

# Part II

## Regional Perspectives



# The Americas

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## The American Health Care System: Entering the Twenty-first Century with High Risk, Major Challenges, and Great Opportunities

BERNICE A. PESCOSOLIDO AND CAROL A. BOYER

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At the end of the nineteenth century, the medical profession stood in the midst of great change in America. The coming of the industrial revolution coupled with new scientific theories for the practice and training of physicians produced the modern system of medicine. Given that great “social transformation” of American medicine (Starr 1982), there was little doubt in the minds of the leaders of the new scientific profession that the American health care system would be substantially different from the one at the beginning of the nineteenth century or even at mid-century. As it evolved during the twentieth century, the modern health care system in the United States took a very different form from many of its European counterparts, building a mixed private and public system of care with powerful physician direction.

What has been less anticipated but equally remarkable is the contrast between the health care system at the end of the twentieth century and its predecessor at the beginning of the 1990s. Escalating costs, the newer burden of chronic and degenerative diseases, the increasing number of Americans not covered by any form of health insurance, and only a modest relationship between health care spending and some important markers of “success” (e.g. the infant mortality rate) compared to other countries led to a major federal government effort to restructure the American health care system. Its failure led to the private health insurance market launching initiatives that greatly transformed the structure and financing of health services. As a result, the richest country in the world, with almost 274 million people, is undergoing a massive social experiment in the form of a new organization of health care.

The purpose of this chapter is to briefly describe the different eras of health care in the United States, concentrating on the challenges and opportunities in this radical, contemporary change. We begin with a review of the eras in the evolution of the American health care system, focusing on the power of its major practitioners, physicians, and the limits of their power in determining the recent

arrangements by which health care is provided. We then discuss the issues that figure prominently in today's debate about how the newly emerging organization of American health care assure access and quality care in a cost effective manner.

### THE RISE OF A HEALTH CARE "SYSTEM" IN THE UNITED STATES

Historians and sociologists alike have argued that the discovery that a bacillus caused anthrax, the routine use of antiseptics, and the introduction of anesthesia combined to produce the "great break" between medicine of the past and the modern form of science-based practice. While different societies embraced the new science in different ways in how it shaped their health care system, the industrializing countries of the United States and Europe all used political, social, and economic mechanisms to place the "scientific" physician at the center of the modern health care systems. Figure 10.1 provides a simple heuristic device charting the relative power of physicians in the American health care system over time. As figure 10.1 indicates, the power and reach of the modern physician grew dramatically from 1860 to 1910. The release of the Flexner Report reinforced physician authority with its indictment of the status of medical training in the United States and a recommendation that only medical schools following the German model of scientific training should receive financial assistance and public support. Suppressed were the itinerant medicine men delivering "elixers" that either were laced with opium or alcohol or that "purged" disease by "cleansing" the body through vomiting or elimination. Gone also was the standard practice of "regular" physicians (i.e. the precursors of the scientific physician such as Benjamin Rush) of "bleeding" the ill person to remove tainted blood. "Granny" midwives who delivered babies at home and female and minority physicians who had learned medicine through apprenticeships were eliminated as well through the establishment of licensing laws.

These laws required all those wishing to practice medicine to take state examinations which were, in practice, written by physicians at the newly established, science-based medical schools like The Johns Hopkins University in Baltimore. Both aspiring and practicing medical providers not trained at these medical schools failed the examinations and were prohibited from practicing medicine in the United States (Brown 1979). Even the well-established chiropractors of the midwest and homeopaths who were the preferred providers of the upper classes in the United States found themselves without substantial support (i.e. health insurance unwilling to cover their services), even though they were not barred from practice. The scientific medical profession became, in essence, a successful if not total monopoly (Berlant 1975; Collins 1979; Starr 1982).

The medical profession's role in building the American health care system looms large and substantial. The American Medical Association, formed in 1847, became extremely powerful and helped direct the use of resources generated by wealthy industrialists in the United States. But these corporate interests, while backing the large infusion of wealth into the emerging system of modern

