Alternative Delivery Systems: The Changing Role of the Physician

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Concern over the cost of care has been a major stimulus for changes in the nation's health care delivery systems and has prompted the growth of "alternative delivery systems." The alternative delivery system, as the term is often defined, is an arrangement by which enrollees are given incentives to seek care from a specific group of health care providers under contract (1). Alternative delivery systems may take many forms including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and a variety of hospital/physician "partnerships."

Often alternative delivery systems are started with an emphasis on alternative means of financing care; later, in their evolved forms, they represent substantially different systems by which health care is delivered. As the health care system adapts to declining relative resources, the newer financing mechanisms and alternative systems of health care delivery will have a profound effect on the style of practice and role of the physician.

Multiple factors contribute to the rapid changes in health care. Ginzberg cites the destabilization of care created in part by the erosion of supports for nonprofit hospitals and for physician dominance in decision-making (2). Increasing growth of the health care sector in our economy and its associated increase in employer and governmental budgets have favored closer inspection and alteration of traditional forms of health care delivery. Goldsmith cites the waning of the "seller's market" for physician services, and the flood of physician talent across the country (3).

Available data indicate the magnitude of alternative delivery system growth. For example, in 1984, 9% of privately insured households nationwide included at least one family member who belonged to an HMO (4). Much of the growth is being led by large investor-owned chains such as Maxicare and CIGNA. The recent Arthur Anderson & Company study, based on Delphi forecasting among panels of 1,000 health care professionals, predicted that 1) a 500% increase would occur in HMOs and PPOs in the next decade; 2) 40% of nongovernment hospitals will be owned, managed, or leased by multihospital systems; and 3) physicians will increasingly be in large group practices or in salaried positions (5). Furthermore, there appears to be no decline in governmental and business leadership advocacy of health care cost containment and fixed expenditure levels, which has prompted further HMO growth.

Physicians as a group have begun to realize the impact of these changes in their practices (4). Some are steadfastly resisting participation in alternative delivery systems, others are negotiating to forestall or limit their perceived impact on professional behaviors, and yet others have accepted new roles and responsibilities in these new systems of health care delivery. Younger physicians may be affected sooner by the health care environment changes, such as relative physician oversupply, increasing market penetration of HMOs and group practice arrangements, increasing costs of medical education, practice competitiveness, and difficulties in setting up freestanding practices (6).

Many of these changes in the health care environment will lead to further alternative delivery system expansion. While the initial concern is often focused on the changes affecting payment for services, it is important to understand other implications. The changes already underway imply significant future alteration in traditional patterns of care and in the roles of health care providers.

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Legacy of Past Structure

In the recent past, social policy clearly favored generous allocations of funds to health care. Health care was viewed as an unqualified right of each citizen, as symbolized by the passage of the Medicare and Medicaid programs. Hospitals were typically paid on the basis of their costs, and federal programs encouraged the burgeoning of hospital numbers and generously supported their development of bed capacity and technology. This encouraged significant growth and diversification of each "community hospital" into an institution capable of handling complex cases.

Government programs subsidized and encouraged an increasing number of medical schools and graduate medical education...
programs. Physicians were rewarded for increased specialization. A growing technological and scientific capability, third party fee structures, and professional ambitions all have encouraged the growth of technology-based, resource-intensive procedures. Patients became exposed to these extended capabilities of the health care system and have increasingly come to expect extensive use of resources to deal with their individual problems.

The heritage from the social policies of the 1960s includes tremendous physical facilities, more physicians with whom to share in caring for patients, effective and expensive medical technology, unsurpassed specialization of medical fields, demanding and increasingly sophisticated consumers, and a pervasive fee-for-service insurance system for those who could afford health care. This system, which provided almost uncapped resources with which to care for patients, also led to costs beyond levels envisioned by policymakers.

