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CHAPTER

2

Where Are We?

As more of us are being told we are sick, fewer of us are being told we are well. People need to think about the benefits and risks of increased diagnosis: the fundamental question they face is whether or not to become a patient (Welch et al., 2007, p. 2).

American health care is always in a state of flux as new scientific knowledge and clinical experience change our prescriptions for illness and wellness. As a society, we respond by changing the ways health care is delivered. The way we choose to provide those services increasingly impacts many aspects of our society, from health status to employment to economics to recreation to professional concerns to our perceptions of our own well-being. This chapter reviews the current status of the U.S. health care system from three points of view:

- Current outcomes and costs
- Industrializing structures for delivery
- Medicalization of our society

CURRENT OUTCOMES AND COSTS

There is a growing consensus that not all is well with U.S. health care. Medicare trust funds are forecast to disappear over the next decade. Health care expenditures are projected to rise to around 20% of the gross domestic product (GDP) by 2015 (Borger et al., 2006). More and more small companies do not provide health benefits, whereas larger companies are shifting significant portions of health insurance costs onto employees and retirees. Politicians on both sides of the aisle are calling for change (Clinton,

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2004; Gingrich, 2003; Gingrich & Kennedy, 2004). At the same time, health professionals' control over health care is being threatened by outsiders calling for more reliance on government programs, more consumer-centered care, or both. Each recommendation has the potential to change markedly the roles and status of health care professionals.

High Comparative Costs and Low Comparative Outcomes

The United States spends far more on health care per capita and as a percentage of GDP than other developed countries, but does not seem to be much better off for it. **Table 2-1** illustrates this by comparing a dozen countries on these two resource input dimensions and on two outcome dimensions, male life expectancy at birth and infant mortality rates. Similar rankings result when looking at a number of other outcome variables. The health care systems of these other countries offer virtually universal coverage but range from mostly private insurance to a national health service. The high U.S. costs and low U.S. outcomes do not seem to be associated with any one specific organizational or financing approach. Yet that is about all that experts seem to agree on.

Consumers in six countries (Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States), especially those experiencing illness, were asked to rate their experience in terms of several factors (Davis et al., 2006; Frogner & Anderson, 2006):

- Patient safety: Perceived error rates were highest in the United States; laboratory errors highest in Canada.
- Effectiveness: The United States ranked best overall and best on preventive care and care for the chronically ill.
- Patient-centeredness: The United States ranked last in almost all respects.
- Timeliness of care: The United States and Germany were quick to receive specialist and elective surgical care, but the United States and Canada had the longest waits for primary care visits.
- Efficiency: U.S. patients reported use of emergency departments because a primary care provider was not available and also reported unavailability of medical records and test results and duplication of tests.
- Equity: The United States lagged in terms of perceived inequities for both poor and average income respondents.

TABLE 2-1 Selected International Comparisons of Health Inputs and Outcomes

	Health Expenditures as % of Gross Domestic Product 2004	Health Expenditures in US Dollars per Capita 2004	Practicing MDs per 1,000 2004	Inpatient and Acute Care Beds per 1,000 2004	Population Life Expectancy at Birth 2003 2003	Infant Deaths Per 1,000 2004
United States	15.3	\$6,120	2.4	2.8	77.5	6.9*
Switzerland	11.6	4,077	3	3.8	80.6	4.2
Canada	9.9	3,165	2.1	3*	79.9	5.3*
France	10.5	3,159	3.4	3.8	79.4	3.9
Australia	9.6	3,120	2.6*	3.8	80.3	4.7
Belgium	10.1*	3,044*	4	4.8	78.8	4.3
Germany	10.6	3,043	3.4	6.4	78.6	4.1
The Netherlands	7.7	3,041	3.6	3.3	78.6	4.1
Sweden	9.1	2,825	2.9*	2.2	80.2	3.1
United Kingdom	8.1*	2,508	2.3	3.6	78.5	5.3
Japan	8.0	2,249	2	8.4	81.8	2.8

* 2003 data
 UK expenditure data is for the United Kingdom, but life expectancy and infant mortality is for England and Wales.
 Source: OECD Health Data 2006. Copyright OECD 2006.