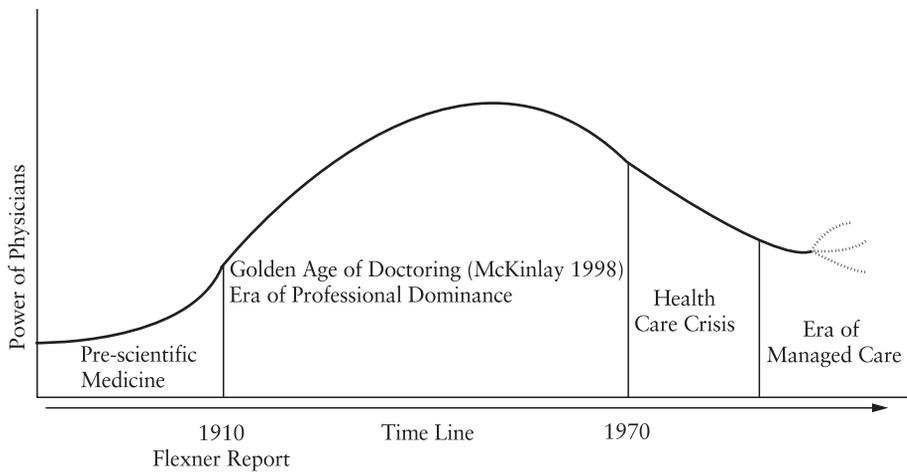


Figure 10.1 Eras in the American health care system

medicine, did it indirectly through their newly established philanthropic foundations. The government, whether federal or state, played a minimal early role in the design of the American health care system. This differed substantially from the European experience in Germany, for example, where the federal government played an early and active role in directing general and employer taxes to cover the services of scientific medical practice (Rosen 1963; Berlant 1975).

Medical care in the United States could only loosely be referred to as a “system” of health care financed by private sources, including patient fees. It was, and still is at best, a patchwork of providers in the private sector including solo-practitioners; incorporated groups of physicians; voluntary, community hospitals; and some early Health Maintenance Organizations such as Kaiser Permanente in California that arose from the lack of physicians to serve the workers in important industries which were developing outside urban centers (e.g. railroads, mining). This private sector is supplemented by a weak public sector that includes city and county hospitals; long-term care facilities (e.g. mental hospitals, TB sanitariums), a Veterans Administration System established at the end of the Civil War in the 1860s, public health nursing, and specialized community clinics (e.g. the Community Mental Health Centers or CMHCs that were established in the face of the decision to “deinstitutionalize” the treatment of mental illness). Only in the 1960s did the federal government develop programs to provide limited health insurance coverage for the elderly (Medicare) or develop a partnership with the states to offer coverage for the poor (Medicaid).

The period from 1910 through 1970 represented an era of great growth, success, and power of the medical profession. The US health care system, aided after World War II by large federal support for research and development as well as hospital building, became one of the most prominent in the world. It was, according to McKinlay and Marceau (1998), the “Golden Age of Doctoring,” or drawing from Eliot Freidson’s (1970) terms, “An Era of Professional Dominance” (see figure 10.1). Physicians in a primarily private health care system determined both the nature of medical care and the arrangements

under which it was provided. Physicians set their prices, worked from predominantly solo-practices, and joined the American Medical Association. For the most part, patients could choose who they wanted to visit for their problems and they purchased private health insurance to do so, starting in the 1940s. Even the Great Depression of the 1930s, which established unemployment, public works, and other federal welfare programs, did not extend to the public provision of health care in a systematic form characteristic of the health insurance or health systems of Europe.

## THE END OF UNQUESTIONED DOMINANCE

In 1970 President Richard Nixon announced the existence of a “health care crisis” in the United States (see figure 10.1). The number of uninsured Americans and those with limited access to medical care was growing. Even the introduction of Medicare and Medicaid were decried as inadequate, the cause of increasing spending, and the source of a “two-tiered” or “two-class” system of health care in the United States. Scientific medicine’s limits on a number of fronts were coming to the fore as cancer, heart disease, and other chronic and degenerative illnesses did not appear to be understood under the “germ theory” so central to modern, scientific medicine. While medicine offered more sophisticated, technological solutions to diagnosis and treatment, people began to question a quick resort to surgery for problems (e.g. prostate surgery), the extension of life through artificial means (e.g. life support in hopeless cases), and the spiraling costs of medical care. Simultaneously, it seemed that there was a growing interest in both older and newer forms of complementary and alternative medicine including midwifery, acupuncture, chiropractic, and homeopathy. Scholars began to write about scientific medicine’s “deprofessionalization” and “deskilling”; about patients’ rights and a growing consumer movement; and about the need for “holistic” approaches to health care (see Pescosolido and Kronenfeld 1995; Pescosolido, McLeod, and Alegría 2000). As health care insurance began to cover “alternative” medicines, albeit on a very limited basis (e.g. chiropractic) and greater numbers of physicians declined to join the American Medical Association, professional dominance was unraveling. Sociologists shifted their discussion from issues of “professional dominance” to notions of “deprofessionalization,” “corporatization,” “proletarianization,” and “countervailing powers”; anthropologists talked about alternative medical systems being “complementary” rather than “competing” and discussed the potential for the integration among different systems of medical care (Unschuld 1976; Light and Levine 1988; Light 1995).

