The Continuing Integration of Health Care

By Richard Pan, MD, MPH

Some organizations may not survive, but integration will continue because of the tremendous economic pressures on medicine and health care to contain costs and increase efficiency.

IN HIS LANDMARK BOOK, The Social Transformation of American Medicine, sociologist Paul Starr talks about how the medical profession evaded integration and maintained its autonomy throughout most of the 20th century. Medicine was one of the last cottage industries in the United States.

However, over the past two decades, society has sought to slow down the rapidly rising cost of health care through several financing mechanisms collectively known as managed care.

Although experts disagree on how to define managed care, for the sake of this discussion I will define managed care as a collection of financing mechanisms that require the providers of health care to assume financial responsibility for the care being delivered. Capitation is an expression of this concept.

Thus, rising health care costs created greater pressures for efficiency and integration in health care. It became more and more difficult for individual providers, whether physicians or hospitals, to survive without forming larger groups that could accept the financial risks forced upon them by insurers and payers.

The evolution toward greater integration and efficiency has already occurred in almost every other economic sector and is likely to occur in health care as well.

Now, many physicians, policy makers and patients have hoped for and predicted the demise of managed care. It is true that that many of the managed care organizations such as IPAs that currently exist may not survive, but the fundamental concept of managed care as previously defined will continue to drive health care unless physicians wish to totally abdicate their autonomy in patient care.

Financing mechanisms such as defined contribution and single-payor systems will not change the fundamental need to increase efficiency and control costs in delivering increasingly expensive and complex care.

In defined contribution, employees are free to select from a menu of health plans and would themselves pay for any cost differences. But can we expect that they will select plans differently than their employers?

One study showed that a difference of less than two dollars per month would induce most people to switch to a cheaper health plan that does not provide access to their current physician.

Health insurers that cannot contain their costs will lose beneficiaries - particularly the healthier ones needed to subsidize those that require more services - and become financially insolvent.

Since insurers are capitated by the premiums they collect, either they will need to assume more control over care delivery or require physicians and hospitals to assume more financial responsibility for the care provided. If physicians and patients do not want the insurers to dictate care, some form of managed care will be required.

It should be noted that the insurance mechanism for financing health care evolved because very few individuals can afford to pay out-of-pocket for more than basic health care. A critical care hospitalization, or major surgery or trauma would bring many families to financial ruin without insurance.

Even today, a leading cause of personal bankruptcy is health care expenses. Thus, physicians became instrumental in forming the Blue Cross and other health plans so families could afford our services.

In addition, technological advances in medicine not only raise costs, but the complexity of care. Teams of physicians, nurses, and other health care professionals are required to provide efficient, quality care. In its ultimate incarnation, managed care would involve the sale of a package of health care services by an integrated system of providers for a fixed price.

Similarly, in a single payor system, the same pressures on the government to reduce costs and increase efficiency will lead to continuation of managed care.

The federal government currently runs a single payer plan in Medicare. Fee-for-service Medicare is rapidly facing insolvency because of exploding costs and changing demographics. Although current managed care organizations have had little success in containing Medicare costs, they have essentially operated more like insurance companies than health systems.

The Canadian health care system is also facing rapidly increasing costs and financial crises in several provinces since little effort was made to integrate the delivery system.

As the single insurer, the government will also need to decide whether to assume greater control over health care delivery or require providers to assume more financial responsibility to control costs. It is likely that the government will apply some form of managed care.

Medicine and health care will continue to integrate due to the tremendous economic pressures on the sector to contain costs and increase efficiency. Although sick people will spend their life's fortunes on health care, individuals can no longer afford catastrophic care.

Society at large is driving health care choices by demanding cost containment either through price selection of plans by individuals or employers, or political unwillingness to greatly increase health care spending.

As long as physicians want to play a significant role in medical decision making, we will have to accept financial responsibility for the care we deliver.

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