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The number of physician visits and hospital days per capita was lower in the United States than the Organisation for Economic Co-operation and Development median, and input prices for health care worker wages, hospital supplies, and drugs were much higher in the United States. Anderson et al. (2003) noted, "U.S. policy makers need to reflect on what Americans are getting for their greater health care spending." They conclude, "It's the prices, stupid." Administrative costs for our system, estimated as high as 30% of overall health care costs, are also high when compared with the rest of the world (Woolhandler et al., 2003).

Overinsurance and Overutilization Arguments

Cannon and Tanner (2005) argued that the basic American problem is overutilization and would explain away comparative international differences because:

- Data definitions and collection methods are not comparable
- Health care is partly a consumption good that normally rises with income
- The U.S. infant mortality is increased by our efforts to save low-birthweight infants that would be stillborn elsewhere
- There is little proven relationship between longevity and health care expenditures
- Our cost figures include the costs of medical research and innovation that are not incurred elsewhere.

They argue that disease-specific data are a better measure. On the mortality-to-incidence ratios for AIDS, breast cancer, colon cancer, and breast cancer, for example, the U.S. system looks very good.

Alan R. Hubbard (2006), assistant to the president for economic policy and director of the National Economic Council in the George W. Bush Administration, opened an April 3 *New York Times* Op-Ed column entitled "The Health of a Nation" by noting that private health care premiums had risen 73% in the most recent 5 years. He observed the following:

Health care is expensive because the vast majority of American consumers use it as if it were free. Health insurance policies with low deductibles insulate people from the cost of the medical care they use—so much so that they often do not even ask for prices (p. A17).

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Ironically, relevant prices for major interventions are not usually available to consumers, even when they do ask for them.

A similar point of view has been expressed by R. Glenn Hubbard (2006), former chair of the Council of Economic Advisers, who saw rising health care costs as one of the biggest threats to the nation's future prosperity. "Despite our national investment of \$1.9 trillion, we get highly inefficient care—spectacular in certain respects, but rife with error, disorganized, and unaffordable or inaccessible to many." He proposed that all health care costs be individual (rather than corporate) tax deductions. He believed this would accelerate the use of health savings accounts (HSAs). To support this, he argued for uniform national health insurance standards and open national health insurance markets. He used the banking reforms that allowed multistate banking as a positive parallel example and disagreed with the President's Advisory Panel on Tax Reform, which had recommended a cap on the tax deductibility of employer purchases of health insurance. That recommendation was aimed at motivating employers to offer only basic, more affordable plans. He recommended giving consumers more choices of providers, greater use of health information technology, and medical liability law reforms (Cogan et al., 2005).

If the United States spends more on health care than any other nation without topnotch results, does that mean we are spending too much? The overspending can be in price or the quantity of services provided, probably some of both. U.S. health care wages are the highest in the world. Research also shows that an increased supply of health professionals leads to more utilization, some of which may be unwarranted, yet attempts to restrict the supply of specialists using licensing systems have led to charges of illegal restraint of trade. Like health care, professional education is a confusing mixture of a public good and a matter of personal consumption. There are many alternative ways—certificate of need regulations, for example—to try to control overuse or underuse by trying to influence the supply or demand for health care services.

Cutler et al. (2006) concluded that if 50% of the increase in longevity between 1960 and 2000 is attributable to our increased medical care expenditures, we have gotten an acceptable return on our money. They suggest that the cost of a life year gained was reasonable, especially for those less than 65 years old. They caution, however, that the returns from added expenditures, especially for older people, have diminished over time.



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Continued High Cost Inflation Rates

The Office of the Actuary, Centers for Medicare and Medicaid Services, and the Department of Health and Human Services are responsible for providing estimates used to assess the financial viability of those two huge government programs. Its report, *National Health Care Expenditures Projections: 2005–2015*, concludes that health care spending is likely to outstrip economic growth (GDP growth) throughout the next decade. Although there will be ups and down because of specific interventions such as Medicare Part D drug coverage, there will be little affect on aggregate health care spending, which will grow at a rate 2% higher than the overall economy. By 2015, it forecasts, national expenditures on health care will reach 20% of the GDP. The government share will gradually increase, leaving health expenditures financed about equally between government and private sources (Borger et al., 2006). **Table 2-2** summarizes historical and forecast data on health expenditures in terms of dollars, dollars per capita, percentage of GDP, and price deflators for both health expenditures and GDP.

