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ABSTRACT

Corporate interests within the health care system are creating changes that are not necessarily in the best interests of physicians or their patients. The introduction of the HMO and the concept of managed care have left many physicians feeling manipulated and micromanaged by businesspeople and managers who do not hold health and well-being as a top priority, but rather profit margins and cost containment. (*Nurs Home Med* 1997;5:249)

Language has always been a tool of manipulation. In recent times, we have seen lexical architects representing special corporate interests such as giant insurance companies manipulate patients and physicians to accept, through a self-invented language structure, a creation and redefinition of a new reality in the delivery of medical services in the corporate image. From this altered use of the language of health care decision making, health care institutions end up being viewed and managed more like businesses than the traditional medical, human services-oriented entities that they are.

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Often we are not aware of the structural implications of daily language. There is a reverence for the printed word; the common belief being that if something is in writing it must be true. Language predicts that the referent, upon observation, will have a certain structure. Linguistically, if this prediction is verifiable, we say the "map" (words) accurately fits the "territory" (reality). Representatives of special corporate interests within the health care system are creating simple verbal maps that fit no known territory in the traditional physician-patient relationship. The structure of the language is not representing that of the situation. From this linguistic perspective, patients in need of medical treatment primarily from physicians are increasingly being labeled as consumers and marketing objects of exploitation rather than individual human beings with unique health care needs. This lexical manipulation is fostering the acceptance of changes in our health care system that are not in the best interests of patients, physicians, and other clinical personnel.

Physicians and other clinicians who understand medical terminology but cannot speak the language of businesspeople are increasingly losing their autonomy and decision-making power within our health care system.[1,2] According to Alan R. Fleischman, Senior Vice President of the New York Academy of Medicine, "Medical professionals are in danger of

losing control of patient care decisions to insurers more interested in saving money than curing the sick."[3]

Business school graduates who occupy top management positions in the health care industry in the United States today have displaced graduates of schools of public health, hospital administrators, and even top-ranking physicians of medical care organizations. They are aggressively imparting an accounting and marketing mentality to our health care system, which is threatening the traditional human-services orientation of our society. The process of language manipulation used to create this crisis in health care has been so subtle and casual that no one was able to anticipate the force of its energy in toppling a delivery system of health care in America, which is second to none in the world.

THE BIRTH OF THE HMO

The notion that cost containment, rather than the most comprehensive quality of medical care for the greatest number, should be the priority of the U.S. health care system started in the 1970s at the urging of the Washington Business Group on Health.[4] By 1982, approximately 80 local business coalitions in the United States were pressuring health care policy makers toward this end.[4] When purchasing power concerns money holders and power holders, rebellion can ensue, and the rest is pure history.

As a result of efforts by frustrated and angry businesspeople to control the perceived runaway system of health care, managed care in the form of the health maintenance organization (HMO) was born. This birth was given high profile in the early 1970s by the business community and the business-sponsored Committee for Economic Development. The Nixon administration proposed on February 18, 1971, that HMOs be established with federal grants and loans throughout the country in order to keep health care costs down. In New York State and California, Republican Governors Rockefeller and Reagan at the same time adopted policies of encouraging the formation of HMOs.[4]

Congress further encouraged the establishment of HMOs by passing the 1973 HMO Act in response to intensive lobbying by corporate interests. By 1980, the majority of HMOs were being drawn into several large networks run by the larger insurance companies, including Prudential, CIGNA, Blue Cross, and the Kaiser Corporation. By 1990, there were approximately 575 HMOs in the United States with 33 million members.[2,4,5]

INVENTING MANAGED CARE LANGUAGE STRUCTURE

The languages of managed care and managed competition were initially developed by Alain Enthoven on behalf of giant insurance companies such as Metropolitan Life, Prudential, Aetna, and CIGNA. In a 1988 lecture in the Netherlands, Enthoven voiced his opposition to such traditional U.S. health care system practices as providing patients with free choice of doctors and prescribed services, doctor-patient fee negotiations, fees for services, and solo medical practices on the grounds that these features did not serve the special interests of insurance companies and corporate employers.[6]

Enthoven did not want insured patients to be free to choose their doctors because that would prevent either the health insurance company or the corporate employer from pressuring the more expensive (and perhaps the most qualified) physicians to reduce the medical fees for which they could bill insurance companies or corporate employers.[6] Instead, Enthoven wanted insurance companies and corporate employers to possess the bargaining power to threaten physicians with the words "My insured patients will not go to you unless you reduce the fees you bill the insurance company or corporate employer."[6] Enthoven also wanted to limit physicians' rights to freely prescribe treatment without the intrusion of an insurance company monitor in order to pressure physicians to adopt less costly treatment plans, even if they were less desirable from a health care standpoint.

