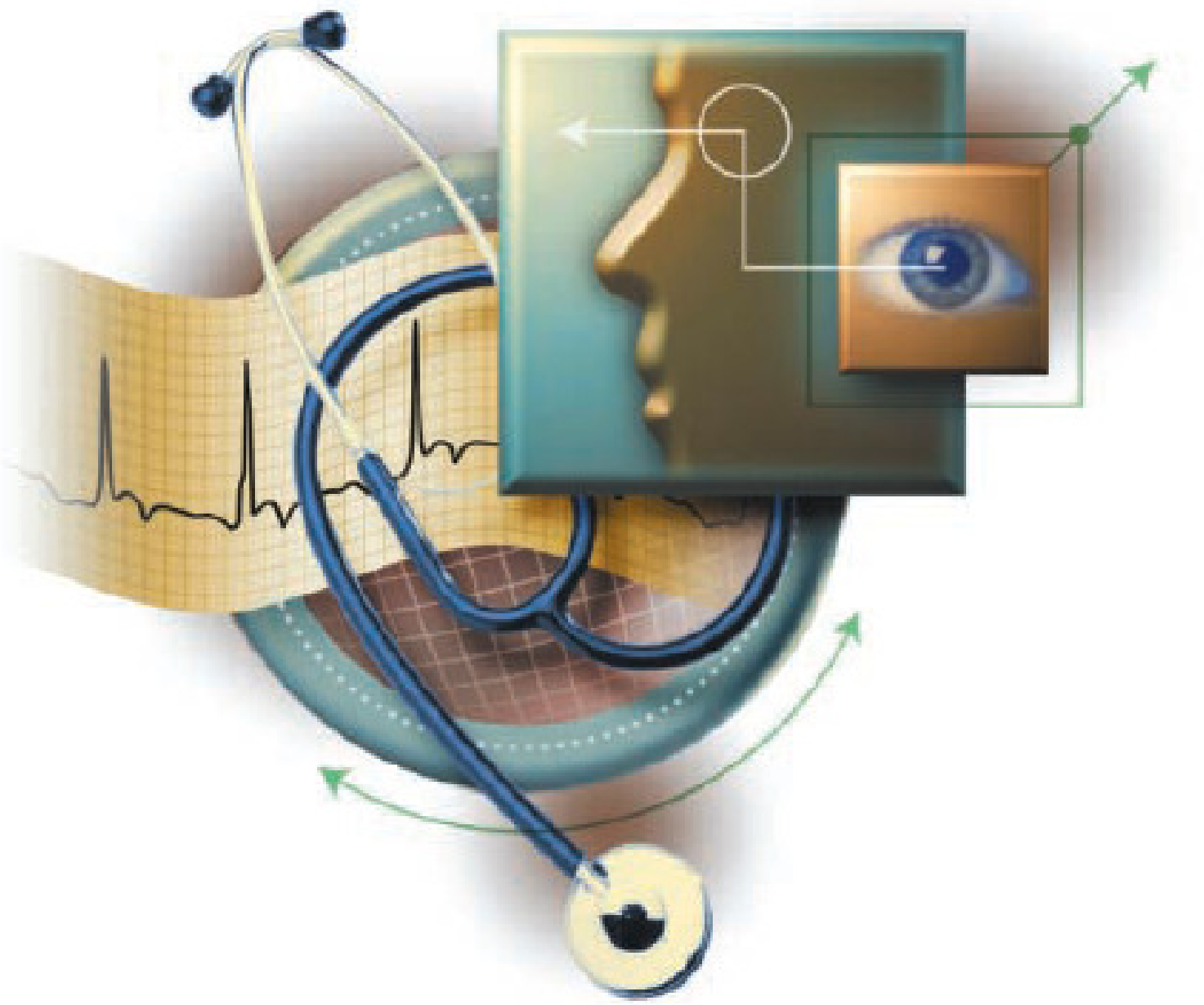
A NEW VISION FOR HEALTH CARE

A Leadership Role for Business



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Chapter 2

THE ROLE OF BUSINESS IN IMPROVING COST EFFECTIVENESS AND QUALITY IN THE HEALTH CARE SYSTEM

Business has a large stake in resolving the major problems described in Chapter 1. Employers can actively address many of the flaws through changes in the way they purchase and manage health benefits. These changes include establishing new relationships with health care providers and health plans (with new demands and expectations), continuing a transfer of more responsibility to employees by providing a wider choice of plans and information on their performance, and designing contributions that encourage "value-based" selections. This chapter presents specific recommendations on how employers can play a leading role in containing costs and improving quality in the health care *system*.

