

Debate & Analysis

A paradigm shift:

from doctor–patient to payer–patient relationship

INTRODUCTION

Before the Second World War most individuals had a physician who was responsible for their health from cradle to grave. I don't want to idealise that situation but there is no doubt that the relationship was a private interaction based on trust. In the past, the payer used to be the patient and the relationship was clear; now we pay indirectly. The payer may be the government through a mixture of taxes, employer contributions, and national insurance, or they may be an insurance company or a health maintenance organisation.

In the brave new world after the Second World War many countries developed models of universal health coverage. The benefits of universal health coverage for the citizens were explicit and defined in the Bismarck model;¹ they were vague and implicit in the Beveridge model.² However, this did not much matter because modern medicine was in its infancy, the populations were younger, and medical technologies relatively cheap. There was no mention or thought given to quality of care provided, the assumption being that the physicians would do their best. In most people's minds health was simply the absence of illness.

The increasing costs of new technologies³ and the ageing population have made the promises of full universal health care very challenging as the payers collect data in their effort to try to keep the costs under control. Herein lays the basic dilemma. The payers' interest is not necessarily the same as that of the patient sitting in the physician's clinic. The payers make decisions on health policy based on epidemiological data and can't take into consideration the specific needs of each patient. This change together with the sets of biometric data that are being collected by the payers on all the patients are an unprecedented change of the doctor–patient relationship and constitute a paradigm shift.⁴ The statement that *'Health statistics represent people with the tears wiped off'* has been attributed to one of the fathers of epidemiology, Sir Austin Bradford Hill.⁵ We physicians see the tears and hear the patients in their daily struggle. Ethically we should be listening and be guided by the patients' agenda but in daily practice this is unfortunately not necessarily the case. In order to satisfy their stakeholders, the payers together with our professional organisations have developed

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quality of care indicators that are now driving medical care in the community at the expense of individually tailored medical care. In the name of economic utility the payers, who might be health maintenance organisations or health ministries, have adopted a 'one suit fits all' solution based on epidemiological data.⁶ The payers look for indicators that are easy to measure such as laboratory data, and not necessarily what is important to measure, such as time spent with each patient. By assessing physicians using quality of care indicators, the payers have succeeded in changing physician behaviour using methods ranging from simple feedback and peer pressure, to the use of financial incentives.⁷

In a 1977 article in *Science*, internist George L Engel gave a new framework for medical thinking and described the biopsychosocial model of illness.⁸ This model was rapidly adopted by primary care practitioners because it explains variation in illness between patients. What matters to patients are whether they feel ill or their function is impaired, not just their biochemistry. Kindness, empathy, support, and assessment of the patients' social and psychological problems are critical parts of our role as physicians. It is equally clear that a low HbA1c is an appropriate goal for patients with diabetes since this too will reduce the illness burden.⁹ Nonetheless, is a low HbA1c relevant for the older patient or the patient with multimorbidity? Is moving the patient to insulin with its reduced quality of life a reasonable trade-off for a potential decrease in complications of diabetes? Is

an HbA1c of 7.7 really poor medical care? In order to achieve goals of 'quality of care', interventions may often be misrepresented to patients. For instance, the benefits of mammography screening are generally not presented together with its risks of overdiagnosis and unnecessary treatment. The benefits of statin treatment are usually not presented to patients with information on the number needed to treat in order for one patient to benefit. The payers seem to be stuck in the 100-year-old model of management formulated by Henri Fayol:

*'To manage is to forecast and plan, to organize, to command, to coordinate and to control.'*¹⁰

The quality indicators have set the agenda for the limited time available with our patients.

THE WAY FORWARD

We must all strive for the highest standards of care; the question is how to achieve this goal. The current focus of care has been shifted from the patient's perceived needs to the demands of the payers and professional bodies. Physicians who function as part of a complex healthcare system often implement these quality indicators with a heavy heart.¹¹ As the English doctor/poet John Keats wrote, *'No man is an island.'* It may well be that the continuing emphasis by the payers on achieving quality indicators is contributing to physician burnout, which is itself associated with poor healthcare delivery.¹² Biometric data are critical for

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the assessment of care at a national level but this should be complimented by efforts to collect softer data such as patient satisfaction.¹³ Data can be used in many ways such as resource allocation to the different regions or by primary healthcare teams in peer review and quality circles. However, to present the biometric data as a quality indicator without the soft data, which may reflect that the physician has addressed the psychosocial aspects of care, is problematic. Quality indicators, and their implication that failure to reach targets suggests poor care, may not be in the patients' interest. Quality indicators that are process indicators have become overvalued and are influenced by many factors over which the physician has little control, such as socioeconomic status and access to care. As a profession we must put emphasis on working with treatment guidelines that, despite their complexity, are an invaluable aid to providing high-quality care. We must

generate this care by providing physicians and their teams with the resources and information to do a better job. Physicians need a secure work environment, additional time with the more complex patients, and a computerised medical record that supports quality care and encourages teamwork. The way forward for high-quality primary care must be to use biometric data intelligently, listen to our patients' needs, and return to the biopsychosocial model.

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