The language of health care has come to include terms not previously equated with the traditional doctor-patient relationship, such as "gatekeeper," which refers to a primary care physician in an HMO setting. Perceptually, the hard-earned MD has been removed from the physician's name and replaced with an MBA. The bureaucratic business management team has turned the physician into a monitor of cost-containment principles rather than a procurer of sound medical treatment. The lan-

guage of managed care justifies providing a set of economic incentives to patients, designed to manipulate them into giving up their freedom to choose from the most advanced health care technologies, in many cases.

The language of managed care also has been used to provide ideologic justification for manipulating patients and physicians into making so-called cost-efficient medical choices instead of those based solely on medical care expertise. There is, however, a positive side to the business term "cost-efficient." For example, clear evidence exists showing that, when under pressure, physicians and other clinical health care personnel as well as medical equipment entrepreneurs have discovered and implemented new procedures and protocols or have refined old ones, making the delivery of medical services indeed more cost-effective. The irony, though, is that these incidences are very few, and the medical community as a whole remains submerged in bureaucratic dictate.

Critics of the managed care concepts that Enthoven developed on behalf of insurance companies, HMOs, and corporate employers argue that managed care leads to lowest-common-denominator medicine and to a health care system in which quality is subservient to cost and access to health care services is limited. In addition, some critics argue that, for many HMO patients, overall costs of annual prepayment premiums actually exceed the amount they would have paid in premiums and deductibles under an insurance plan based on fees for services.[5,6]

From Physician to Health Care Provider

"New age" language redefines physicians and other clinical personnel in ways that may be considered by some to reduce prestige, autonomy, and authority.[2] The term "health care provider," for instance, may not always adequately distinguish between the nature of health care services provided by a lesser-trained medical technician, for instance, and the physician who has had many years of training at medical school. Such lexical constructs reflect a neutrality and sameness that are potentially degrading and that may pose a significant threat to clinical personnel, while allowing insurance companies a greater role in the health care delivery system.

Thus, as corporate managers have attempted to change the language of health care in the United States, physicians run the risk of becoming more like employees than independent professionals. In many ways, within the changed business-dominated U.S. health care system, physicians may have become subservient to outside forces and external bureaucratic controls, even more so than in Britain, where physicians practice within a socialized system of medicine.[2]

Some physicians may feel that they are being overmanaged or micromanaged by representatives of special corporate interests in ways that limit their autonomy. Fleischman, a medical ethicist, also states that "Doctors have lost the right to prescribe treatment and set the price for care. Fee for service is dead."[3] Perhaps the language of managed care is used to justify the way corporate managers treat physicians. Yet, managed care is more about corporate employers' desire to reduce the price they pay for employees' health insurance benefits and about insurance companies' wish to reduce care costs of those they insure than it is about ensuring the quality of the health care delivered.[2]

Language has been used by both corporations and health insurance companies to convince others that the overutilization of medical services by physicians caused U.S. health care costs to increase.[2] Corporate employers, in response to the rising cost of employee insurance rates in the 1970s, sought to undermine the power of the dominant medical establishment over U.S. health care system policies. They began to argue that physicians had to be brought under corporate managerial control in order to reduce health care costs.[2] Corporate language also began to justify the authority of corporate management experts over that of physicians.

Special interests lobbied Congress in the 1970s to pass government regulations and laws that would undermine physicians' power and create mechanisms for subjecting physicians, other clinical personnel, and hospitals to the same kind of bureaucratic surveillance and manipulation techniques that corporate managers had used for many years to control employees.[2] Even hospitals were under attack and seen as villainous, requiring manipulation and control.