Except for the period from 1995 to 1998, the inflation rate for health care costs and health insurance premiums has been well above the inflation rate of the consumer price index and of workers' earnings for at least the last 18 years, as **Figure 2-1** illustrates. No wonder workers and employers feel squeezed by the rising costs of health care.

Disappearing Health Benefits

Employee health benefits (75% paid by employers, including government employers, in 2003) are disappearing at an increasing rate. Between 2000 and 2004, the percentage of insured nonelder people (0 to 64 years old) in employment-based health programs dropped 5% to 61%. In Indiana, Missouri, South Carolina, and Wisconsin during that period, the percentage dropped 9% to 10% (*State Health Facts*, 2005).

Official federal policy has been to encourage employees to participate in HSAs. The theory is that workers will choose health insurance coverage with high deductibles and coinsurance and will put the premium money saved into tax-exempt (income and interest) savings accounts that could be used in case of heavy expenses, for retirement income, or for other uses. These plans have gotten off the ground slowly because employers have been concerned about the problem of *adverse selection*, namely that younger, healthier employees would choose the HSA option, leaving employees who are at



TABLE 2-2 U.S. National Health Expenditures (NHE), Share of GDP and Price Deflators, Selected Calendar Years 2000–2015

NHE Spending Category (\$ billion)	2000	2005*	2007*	2010*	2015*
Total	1358.5	2016.0	2325.7	2887.3	4043.6
Physician and Clinical Services	288.6	429.9	496.5	610.7	849.8
Other Personal Health Care	37.1	58.1	67.8	89.2	134.8
Dental Services	62.0	87.4	101.3	124.9	167.3
Other Professional Services	39.1	55.8	64.0	78.5	109.4
Hospital Care	417.0	616.1	709.1	882.4	1230.9
Nursing Homes, Home Health Care	125.8	170.6	192.2	232.8	320.5
NHE Per Capita (\$)	\$4,729	\$6,683	\$7,376	\$9,173	\$12,357
NHE as % of GDP	13.8%	16.2%	16.8%	18.0%	20.0%
HCFA Implicit Medical Price Deflator (2000 base)	1.000	1.205	1.248	1.453	1.752
GDP Implicit Price Deflator (2000 base)	1.000	1.119	1.171	1.260	1.298

*Projected

Source: Author created. Data from CMS accessed 02/05/06 at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj.2005.pdf>

higher risk drawing from a different and smaller risk pool. Early returns from postal employees showed that the employees signing up for HSAs were much younger than those who chose or kept traditional coverage.

Some employers are also concerned about the “portability” feature of HSAs. If the worker leaves, the premium dollar saved goes with the worker rather than staying to help cover the remaining employees’ health insurance claims. Many employers see health benefits as a cost necessary to attract good employees and reduce employee turnover. Portability can run counter to that objective (Freudenheim, 2006a).



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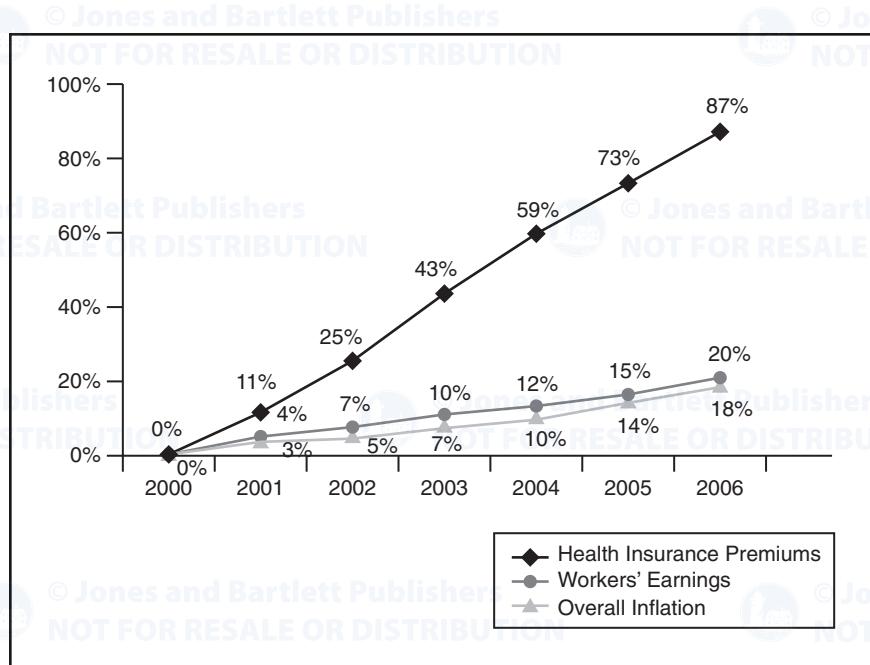