While large employers have the most scope for following our recommendations, many important employer actions do not require a large human resources staff or tremendous market clout. The first step that most companies can take is to offer their workers a meaningful choice of health plans. While very small firms may have difficulty providing multiple choices of plans, many medium-size firms could offer their workers three health plans and structure their contributions so that workers' premiums are related to their choices. They can also educate workers about the important differences among the plans.

ADDRESSING COST AND QUALITY PROBLEMS

The business community has too much at stake to remain passive in the face of the nation's health care crisis. First, the rising costs of health eats into the total compensation package that employers are willing to provide workers; it limits employers' ability to increase wages and to contribute to pensions and other employee benefits. Combined with palpable dissatisfaction with some of the restrictions and delays imposed by managed care, this will translate into deterioration in relations with employees and their representatives. Second, when workers fail to get timely and appropriate medical care, their productivity is likely to be lower and their absenteeism higher. Third, business pays a portion of the cost of the uncompensated care delivered by health care providers to the uninsured through higher corporate taxes as well as higher premiums.

Both positive incentives to reward good medical practices and good value and clear consequences for sub-standard care and inefficiency are needed to improve quality and contain costs. Physicians, hospitals, and other providers of health services who adhere to medical protocols and practice evidence-based medicine should be rewarded with both adequate payments and a larger volume of patients. Those who do not follow these standards should be assisted to improve their practice patterns, and if they ignore this advice, should expect to see their volume decline or be dropped from

provider networks. The business community needs to work with health plans and providers to analyze practice patterns, assess good value in medical care, and design reimbursement strategies that encourage practices consistent with the latest scientific knowledge and efficient management.

Efforts of the following kind can help accomplish these goals:

Demand transparent information on medical practices and use it

The business community should insist upon transparent information on the quality of care from both providers of care and health plans. Employers should not accept the excuses frequently put forward to avoid making this information available—that "it costs too much," "it is not fair," or "providers who report errors will be sued." Steps can be taken to address each of these potential problems. For example, performance measures of quality can be adjusted for case mix or for "transfer patients" to account for the fact that some health care providers serve older and sicker patients.†

Employers should make contracts with health plans contingent upon an assurance that participating providers comply with safe and effective medical practice. The Leapfrog Group, for example, is requiring that hospitals with whom they do business employ computer-assisted physician order entry to reduce medication errors, follow evidence-based guidelines relating patient volume to outcomes, and staff critical care units with appropriately trained physicians. (See box, The Leapfrog Group.)

Since health plans have moved toward more open networks that contain many of the same physicians and hospitals, comparisons between them have become less useful. In response to this problem, some innovative business purchasers have begun to measure the performance of providers rather than only managed care plans.

Employers may use information on patient satisfaction with providers and plans, but they should pay special attention to clinical indicators of quality. The "user-friendliness" of the system as manifest in hours of operation, ease of getting an appointment, and other matters is important, but the critical issue is the likelihood of a patient getting well or having a chronic condition properly managed over time. These questions may literally decide life and death and are far more important than "bedside manner" or the number of telephone rings that occur before someone answers. It is important that the public understand that there are in fact large differences between plans and providers in these critical dimensions.

Transparent and timely information on quality of care will only be helpful if employers *use* that information in their purchasing, both in choosing which plans to offer employees and in providing employees with the information needed to make wise, health-promoting choices themselves. As noted in the previous chapter, employers frequently let such quality information gather dust.

Health care professionals and health plans need to know that if they are consistently receiving low marks for their performance, there will be consequences. In using information on quality in their contract decisions, employers could withhold a small portion of premiums pending attainment of quality improvement targets. Beyond financial rewards and penalties, physicians and hospitals need to know that their continued participation in employers' health plans hinges on their compliance with practice protocols and demonstrable quality improvement.

† Some teaching hospitals, for example, serve a substantial number of patients who are transferred from other hospitals. These tend to be the most serious cases requiring expensive advanced medical technology.

THE LEAPFROG GROUP

The Leapfrog Group is an organization of more than 90 public and private organizations that provide health care benefits. It represents more than 28 million health care consumers in all 50 states. Initially, the group is advancing three methods of improving patient safety. Research conducted by John D. Birkmeyer at Dartmouth University found that these three improvements could prevent 522,000 medication errors and save up to 58,300 lives.