The increasing costs associated with this system of health care have prompted increased public policy discussions concerning cost containment. Garrison and Wilensky have noted the issues surrounding the potential impact of cost-containment efforts on the diffusion of technology (7). While some discussion on rationing health care has focused on the underserved, much has focused on an increased perception that too many services are being performed—that utilization levels are too high and could be altered without any decrease in general health status. As commerce and industry have focused on their own health care costs, there has been a growing increase in cost containment. Providers of health care services perceive this as a “revenue gap,” and purchasers of services are qualifying what had previously been paid for without question.

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Demands of the Present

Medical care cost-containment strategies assume that a significant amount of medical care costs stems from widespread application of tests and procedures and of lengthy hospital stays that have limited value in enhancing the health of patients (8). Thus, under the evolving system of health care, physicians are expected to moderate the use of these marginal strategies in treating patients. Assuming that overtreatment is more prevalent than underutilization, resource-restraint can occur without negatively affecting health status outcomes.

Moderation in utilization is expected to come from more judicious use of expensive technological services and by substituting ambulatory services for traditional inpatient services. Adaptation to an altered style of practice is not easy, yet many health care delivery organizations have found that prepaid programs affect the use of services and that incentive programs can be designed to alter physicians' utilization behaviors (9,10).

Most physicians were trained in medical and economic environments without highly visible resource limitations. Furthermore, they have traditionally practiced in a loose organizational and individualistic setting. Until recently there was little review of resource consumption or communication about less resource-intensive ways of achieving parallel results. Insurance benefits have lagged behind these opportunities by not covering certain ambulatory alternatives. A treatment approach that may be less costly to society may be more costly to the individual patient. Although many physicians are being asked to reduce unnecessary utilization, they are operating in a structure that provides minimal assistance in achieving that goal. Hospitals, spurred on by prospective payment, have just recently moved toward systems of utilization controls, including alternative support systems to minimize unnecessary hospitalization.

An exception to the aforementioned dilemma is the health maintenance organization. Although criticized by a significant segment of the medical profession, health maintenance organizations provide a supportive structure for cost-effective quality health care. However, the HMOs also present a number of challenges which will affect a wide group of physicians as alternative delivery systems grow more prevalent.

Challenges for the Future

Role of the primary care physician in managed health care systems

National studies, such as the Graduate Medical Educational National Advisory Committee (GMENAC), have predicted physician supply and needs for the nation. As alternative delivery systems comprise an increasing proportion of health care delivery, both the numbers and roles of physicians in providing health care to the nation may change (11). An increasingly common feature of alternative delivery systems such as HMOs is the acceptance of a strong coordinating role for the primary care physician. Under traditional fee-for-service systems, payment to individual providers based on services rendered has led to an open system of care. Prospective patients may seek or be referred to specialists and generalists without regard for total resource utilization. In alternative delivery systems the primary care physician takes on a clearer role by initiating and coordinating the patient's total care, including authorization of consultative care.

Primary care physicians assume leadership for coordinating the medical care systems' responses to patients' needs. Primary care physicians are responsible for the total management of the patient, coordinating appropriate referrals to other services and providing follow-up after consultations. They are the first physician the patient turns to—for inquiries regarding the need to seek medical attention, direction in health promotion, for treatment of most illnesses, and for comprehensive management of care.

In such systems primary care physicians take great care to establish a personal relationship with their patients, assuring them of accessibility. They provide written information at the first appointment regarding telephone accessibility, 24 hours a day, seven days a week. Physicians inform patients of their office hours, resolve problems, and make future appointments.应该
Primary care physicians' relationships with consultants

By placing the primary care physician in the role of coordinator of health care resources, alternative delivery systems alter the relationship between primary care services and consultative services. Most plans require that the primary care physician authorize referrals to the consulting physician. Such specialists may be requested to refer day-to-day management of the patient back to the primary care physician, with elaboration of guidelines for case management.