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New health management experts often use the language of managed care to justify the use of surveillance and control techniques in relation to physicians and thereby to cut health care costs, specifically by preventing most HMO patients from gaining access to the most advanced health care technologies. Before patients can see a specialist, they must get the permission of their "gatekeeper" or "primary health care provider." The language of managed care, therefore, was developed to justify the establishment of HMOs rooted in managed care philosophy, after corporate employers began to "blame" physicians for the great increase in employees' health insurance rates and premiums, instead of focusing on the responsibility of the larger insurance companies for the continued rise in health insurance rates and premiums.

To articulate managed care language and to carry out physician surveillance and manipulation, a new occupational elite has emerged in recent years within the health care system. It is composed of health care statisticians, health care administrators, and health care consultants, who are generally not bound by the "old-fashioned" human services professional ethics that traditionally influenced health care decisions of physicians and other clinicians. Some members of this new occupational elite seek to replace the traditional human services values of the health care system with those of a newer generation. Not all patients, particularly the elderly, and certainly not all nurses, doctors, and other clinical personnel adhere to these new values.

One result of this is an occupational elite that, in the interest of special corporate interests, seeks to exercise more bureaucratic control over physicians by the creation of excessive paperwork requirements. This has always been a characteristic of the HMO model of health care delivery because HMOs have always contained administrative surveillance and control mechanisms aimed at physicians within their organizational structure.[2] HMO managers have generally been willing to use these control mechanisms on physicians within their organizations, often despite their own lack of medical training or expertise.[2] Excessive paperwork, which usually does not even lead to better health care outcomes, is the administrative nightmare of physicians and other clinical personnel. It is a language structure unto itself that gives the appearance of improving a system and making it more efficient; however, it tends to function more as a bureaucratic manipulative tool. The problem of "pushing paper" is only exacerbated by governmental agencies that oversee health care and that have HMO-like bureaucratic administrators.

Ironically, although HMOs have tended to decrease the power of physicians in our health care system, managed care has still not been very effective in reducing health care costs. According to InterStudy, a Minnesota-based managed care research firm, HMO premiums jumped by an average of 16.8% in 1990. There is also some evidence that the managed care concepts that HMOs reflect have not succeeded in ensuring quality care for patients who depend on HMOs to manage their health. A study by Shortell and Hughes correlated HMO market penetration and stringent state regulation of physicians with higher inpatient mortality rates.[7]

MAPS THAT DO NOT FIT THE TERRITORY

The language used by special corporate interests to manipulate patients into enrolling in HMOs argued that the "prepayment" of "fixed fees," ie, "premiums," for medical care encouraged HMOs to provide patients with better preventive health care than the traditional U.S. model of health care delivery, which was based on postpaid fees for services. Yet, even in the 1970s, critics of HMOs were asserting that prepayment of fixed fees actually encouraged HMOs to provide the fewest preventive health care services possible in order to avoid losing money on providing care to individual consumer-members.[8] Thus, while consumers were presented with language about "prepaid premiums" and "all-included services," insurance companies became health care brokers, attracted to the concepts of cutting costs, reduced utilization, and so on. The very linguistic magic that was unfolding was, in fact, getting the job done for emerging HMOs—a growth industry.

To manipulate U.S. health care policy makers and to sway public opinion into supporting the development of HMOs in the 1970s and 1980s, emerging technology stressed the ability of HMOs

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to deliver quality health care to consumers more economically than the traditional family physician. Yet, as early as the 1970s, quality unit evaluators who examined the oldest and largest HMO then in question (the Kaiser-Permanente Medical Plan) noted that the HMO actually kept health care costs down only slightly.[9] They pointed out that the Kaiser-Permanente Medical Plan HMO achieved most of its cost-containment advantages only by restricting access to its health care services through understaffing and long waits by patients. Another common practice was to enlist only HMO subscriber-members who were younger and healthier than the average consumer in the U.S. health care system. Large numbers of patients complained of several-week waits for appointments, of rushed and impersonal treatment, and of being unable to find and keep personal physicians within the plan.[9] Physicians at the Kaiser-Permanente Medical Plan HMO also complained about the HMO model of health care delivery as early as the 1970s. As evidenced by evaluations conducted by Kaiser HMO administrators, some physicians reported, for instance, that their schedule at the HMO did not leave them enough time to see their patients adequately and that the quantity of patients they saw was emphasized over the quality of care they delivered. Some physicians were told by their department heads that they were not seeing enough patients.