COMPUTER PHYSICIAN ORDER ENTRY (CPOE) SYSTEMS

CPOE systems with intercept capability based on protocols specified by the Institute for Safe Medication Practices can reduce serious prescribing errors in hospitals by more than 50 percent—yet fewer than 5 percent of hospitals use them. CPOE systems can reduce errors caused by misreading or misinterpreting handwritten instructions. They can also intercept orders that might result in adverse drug reactions or that deviate from standard protocols.

To fulfill this Leapfrog Group safety standard, a hospital must require physicians to enter medication orders via a computer system that is linked to prescribing error software; demonstrate that their CPOE system can intercept at least 50 percent of common serious prescribing errors; require documented acknowledgement by the prescribing physician of the intercept prior to any override; and post the test case interception rate on a Leapfrog-designated web site.

EVIDENCE-BASED HOSPITAL REFERRAL (EHR)

Referrals to surgical teams and hospitals with a lot of experience treating certain conditions offer the best survival odds. To fulfill this standard, hospitals will comply with volume standards with established relationship to positive outcomes. If scientifically rigorous risk-adjusted hospital outcomes measures are available, those should be the preferred standard.

ICU PHYSICIAN STAFFING (ICU)

When ICUs are staffed with physicians with credentials in critical care, or when intensive care specialists are available to respond to 95 percent of pages within five minutes, the risk of patients dying in the ICU is reduced by more than 10 percent.

To fulfill this safety standard, hospitals must operate adult ICUs that are managed by a physician certified (or eligible for certification) in critical care medicine. The physician must be present during daytime hours and provide clinical care exclusively in the ICU. At other times he must be reachable by ICU pages within five minutes and can work with a qualified medical assistant in the hospital who can reach ICU patients within five minutes.

SOURCE: The Leapfrog Group.

Work actively with providers to improve quality

Employers can also work directly with hospitals and physicians to improve the quality of health care. A number of business health care coalitions, and some large employers, are taking up this challenge. For example, the Chicago Business Group on Health has formed a Quality Improvement Council comprised of corporate human resource directors, hospital CEOs and quality assurance directors, and practicing physicians. The Council established a cardiac care program under which Chicago area hospitals developed critical pathways for coronary artery bypass surgery patients. The treatment approach was incorporated into four hospitals' practices and resulted in lower cost and reduced length of stay without impairing the quality of care; one company

saved over $4,000 per case. The Council also participated in a C-section reduction collaborative with the Institute for Healthcare Improvement (a nonprofit organization based in Boston) and other business coalition member companies. The C-section project was to be the first of a number of "breakthrough series" focusing on clinical and behavioral areas with the potential for quality improvement.

The Pacific Business Group on Health (PBGH) is collaborating with the California Office of Statewide Planning and Development to operate the California CABG Mortality Reporting Program. This system is collecting and reporting risk-adjusted, hospital-level mortality data for all hospitals in the state that perform coronary artery bypass surgery. The goal is to produce information to allow hospitals and physicians to compare their performance and to stimulate quality improvement.[39]

Offer workers a meaningful choice and employ contracts that create genuine competition to provide value

Firms should promote competition among health plans by offering workers a range of responsible choices. Choices may include more traditional HMOs featuring restricted panels of physicians and hospitals along with wide-access products such as preferred provider organizations (PPOs) and Point of Service (POS) options in which employees pay more if they select providers outside the network. "Responsible choices" are those in which employers provide employees with financial incentives to select a health care system with high quality and reasonable premiums. (This is discussed further with reference to contribution policies, below.)

Choice among plans will be most effective if it is a *multiple* choice, with real differentiation among offerings that recognizes different preferences among people. Employees should be able to choose among plans that offer a wide network of providers and those that are more restrictive and feature more tightly managed care. But workers who choose a higher-cost plan should also pay the full extra premium cost associated with it, preferably on an after-tax basis. If workers prefer the broadest choice of providers and/or minimal utilization review or prior authorization requirements, they will pay for these features. In addition, firms should ensure that workers have information to make *informed* choices. This will help reduce consumer backlash to managed competition.[40]

It is important to distinguish between providing employees with choices between plans that are more or less restrictive (with attendant cost consequences) and providing unlimited freedom of choice *within* the different plans. In recent years, the business community has signaled health plans that they want few limits on choice of providers and very limited cost consequences for members of the plans when they select providers. The plans, in turn, have responded by creating wide-open networks that often include most of the providers in a community. This latter approach will produce *rivalry* among plans but no real *competition* to provide value for money. The business community may have to take an active role in helping to structure the market so that competing groups of providers are not insulated from competitive forces by undifferentiated networks. We should avoid today's tendency to create "a distinction without a difference."