These disillusionments were not exclusive to modern medicine and, perhaps, reflected larger changes in modern society (Pescosolido and Rubin 2000). Rubin (1996) has argued that the social and economic bases of modern society “tarnished” in the early 1970s, marked a turning point. The postwar growth that had fueled prosperity in all sectors, including medicine, stopped. A long decline in expansion resulted in downsizing of corporations and displacement of large numbers of workers. While new jobs continued to be created, they were also

increasingly part-time, temporary, low wage, and without important benefits like health insurance (Kronick and Gilmer 1999). The costs of medical care in the United States continued to rise at rates higher than inflation in other sectors at the same time that individuals experienced greater barriers to access and faced substantial medical problems. Old problems, thought to have been solved, returned (e.g. the resurgence of tuberculosis), new ones that perplexed medical researchers and strained the limits of scientific medicine arose (e.g. HIV/AIDS, antibiotic-resistant bacterial infection), and persistent failures plagued the country that continued to spend the most on health care in the world (e.g. the relatively higher infant mortality rate compared with countries like Japan, Poland, Italy, or Sweden with lower national spending rates for health care).

### ENTER HEALTH CARE REFORM

For the first time in a century, health care became a central political issue in national, political debates in the 1990s (see figure 10.1). In the presidential elections of 1990, Democratic candidates Bob Kerry and, later, Bill Clinton focused on the crisis in health care as a central issue. To the surprise of many, this issue became a lightning rod among the American people. When he was later elected, Clinton sought major reform in the health care system. He appointed his wife, Hillary Clinton, to chair a Task Force that, between 1992 and 1994, deliberated and crafted the Clinton Health Security Act. Based on the triad of “managed competition,” “global budget,” and “universal coverage,” it sought to achieve improved access to health care through privately provided health insurance and to control costs simultaneously (see Zelman 1996).

The original ideas about *managed competition* focused on the creation of “health alliances,” a group of individuals who would enroll in a health insurance plan together and purchase insurance from a private group (see Enthoven 1978). The system would be employer-based, which would allow the “invisible hand of the market” to set a competition in motion among plans to provide the best and widest range of coverage at the lowest prices. A public agency would be established to certify these managed care plans, monitor quality, and guarantee yearly enrollment. The *global budget* provision would essentially move the United States to a single payer system where the federal government would cap the overall health care budget, develop and receive the paperwork (i.e. reimbursement forms), and cut the checks in order to reduce the high costs of administration. Finally, with the goal of *universal coverage*, health alliances would be created for all citizens. Through various provisions (e.g. Medicaid would no longer exist; Medicare would be folded into a health alliance), the Clinton Plan proposed for the first time that health care in America was a right and not a privilege based on ability to pay. In essence, the Clinton Plan essentially preserved the private nature of health care in the United States while ensuring it as a public good.

While scholars, politicians, and policy makers debated the merits of the approach (e.g. Relman 1993) the Clinton Health Reform Act was gutted after the lengthy report recommendations were issued. Very soon after release of the

report, the latter two provisions were dropped and the entire plan was abandoned by 1994 (see Domhoff 1996; Skocpol 1997). However, in its demise the private health insurance market transformed the structure and financing of health services and increased the complexity of the health care system. Facing total health benefit costs increasing more than 20 percent each year (Higgins 1991), fiscal constraints resulting from a mounting federal budget deficit, and more skepticism about the value of health care given its costs under a fee-for-service system, private employers sought and achieved substantial changes in their health benefit “designs.”

The last decade of the twentieth century represents an historic turn in the American health care system with the expansion of managed care and the privatization of health care markets. No longer is managed care the alternative health care delivery model that it once was, but is increasingly becoming the dominant model in the private sector and a growing one among the public programs of Medicare and Medicaid (Jensen et al. 1997; Gold 1998). And, despite the claims of a “backlash” against managed care and controversy about its impact and growth, two-thirds of Americans report that they are relatively satisfied with their own managed care plan (Blendon et al. 1998).

It is not accurate to talk about “managed care” as a single entity. Managed care refers to a number of diverse insurance options and organizations that integrate the financing and delivery of care (Gold 1998). In fact, there are so many forms of managed care that the term, according to some, has become relatively meaningless. What they share are the goals of increasing efficiency and higher quality of care. Managed care also shares key features including: (1) the use of a fixed prepayment, capitated, or negotiated fee for a defined set of services for a specified population of enrollees; (2) the assumption of insurance risk shared by the managed care organization (MCO) and/or providers to provide necessary services; (3) selective contracting where enrollees are limited to a panel of providers; (4) the use of primary care gatekeepers to coordinate care and control the use of services; (5) utilization review to assess the appropriateness of care and provider decisions before services are provided, including pre-certification, concurrent review, and high-cost case management; (6) the managing of quality of care through the use of clinical practice standards or guidelines; and (7) the tracking of patient and organizational “outcomes,” referred to as “performance monitoring,” that are to be used to ferret out poor quality plans, care, and providers.