FIGURE 2-1 Cumulative Changes in Health Insurance Premiums, Overall Inflation, and Workers' Earnings, 2000–2006

Source: "Employer Health Benefits 2006 Annual Survey—Chartpack," (7451), The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, September 2006.

A MORE SYSTEMATIC EVALUATION

Taking stock of where we are means that we must evaluate our health care system systematically according to a number of criteria—cost, quality, outcomes, and equity. In 1980, Donabedian suggested the following classification when evaluating quality of care:

- Access
- Technical management
- Management of interpersonal relationships
- Continuity of care.

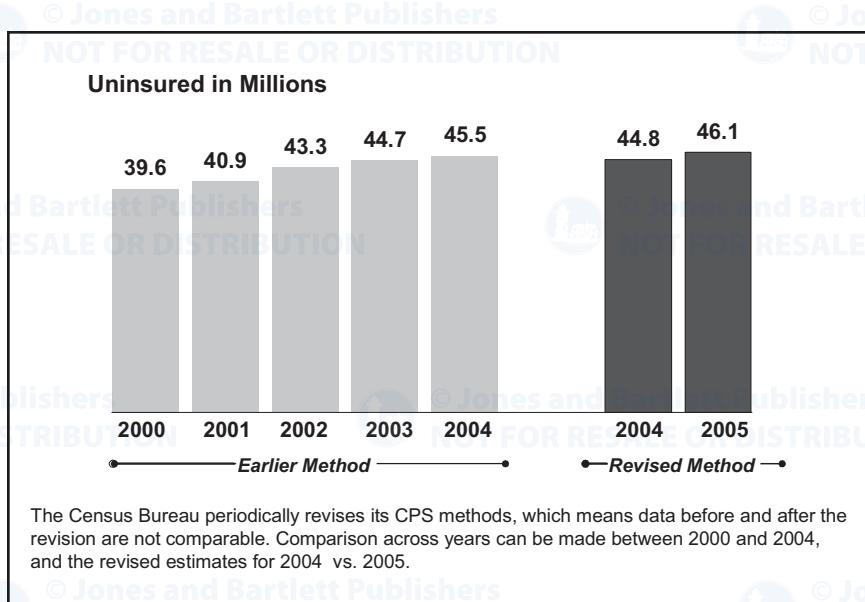
One could easily amplify these categories, but they are a useful starting point (McLaughlin, 1998). All of these factors involve tradeoffs with the cost of care and with one another.

Access and Availability

If you were in a serious auto accident, you would want the ambulance there fast to stabilize you and transport you to a trauma center. You would want that ambulance *available*. If we are in danger, we supposedly are guaranteed *access*. If the situation is life threatening and the hospital participates in Medicare or Medicaid, it must take us regardless of ability to pay. For less serious situations, for emergent medical conditions, and for prevention, there are no such guarantees. The local capacity to care for us and the ability to ensure that payment will be made (either through insurance coverage or out of pocket) are both necessary conditions of obtaining care. Unfortunately, a significant proportion of our population lacks access, availability, or both. **Figure 2-2** shows the number of nonolder U.S. residents lacking health insurance coverage from 2000 through 2004. That number has risen from more than 39 million to more than 46 million. Although federal safety net spending, including Medicare, has increased 15% over the same period, spending in real dollar terms has expanded only slightly because of a 14% inflation in health care costs. Spending has failed to adjust for the additional uninsured, most of whom are young and poor (Holahan & Cook, 2005; Kaiser Commission on Medicaid, 2005). As employers shift more and more of the costs of health care to their employees or to public sector programs and as Congress and the Administration try to reduce budget deficits by cutting “entitlement programs,” access problems mount.

