Managed Care and Patients With Cardiovascular Disease

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Physicians and other healthcare professionals must become more active advocates for patients in this new era of for-profit managed care. We must, for example, add our voices to those of organizations such as the AHA and the ACC that speak out on behalf of persons with cardiovascular disease and institutions that advance knowledge through education and research.1,2

During the early 1990s, for-profit managed care swept over the American landscape like a flood, washing away medical traditions and disrupting doctor-patient relationships. By now, the fast-moving currents of managed care have reached virtually every heart specialist and every cardiac patient in the nation. The unique doctor-patient relationship, built on a centuries-old foundation of altruism and trust, has been undermined.3 Individual patients seeking personalized care are sometimes pushed around like pawns on a chessboard. Meanwhile, doctors sometimes confront hastily constructed but effective barriers that disrupt or destroy long-standing relationships with their patients and their peers.

Most readers of Circulation would agree that American cardiology is a brilliant achievement based on the integration of research advances, technological and pharmaceutical innovations, and highly trained clinicians.4 Heart patients are living longer and better lives as a result of this fertile union and enhanced emphasis on risk factor reduction. Not everyone shares this optimistic view, however, especially those managed care executives whose main goal is to spend less on health care in order to reward their investors and attract new business.

The most aggressive leaders of for-profit managed care often seem unconcerned with the ideals and institutions that physicians and patients used to take for granted.5 They discount the unique mission and special needs of America’s academic health centers, the factories of new knowledge that are a crucial component of this nation’s remarkably productive biomedical research enterprise. Health care, in this age of depersonalization, is portrayed increasingly as a simple commodity: physicians are providers and patients are consumers of services. Although this interpretation may appeal to some economists and investors, it surely troubles most patients, nurses, and doctors.6

Managed care tries to influence medical decision making as part of a strategy to encourage standardization and cut costs. The industry has promoted the concept of the “gatekeeper,” an unflattering euphemism for primary care physicians charged with controlling access to specialists, tests, and treatments. Many health maintenance organizations now expect their primary care doctors to follow referral guidelines such as those drafted by Milliman & Robertson (M&R), a Seattle-based actuarial firm that pioneered the development of proprietary healthcare guidelines a decade ago. Managed care organizations purchase M&R’s ambulatory care guidelines in part because they provide simple algorithms for helping to decide when a patient should be referred to a specialist. The lack of references and outcomes data in these guidelines does not appear to have slowed their diffusion or adoption.

The AHA warned recently that many primary care physicians are now being pressured to “accept responsibility for patient care that could be substantially beyond their level of training, experience, and expertise.”7 M&R’s ambulatory care guidelines encourage primary care physicians who feel comfortable doing so to treat patients with angina pectoris themselves and to consult a cardiologist only if symptoms persist “despite maximal medical therapy with maximally tolerated doses of nitrates, beta-blockers and calcium channel blockers.”8 Given the risks associated with AMI, consultation with a cardiologist before angina becomes intractable would seem to be desirable.9

One unanticipated benefit of restrictive referral guidelines is that they stimulated outcomes research to assess more objectively the effectiveness of consultations, diagnostic tests, and therapeutic interventions. Cardiologists have fared well in most of the studies that have compared the outcomes of cardiac patients cared for by primary care physicians or heart specialists.10 But most cardiologists want to collaborate with primary care physicians, not compete with them.11

Managed care can take credit for encouraging some positive changes in healthcare delivery, such as the promotion of preventive medicine and the accelerated development of case management tools that help medical professionals deliver care in a more consistent and efficient manner. To be sure, the medical community was developing strategies to enhance efficiency and effectiveness before the managed care revolution.

The dramatic reduction in the length of hospitalization for AMI during the past half century is a compelling example of the success that medical professionals have had in conserving healthcare resources while preserving the quality of patient care. Topol and his colleagues12 reported in 1988 that a brief 3-day stay was safe in carefully selected patients with uncomplicated infarctions. Managed care quickly adopted the 3-day target for some AMI patients13 despite a warning from these authors that further prospective studies were needed before their protocol could be recommended for clinical use.

There is much to commend thoughtful and deliberate efforts to determine the optimal length of hospitalization and the ideal location of care. Most patients are willing to adapt to new strategies such as outpatient angiography and shorter stays after AMI or angioplasty because they trust the doctors and nurses who care for them. They need to know, however,
that the care maps they are expected to follow do not recommend risky shortcuts.

Managed care is an impatient industry, especially when Wall Street is involved. Healthcare professionals must be sure that aggressive strategies to cut costs and enhance short-term profits do not harm patients. We face special challenges when new policies are implemented abruptly. For example, a managed care company in Wisconsin gave hospitals less than 2 months’ notice in 1994 that they would routinely authorize just 5 days of hospitalization for patients undergoing CABG despite the fact that fewer than 9% of CABG patients in the state were achieving this target at the time.14

Continuing to challenge traditions and champion efficiency, the latest M&R guidelines recommend even shorter hospitalizations for cardiac patients whose courses are uncomplicated: 3 days for CABG and 1 day for unstable angina, for example.15 Initially, M&R presented their aggressive length-of-stay targets as “best practice,” a catchy but misleading phrase that had little to do with high-quality outcomes. It referred instead to the most efficient practices: those that used the fewest resources.

No matter how such cost-saving strategies are rationalized, managed care plans are acting irresponsibly if they implement them abruptly, without giving hospitals and healthcare professionals time to adapt. It is like putting patients and their caregivers into an unfamiliar car and urging them to drive too fast for conditions. Little wonder that several thoughtful observers, including the editor of The New England Journal of Medicine, have warned repeatedly that the rapid shift to managed care as the way to contain costs has seriously threatened the quality of health care in this country.16

How did all this happen? Who was looking out for the patients while for-profit managed care crashed like a tidal wave across the medical landscape? Although a few individuals and patients while for-profit managed care crashed like a tidal wave on the medical landscape? Although a few individuals and patients while for-profit managed care crashed like a tidal wave across the medical landscape? Although a few individuals and patients while for-profit managed care crashed like a tidal wave in the 1990s, the voices of patients were ignored.20 Physicians, busy caring for individual patients, and nurse practitioners, busy working in their laboratories, were slow to articulate their concerns about this dramatic departure in the organization of healthcare delivery.

The most vocal champions of managed care dismissed many of the complaints and constructive criticisms. They stereotyped those who challenged the principles and practices of managed care as self-interested apologists for traditional fee-for-service medicine, a system they characterized as anachronistic and fatally flawed. For several years, the voices of patients were muted as well. But the pendulum of public opinion is swinging back in favor of patients and their physicians.17 The flurry of bills and laws dealing with managed care proves that our patients’ concerns are now resonating on Capitol Hill and in state houses across the land.18

Managed care is here to stay. It is a paradigm shift that has forever changed healthcare delivery throughout this nation, from the smallest towns to the largest academic health centers. Growing consumer pressure and new laws promise to reduce the opportunities and incentives for the most ambitious agents of for-profit managed care to bully patients, doctors, nurses, and hospital administrators. Today, healthcare professionals, concerned citizens, and politicians (all of whom are potential patients) are helping to shape managed care into something that places less emphasis on corporate profits and more emphasis on patient choice and quality care.19

Recently, the American Association of Health Plans, managed care’s trade organization, launched a new program and media campaign called “Putting Patients First.” Managed care has a long way to go, however, to achieve that worthy objective.20 Meanwhile, as healthcare professionals, we share responsibility for injecting some Hippocratic principles into the hyperbole of managed care. As we advocate for our patients, we need to help this adolescent industry mature into a socially responsible partner in healthcare delivery.

References


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