Only a small portion of the insurance market retains the traditional indemnity plan where the insurer pays for the costs of services included in the benefit package after they are delivered, without any pre-negotiation of fees or oversight. Health care insurers achieved this transition to managed care in many ways but all placed limits on type, amount, and providers who can deliver services. For example, pressures were exerted on traditional indemnity insurers who had previously offered limited participation in health maintenance organizations (HMOs) to increase their HMO options and other “products.” These other “products” have taken the form of preferred provider organizations (PPOs), independent practice associations (IPAs), or point-of-service (POS) designs, all of which allow employers to purchase services at lower costs than

traditional indemnity insurance and manage care in some way (Gabel et al. 1989; 1990; see Zelman 1996 for a discussion of these different models). While more choice was given to individuals by most employers than the traditional HMO, the clear intent was to limit the growth in both insurance premiums and health services costs.

## THE CURRENT SYSTEM

The arrangements in American society between the people, medical care providers, health insurers, and the government have been fundamentally reconfigured. There is little doubt that we have entered into a second “social contract” regarding the provision of medical care in the United States (Pescosolido, McLeod, and Alegria 2000). The growing “penetration” of managed care, as this shift is routinely called, especially in the private sector during the 1990s, has been quite significant. By 1998, 86 percent of employees in large firms (more than 200 employees) were enrolled in some form of managed care plan (Gabel and Hurst 1998). More growth has occurred in the less tightly managed PPOs, IPAs, and POS designs than in the traditional HMOs. These newer managed care models offer more choice in providers and more flexibility (e.g. co-payments for the use of specialists). Even among the traditional plans, various forms of utilization review are being used. Further, there has been substantial growth of managed care among the large public programs for the elderly, disabled, and low income population. For example, among the Medicaid population enrollment in managed care has grown from 3 percent of beneficiaries in 1983 to more than one-half (53.6 percent) by 1998 (Health Care Financing Administration 1992, 1998).

In adopting managed care, states have not only set goals to control costs and improve access for Medicaid beneficiaries, but also to expand coverage to the uninsured (Gold 1997). Many states have taken advantage of this larger shift to the new financing and organization of care to move from being a provider of services to a manager of services (e.g. in the mental health sector). Managed care has grown more slowly in the federal government’s Medicare program for the elderly and disabled, although enrollment varies markedly across geographical areas. As of 1999, approximately 17 percent of all Medicare beneficiaries nationally were participating in HMOs, but 52 percent were in “risk contracts” (i.e. arrangements that lay out who is responsible for costs exceeding the capitation fee) in Portland, Oregon compared to 17 percent in New York City (Brown and Gold 1999; Iglehart 1999).

The nature of the second social contract has dramatically altered the powerful position of physicians, making them more subject to limitations set by those who fund their services and the demands of those employers who purchase managed care plans. It has reconfigured the power and position of many stakeholders of America’s health care system. But it is also the case that, in the end, this reform has been primarily economic in nature. It has not fundamentally altered the patchwork system of care in the United States nor has it attempted to resolve the great disparities in health and health care access that have always characterized

social class and race/ethnic differences in the United States. The second social contract, to date, has neither been guided by nor addressed the social, moral, and political dilemmas facing the American population. In essence, the current reconfiguration of the American health care system has targeted “financial risk” which now may be shared among the organizations that decide on which package to offer employees, the MCO, physicians, hospitals, and health care organizations that provide services (Gold et al. 1998).

The system that has emerged over the past decade is considerably more complex than in the past with changed and complicated relationships among diverse actors. It is a health care system in flux, but one that is no longer centrally focused on the traditional relationship between patients and physicians, with insurance provision as simply a means to an end. People are now “clients” or “consumers.” Physicians, along with nurses, technicians, physicians assistants, counselors, are now a generic category of “providers.” Limiting the costs of medical care has translated into the growth and use of non-physician providers as a first contact. Often choice by client over their providers is limited and both client and provider must seek permission to engage in certain activities of care (e.g. tests, types of medications, experimental treatments). It is the government and employer “purchasers” of health care services, subject to regulatory constraints, who negotiate with health care plans and managed care organizations (MCOs) about the products and services to be offered to their clients in the health care system. Health plans not only pay for services, but define how and which services are delivered. Access to specialty providers is defined by the benefit plan and subject to a “gatekeeping” role with financial incentives affecting primary care providers. For example, many plans require a visit to a primary care physician before any specialty care can be offered. Providers, themselves, must respond to professional and government regulatory statutes that define the content of their work and, along with utilization review processes, that define standards of “medical necessity.” Many insurance companies, MCOs, and providers have merged, creating local, regional, and sometimes national medical networks designed to achieve both economies of scale and more bargaining power (Thorpe 1997). Finally, while the clients’ support system of family, friends, and consumer groups may act as advocates in their interactions with providers and MCOs, managed care has also shifted much of the burden from the medical care system to the community (Pescosolido and Kronenfeld 1995). Families may be the recipients of services as well as be required to provide greater levels of informal support services as allowable days of hospitalization have decreased and outpatient surgery increased.