There are numerous other perceived access problems. Although coverage for children has improved and the older population receives considerable benefits from Medicare and Medicaid, the working population has become worse off. Even before employer coverage decreased, the biggest access problem was with the *working poor*—those who earn too much to qualify for Medicaid but have little or no access to employer-subsidized health insurance and are unable to pay their share of the costs, even when employment-based insurance is available. Even under subsidized programs such as the Maine and Massachusetts programs, there has been slow enrollment by the working poor (Belluck, 2007).

Many improvements in coverage for children came with the State Children’s Health Insurance Program in 1997 and have occurred despite reduced private insurance coverage for children. Racial disparities in insurance coverage remain, with the highest rate of uninsurance occurring among Hispanic children (21% in 2004) and African American children (13.4% in 2004). Overall, 11.3% of U.S. children remained uninsured

32 CHAPTER 2 WHERE ARE WE?**FIGURE 2-2 Number of Non-Elderly Americans Uninsured 2000–2005**

Source: “Covering the Uninsured: Growing Need, Strained Resources” (#7429-02), The Henry J. Kaiser Family Foundation, January 2007.

throughout 2004, but 25.6% were uninsured at least part of the year. Children uninsured for all or part of the year were more than twice as likely to receive no medical care that year (SHADAC, 2006).

Meanwhile, racial discrepancies still abound. Why are black infants as much as three times as likely to die as white infants in many states? Why was a child between 1 and 14 years old about three times as likely to die in 2003 in Alaska, Wyoming, and South Dakota as a child in New Hampshire, Massachusetts, or Rhode Island and more than twice as likely to die in Arkansas, Alabama, Oklahoma, New Mexico, and Mississippi? Why in the same year was the heart disease age-adjusted death rate in Mississippi and Oklahoma virtually twice what it was in Minnesota and some 30% above the national average (State Health Facts, 2006, 2007)?

One hopeful sign is the report from Centers for Disease Control and Prevention that there was no statistically significant difference in the vaccination rate of children 19 to 35 months in 2005, whether black, white, Hispanic, or Asian/Pacific Islander (Centers for Disease Control and Prevention, 2006).

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Access—Structure

The United States stacks up pretty well in the developed world in terms of the total supply of services available, but services are distributed very unevenly. This is, however, a problem almost everywhere in the world. Urban centers attract trained personnel with job opportunities and educational and cultural opportunities for their families. Rural areas everywhere tend to lack personnel and facilities. That is why in 2004 a third of U.S. patients could see a primary care physician the same day; however, a sixth had to wait 6 or more days, and 16% reported going to the emergency room for a condition that could have been treated elsewhere if a regular doctor or source of care was available (Schoen et al., 2004). Over time, this rural problem has lessened as the supply has increased and primary care physicians and even some specialists have moved to smaller communities in response to market forces (Rosenthal et al., 2005).

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Access—Process

For U.S. respondents, the limitations on access were perceived primarily as financial. When asked in 2001 about prescriptions not filled, doctor visits needed but not made, and treatments, tests, or follow-ups missed, all because of costs and problems paying medical bills, 35% to 40% of U.S. respondents with incomes below average reported experiencing such problems, almost double the rates in Australia, Canada, and New Zealand and six to nine times as large a proportion as in the United Kingdom. For the U.S. uninsured, the rate exceeded 50%. More than half of below-average income U.S. respondents and a quarter of those with above-average income were delaying dental work because of the cost; however, these rates were also high in all of the five countries except the United Kingdom (Blendon et al., 2002). People everywhere seem to use every reason possible to avoid going to dentist.

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Access—Outcomes

Americans report that the barriers to health care access are predominantly economic. Morbidity in the nonolder population is concentrated in the lower socioeconomic strata. Certainly, high morbidity contributes to loss of income, but that effect is small compared with the effects of social status on access to care. A study of white, middle-class males in the United States and the United Kingdom showed that the Americans considered themselves less healthy, and thus, the problems apparently are not confined to one socioeconomic class (Banks et al., 2006).



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Technical Management

The heaviest efforts to improve U.S. care have focused on the processes of care delivery. The 100K Lives campaign (see **Case 11-1**) was aimed at implementing effective measures that improve patient survival and quality of life. Still, our care system is wasteful in many ways, inconsistent in treatment and outcomes, and focused on revenue maximization rather than delivering maximum quality at a reasonable cost.

