The Emperor's New Clothes

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The television and newspapers have been filled with innumerable opinions about the future of the US health care system. We know what the President, Congress, CEOs of pharmaceutical companies, liability lawyers, insurance executives, political pundits, and organized medicine think will happen. The certainty of these individuals is humbling to me. As Kerr White, MD, has said, "It is dangerous to make predictions—especially about the future."

It is clear from the recent article by Millard et al[1] in this journal that physicians both are confused by the range of health care reform options and do not agree as to the best approach. As illustrated by the Figure, a chart summarizing the Clinton health care plan, anyone who is not confused should be.

Regardless of which plan is ultimately passed, it is likely that the government will incorporate a mechanism that permits federal control over total health care costs. This will translate into a new role for primary care physicians—the unselling of health care. We will be at the center of the conflict between those who desire care and those who profit by its rationing.

To summarize the President's plan, health benefits will be extended to the 37 million persons who are currently uninsured; the range of benefits will be expanded to include preventive services, prescription drugs, long-term care, and others; and simultaneously, the total costs of health care will be reduced by $200 billion. These seemingly paradoxical goals will be achieved by "squeezing the waste" out of the system. The problem is that one man's waste is another man's standard of care.

The institutionalization of health care rationing will unfortunately occur in the middle of an era marked by the unprecedented commercialization of health services. New prescription medications are routinely advertised in the pages of *Time* and *Newsweek*. Billboards throughout our cities hawk medical wares to patients with chest pain, depression, and menopause.

We have even expanded the definition of "health." It is no longer sufficient to merely comfort or save a life. In addition, we now promise beauty, fertility, and normal stature. As a profession, we have encouraged the "medicalization" of problems that are primarily social in origin. These range from obesity to substance abuse, to violence, to AIDS. Who are we kidding when we claim a central role in the prevention of these problems? It is just not enough to tell teenage patients to use condoms.

The marketing of medicine has created an insatiable demand for health care services, the perception that access to these services constitutes an inalienable right, and the expectation that sufficient medical technology can solve any problem. The public's expectations of health care and the government's goals for limiting it are on a collision course, with us in the middle.

A number of unflattering terms have been used to describe this new responsibility for primary care physicians, including "gatekeeper," "case manager," and "managed care provider." All betray the facts of the job: we will be expected to deny patients access to health care at the same time that the nightly news is promoting the most recent medical advance.

Most physicians have already experienced this new role but in a very limited way. After all, managed care to date has occurred in an environment of limited competition where managed health plans needed to be just a bit more competitive than spiraling indemnity coverage.

Under the current White House proposal, "regional health alliances" will contract with "accountable health plans" to provide "comprehensive benefit packages." The accountable health plans, which can be for-profit corporations, will be oriented to provide services at the lowest cost in order to maximize their profits, ie, the difference between the federal caps and the corporations' expenses. These accountable health plans will know precisely how much it costs for you to provide care—not just your income and overhead, but the cost of the drugs that you prescribe, the number of tests that you order, the number of days that you hospitalize your patients, and the number of consultations and procedures that you request. In

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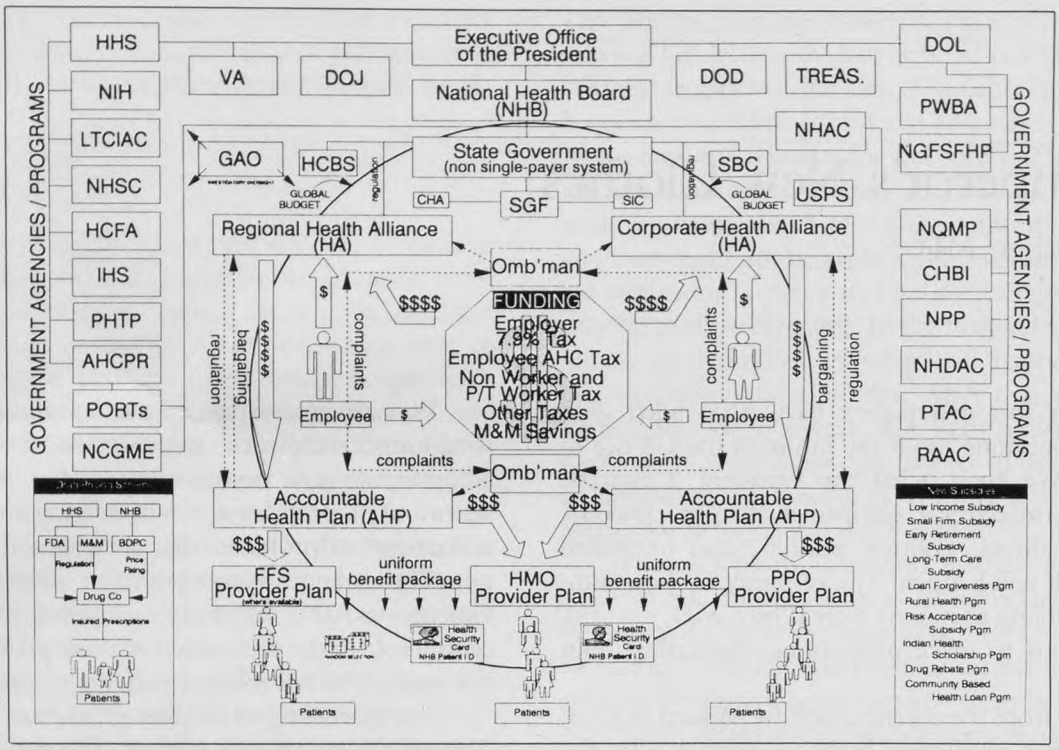

Figure. Flow chart of the proposed Clinton health plan. Courtesy of Rep. Dick Armey, Chairman of the House Republican Conference.

a totally managed care environment, the average primary care physician in the United States would annually control about $5 million of the $900 billion health care budget. Do you cost more or less than $5 million per year?

It is not likely that physicians will receive much help from government in dealing with the difficult decisions associated with limiting health care services. Even in the midst of the current crises, government's instinct has been to promise more services. It is also not likely that the accountable health plans will help; in fact, just the opposite is likely to occur. The plans will aggressively advertise to attract patients, and this advertising will promise more and better services. I do not expect to see accountable health plans advertising: "We Ration Better!"

We will be left in the examination room with our patients, trying to explain why they do not need an MRI for their headaches and continually aware that each decision we make causes a dollar amount to be assigned to our personal UPIN.

When we have done our best, and then explained to a family who have lost their loved one that "I did all that I could do," instead of a response of quiet gratitude, we may be faced with an attitude of betrayal.

Government, and medicine, and science, and health entrepreneurs have all oversold what medicine and health care reform can accomplish. No one has been willing to tell the truth. Who has the courage to shout, "Look! The Emperor has no clothes!"?

References

1. Millard PS, Konrad TR, Goldstein A, Stein J. Primary care physicians' views on access and health care reform: the situation in North Carolina. J Fam Pract 1993; 37:439–44.