The greater complexity of arrangements means that multiple perspectives of many key stakeholders, beyond the traditional physician – patient relationship, must be taken into account in health outcomes, professional norms, and behaviors. The interests of these multiple actors may be compatible, but they are more likely to result in increased tensions and conflicts in the provision of medical care. Physicians, patients, and the courts are struggling with denied request for treatment and grievance procedures following from them (Rodwin 1995). There are also increasing concerns about offering financial incentives to physicians or MCOs that may result in conflicts of interest that can compromise

care. Under a capitated system, for example, physicians have a financial incentive to minimize expensive services, and yet to provide high quality care that may require the use of costly treatments. Referrals to specialty providers may be costly to a provider network, but may offer more appropriate and effective care to clients (Schlesinger and Mechanic 1996).

### EMERGING ISSUES IN THE CONTEMPORARY AMERICAN HEALTH CARE SYSTEM

Coupled with the explosive growth of managed care are serious concerns about the increasing uninsured population, the future control of health expenditures, caring for individuals with chronic illnesses and disabilities under a managed care environment, the changing nature of the medical profession and how new relationships among providers, insurance plans, and consumers will best serve the delivery of care. In moving from a predominantly fee-for-service system controlled by physicians to a corporatized system dominated by financial and industrial interests, McKinlay and Marceau (1998) contend that the federal government has abandoned its role in protecting public health or producing any significant change in America's health care system. Among the major concerns that have arisen, two issues are likely to dominate the policy agenda of both state and federal governments: (1) the impact on Medicaid and Medicare, and (2) the public reaction to experiences in managed care.

*First*, the only groups in America served by government-sponsored insurance programs may be at risk. Medicaid beneficiaries are especially vulnerable to the new financing and delivery arrangements because they are more likely to have special health care needs that require a complex array of social and rehabilitative services in addition to medical treatment (Gold, Sparer, and Chu 1996). The medical necessity criteria used by MCOs have been narrow, failing to encompass the ongoing services and care that persons with chronic illnesses and disabilities may require. Second, there may be a "fraying national safety net" (Zelman 1996), that results in a decrease in care for the uninsured population as Medicaid managed care programs expand. Under managed care, hospitals and other community health centers face reduced revenues from capitated or negotiated fees to cross-subsidize the care for the uninsured. Under prior rate regulation, hospitals received enhanced rates from private insurers to finance charity care. Improving access, but not universally, through managed care plans may paradoxically occur at the expense of the uninsured and the public hospitals that can no longer shift the costs from "profit-making" services to those that routinely serve the uninsured (Gold, Sparer, and Chu 1996). Similarly, at the state government level, policymakers use funding sources for eligibility expansion under their managed care plans that in the past were used to finance uncompensated care.

Further, despite enrollment gains, the Medicare program has also faced 28 percent of their HMO contracts terminating coverage or reducing services in selected unprofitable areas in 1998 with additional withdrawals occurring in 1999 and others expected in 2000 (Laschober et al. 1999). These withdrawals

have been more likely to affect beneficiaries enrolled in for-profit managed care plans, those in HMOs with lower Medicare payment rates, and those whose plans had significant financial losses (Neuman and Langwell 1999). This retrenchment in HMOs serving Medicare beneficiaries results in the elderly and disabled having to switch to another managed care plan or return to a fee-for-service option. In addition to the disruption in their care, beneficiaries face higher premium costs and the loss of some benefits not currently covered by the Medicare program, notably outpatient prescription drugs and vision care, that may not be available in another plan or only with much higher premiums.

Similar to Medicaid beneficiaries, the Medicare population has subgroups whose care is expensive because of chronic illnesses and catastrophic events. A fundamental, yet unresolved issue, is adjusting for health risks for "sicker-than-average" enrollees in order that plans are not unfairly penalized and those plans with healthier enrollees are not too generously reimbursed. At the present time, providers with a good reputation in providing care for the most seriously ill are disadvantaged (i.e. referred to as "unfavorable risk selection") and incur large income losses forcing their withdrawal from managed care plans. With the financial incentive under a capitated fee to minimize services to control costs, quality of care is threatened for the most vulnerable beneficiaries with poor health status and complex needs.