In contracting with health plans, employers should develop requests for proposals with clear specifications about the services they are willing to cover, the premiums they are willing to pay, and the quality improvement targets they require. Employers should seek bids from integrated service networks and health plans that are willing to be held accountable for cost and quality and then allow them to compete with all-inclusive networks on the basis of their superior cost-effectiveness.

Purchasers should purchase and offer to their employees plans that provide the same package of benefits. This will encourage competition based on reducing inefficient and inappropriate care, rather than on risk selection. As noted by Professors Alain Enthoven and Sara Singer at Stanford University, standardization of benefits does not necessarily mean that there should be one national uniform benefit package—there could be a different package for different aggregations of people, such as employer groups and purchasing cooperatives.[41] Their vision of managed competition,

> ....would build on the successes of the present employment-based system, correct its defects in incremental steps, and extend it to people who are now outside of it. Everybody would be covered through one or another sponsored group, which offers price-conscious multiple choice of plans and cost savings through economies of scale: large employers, mid-size employers pooled in purchasing cooperatives or other coalitions, small employers pooled though cooperatives, free-standing individuals who are not members of employment groups (early retirees, unemployed, self-employed) pooled through purchasing cooperatives or permitted to buy through a public sponsor agency, Medicare beneficiaries through their own competitive system, and low-income persons subsidized through a public sponsor.[42]

Under this approach, the financing and delivery of health care would be integrated under some form of risk-adjusted pre-payments with reinsurance caps. This approach would allow resources to be transferred across the continuum of care, so that, for example, savings in hospitalization could be redeployed to improve outpatient care. It would enable providers to contract with the right resources to care for their defined enrollee groups and to practice "population medicine." Such integration also requires teamwork and collaboration among hospitals, doctors, nurses, and other health professionals to improve health outcomes and reduce cost. Relaxing traditional "scope-of-practice" limitations tied to overly restrictive credentialing, and instead emphasizing the outcomes for which integrated medical teams are responsible, would facilitate this.

Integration also may involve establishing a systematic relationship among hospitals so that there is appropriate regional concentration and a sharing of resources. Finally, there is a need for integrated patient information that would feature complete, accessible, and longitudinal medical records, while addressing privacy concerns. In this way, diagnostic tests would not have to be repeated every time a patient meets a new provider.[43]

Coalitions of employers in Minnesota and Iowa have worked to organize the market into competing, non-overlapping integrated delivery systems. In Minneapolis-St. Paul, for example, employers make their contributions directly to care systems rather than to HMOs, and each primary care physician who wants to be a part of this bidding process must align with just one care system. (See Boxes, Iowa's Community Health Purchasing Corporation and The Buyers Health Care Action Group.)

Set contribution policies to encourage the purchase of efficient and high-quality health plans

Employers too often underwrite the high cost and poor quality waste in our health care system with open-ended contribution policies. These policies insulate workers from the adverse effects of plans that are inefficient and lax in monitoring both patients' care and the qualifications of the providers who deliver it.

A number of contribution arrangements would improve on this traditional design. The essential feature of an effective contribution policy is that employers not automatically

IOWA'S COMMUNITY HEALTH PURCHASING CORPORATION

The Community Health Purchasing Corporation (CHPC) is a cooperative that offers health coverage to large employers in central Iowa. It currently enrolls 10,000 individuals and families. In the belief that direct relationships between purchasers and providers are more likely to lead to improvement in care delivery, CHPC offers direct access to provider networks (Care Systems) in addition to more traditional health plan options.