Ideally, such a relationship between the primary care physician and the consultant should be attractive to all involved. It is attractive to the primary care physician who maintains a strong relationship with the patient and is rewarded with a coordinative role in the patient's care. It is attractive to consultants who then can participate in the care of more patients needing their special skills. Such an arrangement is also attractive to patients because of the comprehensive role the primary care physician can serve in relating to the whole individual.

Despite the advantages for the primary care physician in coordinating total care, such a role involves a number of potential conflicts. The traditional emphasis on increased specialization and the advancement of medical technology have resulted in an ascendency of the consultative specialist relative to the primary care physician. That, in turn, has led to the training of a great number of specialists. As a result, the newer role of primary care physicians in alternative delivery systems creates two types of number of specialists. As a result, the newer role of primary care physicians in alternative delivery systems creates two types of number of specialists. As a result, the newer role of primary care physicians in alternative delivery systems creates two types of number of specialists. As a result, the newer role of primary care physicians in alternative delivery systems creates two types of number of specialists. 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Ethical concerns

Changes in health care delivery alter the relative factors that may comprise risk to the ethical provision of health care. Increasingly, physicians are concurrent providers to fee-for-service and prepaid health care systems. Since these different financial methodologies may affect physicians' reward systems, each merits inspection for its potential impact on the ethical provision of health care. Stone cites some of these ethical considerations as society moves towards cost containment (13).

In a fee-for-service plan revenues are apportioned according to the numbers and types of services performed. Increasing revenues are generated by providing more care, and the ethical risk is excess treatments and interventions. In a capitated program revenues are fixed, regardless of the number or cost of treatments. Profits are generated by using resources below the capitation level, and the ethical risk is too few services to meet the patient's needs.

Both the fee-for-service and the capitated alternative delivery systems are dependent on the professional norms of the physician in maximizing the patient's welfare regardless of payment methodology. Both types of error—too much care under the fee-for-service system or too little care under the capitated system—can be equally harmful to the patient. Some additional buffering may occur in withstanding these influences in delivery systems in which the physicians themselves are predominantly salaried or where the capitation is offered to a medical group as opposed to individual physicians.

Regarding this underlying ethical issue, the primary care physician has the most significant role as the coordinator of care. Whereas the issue of too much care under fee-for-service is often diffused among all the practitioners involved, the risk of too little care under certain capitation programs may be controlled by the primary care physician's case manager role. Therefore, primary care physicians in alternative delivery systems have a special responsibility to operate within an effective collegial structure to assure the maintenance of the highest quality care.

The level of social commitment to health care resources and delivery is an issue which merits public policy resolution as cost containment becomes a more visible feature of the medical care landscape. Spokespersons on this important professional social issue have included Thurow (14), Fuchs (15), and others (16), each serving to highlight the growing importance of public and physician participation in the determination of resource allocation to health care.

Summary

Alternative delivery systems are rapidly growing and likely to continue to do so. With these major changes in the financing and organization of care, physicians' traditional roles are increasingly challenged, just as new roles are evolving. Some of the changes expand the role of the primary care physician and alter the relationships among primary care physicians and consultative specialists.

Primary care physicians may have new responsibilities for patients' total health care, for appropriate resource allocation, for meeting patients' increasing expectations, and for assuring that patients receive quality health care. Some specialists will experience a shift in roles, including some strengthened responsiveness to the expectations of primary care physicians. Teamwork between primary care physicians and consultative specialists is likely to be promoted by alternative delivery systems, with primary care physicians having increased responsibility for success through managing health care in response to patients' needs. Specialty physicians will be able to concentrate more on their specialty of interest, rather than mixing specialty and primary care.

As alternative delivery systems are increasingly designed to meet consumer needs regarding quality and cost-effectiveness, competitive factors should actually reinforce the professional objectives that physicians have long endorsed. Consumerism on the part of the patient, physicians' own aspirations to excellence, and increased emphasis on efficient methodologies of care all will be more visible in the years to come. In the changes that challenge the traditions of medical care, many opportunities exist for fulfilling professional goals and for meeting patients' evolving needs.
References