Under the 1997 federal government's Balanced Budget Act (BBA), wide-ranging changes occurred in the Medicare program. Changes made in the payment "methodology" resulted in tighter restraints on rates, beneficiaries were allowed expanded choice in managed health plans, and risk adjustment mechanisms based on health status are to be implemented in 2000. The new payment rates to MCOs and providers are to be based on the "expected relative health status of each enrollee." Because of the "imperfect nature" of risk adjustment, a partial capitation approach has been recommended with both the capitated rate and a payment based on the actual services used. This strategy could reduce risk selection in managed care plans and lessen the incentives to minimize services for the most seriously and chronically ill persons (Newhouse 1998; Wilensky and Newhouse 1999).

*Second*, the rapid growth of managed care over the past decade has not occurred without considerable controversy and consumer backlash evidenced in the courts, the media, and public opinion surveys. A series of class action lawsuits are underway, more than one thousand bills have been introduced in state legislatures and the Congress to address consumer protection, and a presidential commission was created to consider future guidelines for the managed care industry (Blendon et al. 1998). Surveys show that under managed care the public has concerns about the quality of health care, the denial of services when sick, difficulty in getting referrals to specialists, and that health plans value cost control over the best medical care. The public also seems to regard possibly rare events, such as the denial of cancer treatment for a child, as a common occurrence among managed care plans (Blendon et al. 1998). For the first time, at the end of 1999, a plan in one state (New Jersey) announced its intention to cover experimental cancer treatments. Still, most Americans remain relatively satisfied with their own health insurance plan whether it is managed or not

(Blendon et al. 1998). This contradictory finding of individuals being satisfied with their own managed care plan, yet skeptical of managed care generally fits with a long tradition of research that similarly showed Americans as being satisfied with their own physician but critical of the larger system of health care.

## CHALLENGES AND OPPORTUNITIES IN THE AMERICAN HEALTH CARE SYSTEM

Ultimately the success of the current system of health care in the United States will be measured by its ability to achieve cost control while enhancing access, outcomes, and satisfaction among the public. Broadly speaking, most research shows mixed results and few significant differences in how patients fare in managed care compared to the more traditional fee-for-service arrangements. But few studies are currently available which compare various forms and arrangements of managed care to fee-for-service plans, so little is known about which financing strategies work most effectively to ensure quality of care. There are some studies showing that the poor, elderly, and others with chronic illnesses receive less appropriate treatments under managed care (Miller and Luft 1994; Ware et al. 1996). For children and adolescents, there is some indication that managed care may compromise quality of care, but insufficient data exist to be fully certain about its impact. For example, one large study of utilization management in a managed fee-for-service health plan showed that concurrent review reduced inpatient days, but also significantly increased the risk of readmissions within 60 days after discharge (Wickizer, Lessler, and Boyd-Wickizer 1999). Enrollees in HMOs and other managed care plans are more likely to receive preventive services (e.g. mammograms), but the long-term benefits of these services across populations with different risks is unknown. Finally, the expectation that managed care, in general, will lead to better integrated systems and promote continuity of care has yet to be demonstrated.

These concerns set the agenda for three basic challenges for those in the health care system, those who study it, those responsible for the public's health, and those who live under its arrangements. We detail these below.

### CHALLENGE 1: THE RISING UNINSURED POPULATION

One of the most pressing issues facing policy makers, state administrators, and providers today is the rising numbers of uninsured individuals in the United States. The most recent estimate from the Census Bureau was that 44.3 million people or 16.3 percent of the population had no health insurance in 1998, an increase of about one million people since 1997 (United States Department of Commerce 1999). Over the past ten years alone, the number of uninsured has grown by 35 percent or by 11.6 million people.

Using a comparison with national census data, it appears that several characteristics influence the risk of not having health insurance coverage. The number of uninsured children in 1998 was 11.1 million or 15.4 percent of all

children less than 18 years of age (United States Department of Commerce 1999). Individuals aged 18 to 24 years old are more likely than other age groups to lack coverage (30 percent). Those of Hispanic origin have the highest rate of being uninsured (35.3 percent) within racial and ethnic groups. Among the poor, Hispanics also have the highest rates of being uninsured (44 percent). In general, not having insurance declined as educational level increased; but among the poor, no differences in uninsurance rates existed across educational levels. Further, among the poor, workers were less likely to be insured than non-workers creating a growing pool of uninsured workers (i.e. approximately one-half or 47.5 percent of poor, full-time workers in 1998). Workers employed by smaller firms (with fewer than 25 employees) were least likely to be insured (Cooper and Schone 1997; Ginsburg, Gabel, and Hunt 1998; Kronick and Gilmer 1999).