The Care Systems under contract with CHPC are required to provide identical benefits, enabling consumers to compare the care systems easily and thereby promoting competition based on price, quality, and performance rather than benefits. CHPC is currently beginning a transition toward a new value-based provider payment methodology. They are planning a phased-in approach including the following:

1. Each Care System will develop (with the assistance of outside consultants) a standard per member per month price.
2. The Care System fee schedules will be locked in for a twelve-month period based upon the above negotiated fee schedules.
3. Care Systems will be placed into cost groups based on the above.
4. Employers will pass on differences in these cost groups to their employees.
5. Consumers/employees will choose Care Systems based on price differences and quality information (consumer guides), during calendar year 2002.
6. Data will be accumulated during this time in order to develop and activate adjustments for case mix in 2003.
7. There will be no quarterly provider payment fee schedule adjustment or ability of members to change Care Systems back and forth within the calendar year during 2002 or 2003.
8. Data and education for Care Systems will be given on an ongoing basis.

SOURCE: Community Health Purchasing Corporation, "Care System Severity Adjusted Provider Payment Method," (draft, Community Health Purchasing Corporation, Des Moines, IA, January 2001); CHPC, private communication.

raise their contributions to reflect higher costs. We urge employers to design their contributions in this manner to encourage cost discipline, while continuing their helpful roles in screening and negotiating with health plans, managing health benefits, and promoting quality care.

Some employers are adopting one of several defined contribution models. Under the least radical departure from the current system, some purchasers have switched from paying all or a fixed proportion of the total health care premium to paying a fixed-dollar amount. Under this approach, employers offer a range of plans and anchor their contributions to a "benchmark" plan with a superior record of cost management and quality of care. Workers' contributions would then vary inversely with a combination of cost and quality "scores" that plans receive. General Motors follows this approach for its salaried workers.

There is evidence that the switch to contributions pegged to cost-efficient plans is paying off. For example, prior to 1994, the University of California health system set its health care contribution equal to the cost of the health plan with the largest membership. In 1994, the UC system switched to a fixed-dollar contribution pegged to the amount

THE BUYERS HEALTH CARE ACTION GROUP

The Buyers Health Care Action Group (BHCAG), representing 27 major employers in Minneapolis-St. Paul, contracts with a variety of *provider-based* health care systems. It has 115,000 enrollees. A unique feature of this model is that primary care physicians must align themselves with just one care *system*. This facilitates assessments of provider performance and requires patients to remain with a care system for at least a year if they want to see a particular primary care physician.

Care systems submit bids with "claims targets" for the coming year's total costs. Claims targets are risk-adjusted to reflect the varying case mixes of different care systems. Based on these bids, each system is placed into one of three "price tiers." Enrollment in the high-priced tier requires a consumer to make a greater premium contribution than enrollment in a medium-price system, which in turn is costlier than a lower-price system. This creates incentives for consumers to enroll in less costly systems. But since the 27 participating employers agree to a common benefit package, and risk-adjustment is used, the competition is based on quality and efficiency rather than on risk selection or "cheapening" the benefit package.

The BHCAG model is supported by information on quality of care produced by the Institute for Clinical Systems Integration. This institute has produced over 50 medical practice guidelines, and it also provides technical assistance to help medical groups implement the guidelines. Health outcomes studies and annual population health surveys also contribute to quality improvement. Each care system must establish a quality improvement oversight group including medical staff, set specific quality measurement goals, and develop a plan to implement and sustain improvements in quality. In addition, BHCAG uses Medicare's Consumer Assessment of Health Plans Survey (CAHPS) to compare consumer satisfaction with the care systems in each of the price tiers. This survey includes consumers' ratings of their clinic or personal physician, how well doctors communicate, and their ability to obtain timely referrals.

Enrollment shifts are encouraging. Consumers are moving away from higher-cost systems and those with relatively poor patient satisfaction scores, and toward those with lower costs and better performance records.

SOURCE: Glenna Crooks, Jack A. Meyer, and Nancy Bagby, *Quality Health Care for Children in S-CHIP*, (Washington, D.C.: New Directions for Policy, 1999); Milbank Memorial Fund, *Value Purchasers in Health Care: Seven Case Studies*, (New York: Milbank Memorial Fund, 2001); BHCAG, private communication.

charged by the least-costly plan available statewide. Among employees whose premiums did not increase, only five to six percent switched plans. But among those facing premium increases, 30 percent of the HMO enrollees switched plans, while 50 percent of the fee-for-service enrollees switched. Overall, a $10 per month increase in out-of-pocket premiums resulted in roughly a fivefold increase in plan switching. The vast majority of those switching plans chose plans that provided similar benefits and did not require out-of-pocket premium contributions. In the three years following the benefits change, real

spending per employee by the UC health benefits program fell by 24 percent.[44] As another example, a survey of over 500 employers offering a choice of plans found that employers that did not pay more for higher-priced plans experienced much smaller premium increases than employers that did so.[45]

