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SEATTLE, WASHINGTON 98105
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April 26, 1993

Dear Mr. Lamb:

The Washington state legislature has just enacted a health care reform bill which the Clinton Task Force is said to have called "a model for the nation." The bill does, in fact, contain many of the concepts, in particular that of "managed competition," that will be at the center of the health care reform package soon to be announced by the President.

As you may know, the concept of managed competition has become the dominant idea in health care reform planning around the country. At least ten states have already voted for, or are preparing to pass, legislation embodying this approach and more states are expected to follow suit.

Most of the debate over managed competition has focused on whether it will actually produce the cost savings its proponents claim. By contrast, the crucial question of the quality of care people would receive under this system has barely been examined.

For example, the public is largely unaware that the promised cost savings of managed competition are to be achieved by building in a financial benefit for physicians who cut back on the level of service--tests, procedures, referrals to specialists, hospitalizations--they would normally recommend for their patients. The resulting conflict of interest--its impact on patients' physical health and peace of mind--has received little attention thus far in discussions of the managed competition concept.

A second major way in which the quality of medical care will be adversely affected under managed competition is that the range of physicians available to the individual will be greatly restricted. This issue, though frequently mentioned, has not been brought out in the concrete terms necessary for a real appreciation of its implications for patient well being. These two problems--the conflict of interest for the physician and the restriction in choice of doctors--need to be given better exposure if people are to make an informed judgment about how they would fare under the new system.

An article of mine touching on these points appeared recently in the Seattle Post-Intelligencer, and I have enclosed a copy for your information. I hope that you will consider the issues raised in the article worthy of further investigation.

Sincerely,

[redacted]

Medical care will suffer under proposed state reform

By [redacted] M.D.

When the state health care reform bill clears the House-Senate conference committee and is signed by Gov. Lowry, it will profoundly change the conditions under which state residents receive health care.

Though reform advocates in the Legislature have maintained that the traditionally high quality of Washington's medical care will be preserved under the new system, there are good reasons to doubt whether that will be the case.

The quality of medical care is likely to suffer in at least two ways under the new program. First, cost savings are to be achieved in large measure by giving physicians a financial interest in cutting back on diagnostic and treatment services they would ordinarily prescribe for their patients. Second, there will be a major reduction in the choice of doctors allowed to each individual. Both those points — the conflict of interest for the physician and the restriction in the choice of doctors available to the patient — need to be fully aired if Washington residents are to have a balanced understanding of how they will be affected by the new legislation.

The health care reform bill is based on the concept of "managed competition," in which health care is delivered by doctor groups, each consisting of a limited number of physicians and offering medical services for a fixed yearly fee. Provider groups will compete with each other to obtain medical service contracts from employers or cooperative networks of employers for the care of their employees. In the new system, there will be a great proliferation of such groups, which will largely replace the independent practitioners who presently take care of the major portion of the state's patients.

Every provider group will have to offer the same list of benefits, and the successful bidder would be the group with the lowest price. Having secured the contract, the provider group must keep its cost of care below the contract price ceiling in order to continue operating. There is thus created an intense, constant pressure on physicians to hold down the level of service — tests, procedures, referrals to specialists, hospitalizations — they recommend for their patients.

In the managed competition system, the livelihood of physicians depends upon their minimizing expenditures on patient care. Physician members of competing provider groups are constantly exposed to the danger that medical decisions that are too costly may result in the loss of the employer contracts, which are the source of their patients and income. Many doctors are concerned about having to practice in a system in which they will be forced to consider their own economic survival in decisions about what is best for their patients. That conflict is no different in principle than that which exists where doctors own laboratory and X-ray facilities to which they refer their patients. In one case, too much may be done for patients; in the other, too little.

The responsible practice of medicine requires that the best interest of the patient be the only concern of the physician. A sound physician-patient relationship is impossible on any other basis. It is not clear how that relationship can withstand the situation where patients know that their doctor benefits from withholding diagnostic and treatment measures.

Turning to the question of physician choice, the public is largely unaware of the degree to which its selection of a doctor will be restricted under the new system. Rather than having available the broad range of physicians in the community at large, patients will be limited to the panel of doctors of only one provider group.

A patient who is unhappy with the care he or she gets from that group is still committed to it until the employer contract expires, or even longer if the employer decides to renew the contract with the same group. Conversely, patients delighted with their physicians will not be able to continue under their care if the contract is changed to a lower-priced provider group.

It is also important to recognize that in the changed system, many patients will find themselves in a provider group that does not include their present physician. That will create a particular problem for people under the care of more than one doctor. For example, a woman undergoing chemotherapy for ovarian cancer, a man with severe heart disease, a diabetic with high blood pressure and kidney failure, a child with severe allergies all require the services of one or more specialists in addition to the general medical care they receive from a family doctor, internist or pediatrician.

Patients frequently have strong attachments to their physicians, which may go back many years. Nevertheless, in the changeover to the state's new health care system, one or all of the doctors they know and trust may no longer be available to take care of them. As a physician with family under others' care, I can testify personally to the disturbance to one's peace of mind that a forced change of doctor would create.

There is no question that the public has an important interest in assuring universal access to medical care and in containing health care costs. The problem is that under the pending health care reform legislation those goals are to be achieved at the price of restricting a patient's choice of doctor and pressuring doctors to do less than their independent judgment deems best for their patients. With those drawbacks, there is good reason to question whether the Legislature's health care reform program can be said to provide the high quality of care the public expects and deserves.

In any event, it is incumbent upon the Legislature and the governor to make clear to the public not just the advantages they see in health reform legislation but to forthrightly acknowledge the virtues of the present system the public will be giving up.

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BACKGROUND NOTE

Before going into medicine [redacted] studied philosophy, politics, and economics at the University of California and at Oxford. For the next five years he worked as a journalist; first as a contributor on national economic affairs to the Washington Post, then as a national affairs staff writer with the National Observer, also in Washington, DC. He did his residency in internal medicine and a fellowship in oncology at the University of Washington in Seattle. An article of his dealing with current management of ovarian cancer has been published in the New England Journal of Medicine. He is presently in the private practice of internal medicine in Seattle.