Paradoxically, the uninsured population has increased at a time of fairly robust economic growth and relatively low unemployment levels. However, the sharp decline in the number of Americans with health insurance appears to be linked to increases in health care spending relative to real family income (Custer 1999; Kronick and Gilmer 1999). As personal health care costs consumed a larger portion of personal and family budgets, health insurance premiums and the proportion of premiums paid by employees became less affordable.

The most recent major legislation to address the growing number of uninsured is directed to children, the Children's Health Insurance Program (CHIP), enacted as part of the Balanced Budget Act of 1997. The program is a federal/state government partnership initiative that gives considerable discretion to the states in implementing the program. CHIP provides three options for increasing affordable insurance coverage to low income, uninsured children in working families who earn too much to be insured through the Medicaid program but whose income is insufficient to afford private coverage. The options include designing a new children's health insurance program, expanding the current state Medicaid programs, or introducing a combination of both strategies. Ambiguities in the legislation and conflicting policy agendas at the state level have hampered initial enrollment and implementation, but it is too early to document CHIP's impact (Rosenbaum 1998; Halfon et al. 1999).

## **CHALLENGE 2: DOES MANAGED CARE CONTROL COSTS? HEALTH SPENDING IN A COMPARATIVE PERSPECTIVE**

Given the major transformations in the American health care sector during the past decade, a key indicator of success is how well health expenditures have been controlled. An unprecedented slowing in the growth of health expenditures occurred between 1993 and 1997 in the United States. Health care's share of the gross domestic product (GDP) fluctuated between 13.5 and 13.7 percent, an unexpected plateau given the previous trend and predictions at the start of the decade (Smith et al. 1999). The decline in health expenditure growth as a share of GDP was also accompanied by increases in the GDP.

Between 1993 and 1997 the average annual growth in health spending was 3.3 percent for the private sector and 7.1 percent for public spending. For the Medicaid program the average annual growth was limited to 5.6 percent, a record decline since 1960 and a sharp comparison to the 21.7 percent steep growth between 1990 and 1993. For Medicare, only a slight decline in average annual growth (9.6 percent) occurred between 1993 and 1997 compared to the 10.1 percent growth in the three previous years. Tighter constraints on Medicare payment rates associated with the Balanced Budget Act of 1997 may result in sharper, recent declines in the rate of growth of spending in the Medicare program (Smith et al. 1999).

All industrialized countries have encountered escalating health care costs, and various forms of rationing, however openly discussed, have helped to slow health expenditure growth cross-nationally (Mechanic 1999). The percent of GDP spent on health care between 1990 and 1997 appeared to be relatively stable cross-nationally, even declining in 10 of the 29 countries that are members of the Organization for Economic Cooperation and Development (OECD). The United States still continues to spend a substantially greater share of its GDP on health than the median (7.5 percent) for the OECD countries (OECD 1998). The historical trend showed the percent of GDP spent on health care in the United States increasing from 5.2 percent to 13.5 percent from 1960 to 1997 compared to the median levels of 3.8 percent to 7.5 percent in the OECD countries. Further, in comparison with these countries, per capita health spending also continued to diverge substantially between the United States and the OECD countries during that same time period (i.e. from \$141 to \$3,925 compared to the median increase of \$66 to \$1,728).

The question at the center of the current controversy is whether managed care has resulted in a one time reduction in the growth of health expenditures or whether some permanent control of spending can be sustained. Some analysts project that the slowing of health spending will not continue as national health expenditures are projected to reach \$2.2 trillion (16.2 percent of the GDP) by 2008 (Smith et al. 1998). Enrollment in less restricted forms of managed care; a loosening of constraints on access to treatments and services under managed care given consumer backlash and patient protection legislation; appropriate risk adjustment for seriously and chronically ill individuals; the aging of the population and increasing technological innovation stand at the heart of these projections. However, the growth of managed care in the Medicaid and Medicare programs should also moderate the growth of health spending to some extent given payment reductions from the Balanced Budget Act.

### **CHALLENGE 3: HOW WILL MANAGED CARE AFFECT THE PHYSICIAN–PATIENT RELATIONSHIP?**

As the organization and financing of health care have changed in the United States, so has the practice of medicine been transformed in significant ways. Starr (1982) predicted that the coming of corporate medicine and the financial behavior of large corporations in the 1980s would threaten the autonomy and

power of the medical profession. As figure 10.1 indicates, the relative power of physicians has declined in the era of managed care but we have yet to know whether, how, and if this will level off, be reversed, or continue downward (see dotted lines). The continuing frustration and dissatisfaction among physicians about their loss of authority in clinical decision-making, the ethical dilemmas faced in balancing financial incentives with good care, and their inability to refer to specialists and prescribe optimal drugs are invariably associated with the expansive presence of managed care in medical practices (Grumbach et al. 1998; Hadley et al. 1999).