Technical Management—Structure

In the United States, most health professionals are well trained. Their credentials are carefully checked by the institutions where they work, and their licensing boards and certifying bodies require some continuing professional education. Entry by foreign physicians is relatively tightly controlled, with requirements for additional postgraduate training and testing before practicing; however, the results of this process still show providers and institutions to be poorly distributed. Poor states, rural areas, inner cities, and areas with high minority concentrations and low incomes have very different health care utilization rates from the more privileged areas of the country.

Technical Management—Process

Most systems to assure quality of care focus on the process of care delivery. They concentrate on the variability in treatment approaches among practices, among various areas of the country, and on failure to implement evidence-based practices. This focus on specific care processes, supported by measurement and reporting systems such as National Committee for Quality Assurance's Health Plan Employer Data and Information Set system, has improved the rate of conformance in the areas measured, but there is still a long way to go.

One indicator of poor resource allocation and questionable quality is variability in medical care delivery from one area to another. Wennberg et al. (2002) showed, for example, that Medicare spent twice as much per enrollee in Miami than in Minneapolis without any apparent improvement in results. Miami patients might be sicker to start with, but case mix differences are unlikely to justify a doubling of average costs in a fee-for-service program. They suggest that there is relatively little variability where the medical evidence is strong and much more where the evidence is less so, such as with hospital-based care during the last 6 months of life.

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Estimates of waste in the U.S. health care system run to 30% to 40% (Milstein, 2006). Not only are tests duplicated and medical records unavailable, but there is little attempt to optimize processes and coordinate activities to maximize the use of personnel. Each specialty and department tends to operate to meet its own preferences and maximize revenue, rather than to improve system efficiency. Staff departments assigned to improve processes have fallen by the wayside during cost-cutting drives (Sahney, 1993).

Technical Management—Outcomes

Much attention has been paid to medical error rates in recent years. The 2000 Institute of Medicine report *To Err Is Human* and the follow-up report *Crossing the Quality Chasm* focused the attention of the government and a reluctant medical profession on this problem (IOM, 2000, 2001). The Leapfrog Group, an employer-oriented organization, has suggested several measures that are in the process of being implemented, including computerized physician order entry and widespread use of intensive-care hospitalists. The experience with the 100K Lives program illustrates the magnitude of the improvements that can be achieved.

Management of Interpersonal Relationships

One area the American public has emphasized has been the importance of a relationship with a personal physician. Members of the public do not want to be told whom they may or may not see. They will even pay extra to have the relationships that they think suits their needs.

Management of Interpersonal Relationships—Structure

Americans rebelled at the idea that their health maintenance organizations (HMOs) could interfere with their existing relationships with their personal physicians. They clearly value that relationship where it exists; however, a substantial number of Americans report financial and spatial access problems and use less personal services such as emergency rooms or urgent care centers. Even those with relatively poor access to care triage their own care considerably, driving greater distances for more sophisticated care, if they believe a problem may be serious.

Management of Interpersonal Relationships—Process

Much of the expressed dissatisfaction with interpersonal relationships in U.S. health care has to do with the brevity of encounters. Patients feel rushed by

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their primary care providers, who are under pressure to see more patients as preferred provider contracts and government discount pricing have eroded income per visit. This weakens patients' confidence that their providers have their welfare at heart. Clinically, it means many emotionally fraught issues—issues that used to be addressed when the provider listened carefully for the “by the way” comment toward the apparent end of the visit or at what some counselors call the “doorknob moment”—are no longer addressed.

Management of Interpersonal Relationships—Outcome

Increasingly, payers evaluate providers on the basis of questionnaires that measure consumers' satisfaction with the interpersonal aspects of their encounters. For example, the Hospital CAPS 27-Item Survey Instrument asks questions such as these:

- During this hospital stay, how often did nurses and doctors treat you with courtesy and respect?
- During this hospital stay, how often did doctors and nurses listen carefully to you?
- During this hospital stay, did doctors, nurses, or other hospital staff talk to you about whether you would have the help you needed when you left the hospital?

Other Factors to Consider

Donabedian's structure was developed ahead of most of our concerns about costs and at a time when the health community shared a more homogeneous value system; therefore, we must consider the additional factors relating to costs and values, especially notions of equity in health care delivery. The values issues will be addressed in subsequent chapters.