Leyerle indicates that some of the same criticisms of HMOs that were made in the 1970s and 1980s continued to be made in the early 1990s and that HMOs have not really reduced national health care costs; rather, they have decreased medical services that patients receive. Leyerle also asserts that HMOs have helped to create a health care system in this country in which a greater portion of health care dollars is channeled into a massive administrative apparatus for monitoring physicians instead of being used to provide adequate medical services for patients.[2]

The language that is used to encourage patients to enroll in HMOs also asserts that managed care will ensure that care costs are reduced without sacrificing the quality of care. Yet, HMO critics note that whereas the fee-for-services physicians and hospitals in the traditional model of health care delivery made more money by seeing more patients, HMOs only increased their net income by discouraging their patient-members from seeking medical care. The profit incentive encourages fee-for-services physicians to provide the maximum amount of medical care to their patients but encourages the HMOs to provide as little as possible in the way of medical care. The *New York Times* noted that less than 73 cents of each health care HMO premium dollar is actually spent on the HMO's medical costs.[10] HMOs in the United States over the last 20 years have capitalized on the short-term gain of limited use of service because of the large number of patients who see a physician only when something "goes wrong." This is in sharp contrast to ancient Chinese medicine in which the physician would see patients quite regularly and get paid only when he or she kept the patient well. When patients got sick, the physician was required to care for them without charge. This practice undoubtedly promoted good health practices among physicians as well as the general population. As the U.S. health care culture evolves and our heightened health awareness leads to increased routine physician visits and laboratory work, a heavier use of HMO services could cause financial strain (if not disaster), reduce profits, and cause major increases in prepaid fees.

HMOs have on the whole become more patient friendly in order to maintain their market share of health care business in a competitive arena. However, some people who are currently enrolled in an HMO may have less-than-perfect experiences in accessing care. We are beginning to witness the stress and strain of language usage between patient expectations and the reality of services provided, as this type of management begins to enter the developing HMO industry.

CONCLUSION

It is not inevitable that in the future, health care in the United States will be paid mainly by voluntary insurance. In Belgium, France, Germany, Japan, and Luxembourg, health care is paid for by patients mainly by government-sponsored social insurance. In Ireland, Spain, Denmark, Finland, Greece,

Iceland, Portugal, Norway, Sweden, Canada, Australia, New Zealand, and Britain, health care is paid for by patients mainly as a result of the financing created by governmental taxation.[11] Although the health care systems in the above countries face their own set of problems, more of their citizens have access to quality health care than do people in the United States, and physicians in those countries are not presently being pressured into an HMO model of health care delivery.

In most of the countries mentioned above, physicians' salaries and the fees for services charged by physicians are determined by negotiations between health care professionals and government officials, not by the pressure or dictates of corporate managers or insurance company executives. Although medical bills in Canada are paid for through financing and not voluntary insurance, Canadians (unlike HMO patients) are not limited in their choice of primary care physicians. Physicians in Canada, unlike physicians in the United States, are also not pressured by cost containment advocated within the health care policy-making establishment to accept the inevitability of the eventual elimination of fee-for-services billing practices.

To reverse the trend in the U.S. health care system of representatives of special corporate interests using new terminology to justify the micromanagement of physicians, the physicians themselves must learn the ideas, principles, and practices of scientific yet humanistic health care management. Through a system of self-regulation and self-management, physicians should also begin to control tendencies to overbill or overcharge patients for their medical services. Identifying deviations from this by an individual physician or other clinical personnel should be a priority function of peer-review procedures rather than of bureaucratic administration. Medical schools should be heeding and responding to this trend by offering guidance to their students in administering the business aspect of their practice. Physicians and patients, not self-serving representatives of giant insurance companies and corporate employers, must not allow misleading language or terminology to interfere with or cause confusion regarding the concept of quality care in a humanistic model. The physician, other clinical personnel, hospitals, and other health facilities must be committed to the fair and ethical nature of the delivery of clinical services, including financial matters.

We must enter the 21st century with honest communication within our health care system and not allow its lexicon to encourage or indicate a shift in profits, a self-corporate promotion, and a diminished role of the patient-consumer.

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