The significant change has not been the introduction of financial considerations in client/physician relationships. Financial incentives have always existed for physicians in their medical work even beyond the early forms of pre-paid practices where physicians were paid a salary or a capitated fee to provide necessary medical services. Though the medical profession has portrayed itself as having erected a wall between money and medicine, and the professional ideology has been that “doctors’ decisions and recommendations were dictated by the best interests of the patient and by science and distinctly not by the pecuniary interests of the doctor” (Stone 1997), the reality of medical practice has been much more complicated and different from this idealized conception of professional practice.

The fee-for-service payment system prompted physicians and other practitioners to provide more services for their clients without the pressing consideration of their cost-effectiveness nor financial risk to themselves. Under managed care arrangements, the financial incentives are reversed. Physicians and other providers are to care for their clients with fewer services to attain high quality care. But the more significant changes in the practice of medicine have been in the social and cultural depiction of the physician and the medical profession where physicians are seen as “subordinated to financiers” (Stone 1997).

In essence, the explicit linking of the financing and delivery of services under managed care has changed the locus of decision-making in medical practice. Representatives in organizations beyond the physician dictate the process of referrals, certify admission and discharge decisions, profile the services that physicians use, and recommend types of services. Managed care organizations establish the networks in which physicians operate and to which clients seek care. Treatment guidelines have been established in an effort to standardize care and reduce variations in practice that can limit the independent decision-making of physicians. Physicians may be dropped from networks and health plans if they are not performing to standards set by the MCO. Some treatments that were previously performed by physicians are now delegated to other health professionals. All of these changes remove the power over medical care from the physician and transfer it to others.

The call for a “responsive medical professionalism” (Frankford and Konrad 1998) brings attention to the potential of physicians to recapture levels of leadership, albeit in different ways than under the era of professional dominance. A united effort between physicians and community programs can lessen the long-standing resistance of physicians to public health efforts and serve the profession, the public, and MCOs (Mechanic 1998). Further, since one of the

most troublesome issues under managed care is the potential for the denial of treatment, physicians may become effective advocates for their clients. In representing their clients' interests to MCOs and others, physicians can preserve the trust that is an essential component of the physician – patient relationship (Mechanic and Schlesinger 1996). However, the shift to managed care requires that these new organizations *also* inspire trust and “prove” their trustworthiness, in part, by assuring their enrollees that they will not interfere with the trust that patients can put in their physicians (Flood 1998; Sleeper et al. 1998). In a national study of utilization review firms, about one-third of the firms reported successful appeal rates of 2 percent or less which might suggest that this low rate results, at least in part, from physicians failing to take a strong advocacy role (Schlesinger, Gray, and Perreira 1997).

### CONCLUSION: WHERE TO NOW?

The now dominant payment system of managed care in the United States continues to expand, and yet considerable flux exists in its various organizational and financial arrangements. Changes are ongoing as evidenced by the recent decision by the United Health Group (UHG), one of the nation's largest MCOs, to return decision-making about admissions and other treatments to physicians. That is, upon documenting that utilization review was costing more than it saved, they eliminated the practice and dismissed employees engaged in that process. Prior approval about certain treatment decisions will no longer be necessary. While UHG will continue to monitor physicians' use of hospitalization and other services, this landmark decision represents the return of some discretion to physicians (New York Times 1999). Aside from the financial issue, this decision responds to patients' rights laws, the potential of litigation, and physician dissatisfaction. These forces are shaping the American medical care system of the future.

From a comparative perspective the United States, as well as other countries with very different health care systems, continue to search for strategies to contain costs, manage the care for chronic illnesses and disabilities, and develop new and better services. A study of reform in seventeen OECD countries noted the “emerging convergence” of strategies “pioneered earlier in other countries” (OECD 1998). The Diagnostic Related Group (DRG) prospective payment methodology has been implemented in several Australian state governments to decrease inpatient length of stay (Davis 1999). Canada has adopted model community-based programs for caring for the seriously mentally ill that have been used in the United States (Rochefort and Goering 1998). Britain considered, but found unworkable, a plan to compile a list of procedures that would not be covered by the National Health Service (Klein 1994). In the United States, physician associations are negotiating capitated managed care contracts not unlike the general practitioner fundholding in Great Britain and the physician groups in New Zealand who plan to operate under risk-based contracts (Davis 1999). Although the various health care systems operate under different organizing principles and evolve from unique political and social cultures, economic

climates, and the roles of the medical profession, many common problems exist cross-nationally. The American health care system can benefit greatly from sharing strategies and learning from what is happening beyond its borders.

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