Some employers are experimenting with other types of arrangements for their workers such as personal medical funds (PMFs), medical savings accounts, and flexible spending accounts. Under PMFs, for example, an employer annually places a fixed sum into an employee's personal medical fund to cover routine medical expenses, such as physician visits, eyeglasses, and prescription drugs. Workers have ready access to their account balances through the year, and unused funds can be carried over into the next year. For more serious expenses related to hospitalization or prolonged care, the employer may purchase a catastrophic illness "wraparound" insurance plan to supplement the PMF.

Other firms are exploring the possibility of treating health contributions like 401(k) pension accounts, with fixed contributions that workers control and have available to use as they move from job to job, as with a vested pension account. This approach would probably require tax law changes to assure that employer contributions did not become taxable income for workers who changed jobs. Finally, some small and medium-size firms contract out for the entire employee benefits package, including health, pensions, workers compensation, and disability, using professional employment organizations (PEOs) to "outsource" these benefits.

With respect to the movement towards defined contribution plans, we believe three caveats are in order.

First, if employers totally disengage from screening and selecting health plans and care systems for their employees, we would lose an important force for quality improvement. While employees would have a wider choice of plans and could make those plans portable from job to job, some oversight would be necessary to protect consumers from unstable, or even disreputable, organizations and to hold the newer systems accountable for cost and quality. Since employers would still have a stake in a healthy workforce, they should continue to have a role in improving workers' health care.

Second, some employers attempting to change contribution policies will face difficulties related to contractual labor agreements or to an inadequate number of health plans to provide genuine competition in some rural areas.

Third, employers should recognize an important difference between their contributions to employee pensions and to employee health care. Private pensions put aside money to be combined with private savings and Social Security to meet relatively predictable income needs after retirement. Health care is a very different matter. It is difficult to "save for" catastrophic illnesses or chronic medical conditions, which are largely unpredictable and often extremely costly to treat, and there is no "safety net" program that provides a floor for the health expenses of working adults like Social Security provides for the income of retirees. For this reason, defined-contribution plans may not fit workers' health care needs as well as their pension needs if they simply limit employer exposure without providing for catastrophic and chronic health contingencies. Some companies are using a mix of defined-benefit insurance to cover catastrophic care and defined contributions into tax-sheltered personalized funds that create incentives for workers to economize on their use of health care resources.

In sum, CED recommends that employers move carefully toward contribution policies that help control costs but still enable workers to afford their share of the health care bill. Employers should continue to be active in

quality-improvement activities and provide some oversight and guidance to workers under any form of a defined contribution model. If firms step back from selecting plans, negotiating premiums, and managing benefits, they should not completely abandon health reform. However, if employers play a less-active role in plan screening and selection, quasi-public organizations in various regions of the country may be necessary to perform some of the oversight previously conducted by business. This need not entail detailed regulation of the health care industry; a model of sensible oversight without excessive intervention is described in Chapter 8.

Provide workers with reliable information about the quality of health plans and care systems

Employers should foster accountability for cost and quality by providing workers with understandable and timely information on the performance of providers and plans. Such information must be user-friendly—clear, concise, and delivered to employees just before their "open-seasons" when they select a health plan. Consumers want information about their physicians and other providers, not just a comparison of plans. Because many health plans have heavily overlapping networks of doctors and hospitals, comparisons to date have shown few meaningful differences in quality. Consumers also indicate a strong desire for information from an unbiased and reliable source. Businesses should tailor the information they offer to these clearly expressed desires and obtain continuous employee responses to revise and refine the information. The Pacific Business Group on Health (PBGH) and the California Public Employees Retirement System (CalPERS) are working together to provide their members, which together number about four million, with this type of information. (See Box, PBGH's HealthScope.)

Consumers frequently choose providers on the advice of family and friends, with little knowledge of the providers' experience, qualifications, and performance. Employers can help workers and their families obtain and use such information on provider performance. However, this will require a very large change in habits and behavior, and it will not happen overnight. Nevertheless, we know that at least 70-80 million Americans now use the Internet to obtain some type of information about their health. Highly-publicized reports by the Institute of Medicine on widespread medical errors and inappropriate care have spread awareness and concern beyond the experts to both patients and those who help pay their bills.

