for doctors to keep track of all the sundry ways that HMOs might induce them to behave in this way or that way, and besides, the need to disclose would impinge on the doctor's valuable time with the patient and therefore disrupt the doctor-patient relationship. Interestingly, the AMA's own Council on Ethical and Judicial Affairs (CEJA) had previously written that, "physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients. . ." In explaining why its amicus brief differed from the opinion of its own Ethics Council, the AMA explained that its CEJA standard was just an ethical one, and not a legal one.

So what we have here is: 1) an HMO induces doctors to withhold medical care; 2) a doctor acts on that inducement; 3) as a result, predictable harm comes to a patient; 4) after which, the doctor and the AMA whine that he shouldn't have to inform patients of his financial incentives because; 5) to do so would harm the doctor-patient relationship. This is all just too precious for words.

It seems quite obvious that commonly used covert rationing techniques have relegated even the most straightforward of the medical profession's ethical precepts to the status of a "nice-to-have," instead of a standard to be maintained, embraced, and fought over when threatened. While various ethical panels may still voice the proper sentiments, in the real world those sentiments are the first to go.

Item 4. The AMA recently conducted yet another study documenting that the medical insurance industry has become overly dominant within the healthcare system, leaving "doctors and patients at a severe disadvantage." The AMA's solution, of course, is to renew its lobbying efforts to get Congress to legalize a Doctors' Union, so physicians can engage in collective bargaining with HMOs, the better to advocate for their patients. A union is the only way doctors are likely to gain enough power to help their patients, the AMA maintains.

As a former card carrying member of the United Steelworkers of America, I well understand how important unions can be for wage earners who must deal with an all-powerful employer. But unions can be effective only to the extent that they demand utter, absolute, and unquestioning loyalty to - the union. It's the only way the union can guarantee the solidarity it needs when it engages management in collective bargaining. Only union solidarity can render their one and only weapon - the strike - credible as a threat, and that solidarity must be maintained at all costs, sometimes even by violence if necessary.

This, of course, is the problem when we talk about unionizing the professions. Professionals by definition have a primary obligation to their "customers," be they clients, students, or patients, and that obligation is supposed to supersede any

other. Professionals cannot be primarily obligated to their clients, and at the same time primarily obligated to their union. For a doctors' union ever to be a "threat" to an HMO, that union must be inviolate in the minds of its physician members, who must be willing to do harm to patients, if necessary, through a work stoppage or slowdown, if that's what it takes to bring the HMO to heel. For the AMA to lobby for such a thing, however reluctantly, is a further illustration of how damaged the doctor-patient relationship has become.

So what's happened here? What's happened is that both patients and doctors have been completely marginalized within our healthcare system. The individual doctor and individual patient, together, no longer comprise the basic nuclear unit of healthcare. Doctors and patients have been separated from one another, and reduced to ciphers, to mere commodities in the vast healthcare marketplace.

And when a commodities trader is dealing in pork bellies, he's only concerned about buying, selling and thus maximizing his profit on large quantities of pork bellies. Concern for the careful handling of the individual pig never crosses his mind.

If it becomes too difficult to follow ethical precepts, just change them.

The physician's change in focus from the individual to the group is more than just tacit. Until recently, professional codes of ethics still held the physician's primary responsibility to be a fiduciary one toward his or her individual patients. But in the late 1990s, after a few years of being exposed to Gekkonian HMOs, many healthcare experts and even ethicists began to propose explicitly that this ideal be changed. For instance, a 1998 article in the *Annals of Internal Medicine* had this to say about the physician's traditional fiduciary role:

"It is untenable for the medical profession to continue asserting an idealistic ethic that is contradicted so openly in clinical practice. . . . We propose that devotion to the best medical interests of each individual patient be replaced with an ethic of devotion to the best medical interests of the group for which the physician is personally responsible."

After kicking this sort of idea around for a few years, three prestigious medical societies finally published a new definition of "medical professionalism." This new statement of a physician's ethical obligations added to the time-honored principles of a) primacy of the welfare of the individual patient, and b) patient autonomy (the two precepts that required doctors to always make their patients' needs their primary concern), a third precept: c) social justice. Under social justice, doctors are now exhorted to work for the "fair distribution of healthcare resources," based on "wise and cost-effective management of limited resources."

There's nothing wrong with working for social justice, of course. Social justice is very important. Even doctors should care about it. But when they are seeing a patient who has come to them for help, that patient - and not social justice - should be their primary concern. They should not cheat or lie for that patient, not even to rapacious Gekkonian insurance companies. But within the rules of engagement (rules to which the patient, in one form or another, has signed up for) they should leave no stone unturned to see that the patient gets whatever medical services that might benefit him or her. Doctors should not be placed in the position of having to "fairly distribute limited healthcare resources;" of having to decide which patients are worthy of being offered available services and which are not; of having to weigh the needs of society against the needs of their individual patient and decide, on a case by case basis, which is to predominate; of having to ration at the bedside. But this is precisely what the new professional ethical standards provide for. For the first time, doctors have been given explicit ethical cover for covertly rationing healthcare.

It is noteworthy that this change in ethical standards would not be necessary if we conducted healthcare rationing under a system of open, society-approved rules, where everybody knew where they stood. Under such a system doctors could still advocate entirely for the individual patient, doing whatever he/she could for that patient under society's explicit rules for rationing (much like a lawyer, pulling out all the legal stops for his/her client.)

This new "social justice" precept is only needed in order to provide some comfort to doctors who find themselves having to ration covertly, and who might be bothered by this clear violation of their traditional fiduciary duties to individual patients. "Sure I'm violating precept # 1," they can now tell themselves, "but I've got to do that to accomplish precept #3." If doctors can avoid too much introspection and self-analysis (which should not be a problem for many of us) this new precept may take away some sense of guilt. But in truth, as long as doctors are silently withholding care from patients who need it, without telling them and perhaps without telling themselves, no new revision of ethical principles can rescue them. The Gekkonian legacy

When (if) the Gekkonians finally withdraw from the field, they will leave doctors, patients, and our healthcare system very different from the way they found them. They will leave us more cost-aware, and somewhat more efficient. But they also will leave us much readier to sacrifice the individual for the sake of the group. And, with our principles thus subtly softened (or flagrantly redefined) by the Gekkonians, the inexorable escalation in healthcare costs will inevitably lead us to far more blatant violations of individual rights and individual welfare than any we've seen to date.

Next: The Wonkonians strike back.