PRINCIPLES FOR APPROPRIATELY-MANAGED CARE

Business leaders should help drive the transition to the next generation of health care management—one that incorporates managed care, patient responsibility, and incentives for providers to deliver higher quality, more efficient services.*

"Unmanaged care" is not a viable option. We should not use payment systems that treat all physicians and hospitals alike regardless of their adherence to established best medical practices. A good managed care model involves an emphasis on preventive care and early detection and a determined effort to reduce medical errors and inappropriate care.

However, some employers have effectively forced HMOs on their employees and used them as "single replacements" for their old-fashioned indemnity plans. Employees often received little explanation of the differences between the indemnity plans, preferred provider organizations, and HMOs. This, in turn, led to an understandable backlash among workers while still failing to control costs.[48]

*See memoranda by RICHARD W. HANSELMAN (page 45).

PBGH'S HEALTHSCOPE

The Pacific Business Group on Health (PBGH) represents 45 major purchasers accounting for 8 million employees, retirees, and their families, and $8 billion in annual expenditures. In addition, PBGH now oversees a small business purchasing group that includes approximately 10,000 small companies with 2 to 50 employees, representing about 140,000 covered lives.

PBGH has developed HealthScope, an Internet-based tool allowing employees to view pre-designed report cards or to create their own report cards simultaneously for their own medical group and two other groups. Users can enter their region in the state, and identify the group of physicians whose performance assessments they want to scan. The next step is to select the quality measures that they believe are important to their own health or the health of a family member. They next click on a "Create My Report Card" button and obtain a personalized report card with scores for the quality measures that matter most to them. They can view a side-by-side comparison of medical groups along the key quality indicators that interest them.

Thus, consumers interested in such areas as asthma care, diabetes, or high blood pressure can focus on these chronic illnesses and comparatively assess various medical groups as to their degree of compliance with best medical practices, such as the proportion of patients with diabetes who obtain annual retinal exams. They can also obtain an account of the performance of the medical group on various measures of patient satisfaction, including access to care, promptness of care, physician communication and courtesy, and an overall satisfaction indicator.

Accompanying this customized report card is a guide to appropriate preventive and primary care. This includes guides to the timing and frequency of various preventive tests. For example, for women 18 to 85, there are schedules for PAP smears, breast cancer screening, prenatal care, etc. There are also immunization schedules for children. In addition, consumers may obtain written counseling on lifestyle and behavioral patterns (e.g. tobacco avoidance, exercise, nutrition, dental health, injury prevention, hormone replacement therapy, sexually transmitted diseases).

SOURCE: www.pbgh.org

We believe that employers should design managed care contracts that stress the following components:

1. Developing disease management strategies customized to people with serious illnesses and disabilities. The 10 percent of patients who account for about 70 percent of health spending need team-based care, case management with individually customized care plans, patient education to comply with treatment plans, and disease management to guide them through severe episodes and serious flare-ups of long-term conditions. Such an approach can lower costs and improve health status at the same time;
2. Rewarding providers for helping people stay well instead of waiting to treat them, more expensively, when they are sick. This could also involve incentives for managed care organizations to provide health education, to encourage people to change harmful personal behavior, and to use preventive services;
3. Developing and using evidence-based standards for diagnosing conditions and treating illnesses, and work to see that physicians adhere to best medical practices;

4. Finding the best mix of medical, public health, and social services to manage care efficiently and effectively. This can involve using nurse practitioners, physicians' assistants, physical therapists, and social workers as front-line workers, in coordination with specialist physicians;

5. Integrating financing and delivery so that providers are responsible for managing resources; and

6. Targeting high-priority conditions and highly vulnerable patients for intense care management.

The business community can also take the lead in insisting that undesirable features of managed care are set aside. These adverse features include:

1. Creating bureaucratic barriers that lead to substantial and unjustified delays in authorizing appropriate care and in claims payment;

2. Substituting specialist physicians for subspecialists in cases where the latter are more qualified to identify and treat serious medical conditions; and

3. Asking primary care physicians to do the work of specialists that stretches the limits of their training.

Employers should work to change the debate over quality from a focus primarily on giving patients virtually unrestricted access to all types of care (often couched in terms of patient "protection"), to a broader discussion of promoting patient safety and reducing inappropriate medical care. *Patients need to be protected not only from arbitrary managed care rules, but also from poor-quality care. Managed care plans need the flexibility to steer patients away from such care.*