Costs—Structure

The unit costs of health care inputs are high in the United States, especially professional salaries, drugs prices, and the costs other medical supplies and devices. This is leading to a burgeoning international trade in health care. Costs would go even higher if unmet needs were addressed. There is a shortage almost everywhere of registered nurses, which may be constraining some hospital use. There are huge untapped needs in the field of child psychiatry and community psychiatry. People report being constrained on their consumption of psychotherapy because of the limi-

tations on insurance reimbursement. We also know the poor do not see physicians and other providers as much as those with adequate insurance, although that can beg the question of whether the problem is overutilization by those with health insurance or underutilization by the poor or both. Given that a significant proportion of the poor are poor because of their health status, one would expect higher utilization on their part if they had sufficient insurance.

Costs—Process

Variability in processes is evident through differences in costs across areas and institutions. A substantial amount of gaming goes on between providers and the payment system. Where the system will not pay for a diagnosis and an office procedure on the same visit, a dermatologist may schedule two visits. If the patient needs multiple minor procedures but the payer will not pay for each one separately, there again may be as many visits as procedures, wasting patient time and payer money. Kleinke (2005) reported that the three large independent clinical laboratory firms have failed to adopt a common reporting system that is available to them because they do not want to support electronic data interchange that might avoid tens of billions of dollars in duplicate laboratory tests.

In an industry rife with dirty little secrets, this is health care's dirtiest: Bad quality is good for business and the surest road to bad quality is bad information or no information. The various IT systems out there are expensive to buy, implement, and train staff to use, but this expense pales in comparison to all of the pricey and billable complications those systems would prevent.... As Walker et al. pointed out with this agonizing understatement, "Those who depend in subtle ways on redundancy could find such change costly." This is health care's second-dirtiest little secret: One organization's unnecessary medical product or service is another's revenue source (Kleinke, 2005, pp. 1250–1252).

Costs—Outcome

Earlier sections of this chapter provided information on health costs and outcomes for the United States compared with other developed nations. They also noted that perceived cost and inability to pay were major impediments to obtaining needed health care. The magnitude of those costs is

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also motivating major corporations to dismantle their employment-based insurance plans for employees, families, and retirees and keeping many smaller employers from offering health care plans to their staff.

COMPLEXITY

One barrier to access may be the complexity of publicly financed programs. Some programs are available only to those who are below the federal poverty level (FPL), whereas other specific state programs can enroll families up to 300% of FPL. Programs also have requirements for cost-sharing with premiums, co-payments, and deductibles. For example, the Medicaid working group of the National Governors' Association has suggested that the states be allowed to impose and enforce cost sharing provisions up to 5% of family income for those below 150% of FPL and 7.5% for those above 150% of FPL. Take a look at the implications of this as outlined in **Table 2-3** for a minimum wage worker. First, note how complex it all is. Assume that a worker at a minimum wage job has the alternative of either accepting the typical employer plan with payroll deductible annual premium of \$610 for personal coverage only and \$2,713 for family coverage (approximately the national average). The latter is over 25% of one worker's annual wages for the family. Even with two minimum wage workers in the family, the premium percentage is still large. The worker is likely to go without family coverage in just about every conceivable scenario unless there is high-cost chronic illness in the family. The individual worker is not likely to pay the \$610 premium either, as the \$536 cost share is less than the premium. Table 2-3 oversimplifies things considerably. A person changing employers may experience gaps in coverage or may lose benefits if he or she works less than full time. There are waiting periods for new employees to become eligible, and complex descriptions of coverage that can be off-putting to many employees. Usually the company human resources department tries to help out with the enrollment process, but the economics of the process can only be understood in retrospect by most individuals. After all, very few of us plan to get sick.

The result is the following snapshot of insurance coverage as of 2004: employment-based insurance coverage, 174 million; individually purchased coverage, 27 million; Medicare coverage, 40 million; Medicaid coverage, 38 million; and uninsured, 46 million.

TABLE 2-3 Example Based on the 2005 National Governors Association Working Group Proposal

Worker's Income	One Earner	Two Earners
Single Worker Income 100% of Poverty Level	\$ 9,570	
Minimum Wage One Full-time Worker (\$5.15/hr.)	10,712	
Family of Four Income 100% of Poverty Level	19,350	
Two Minimum Wage Workers		\$21,424
Premium in Employment-Based Programs		
Total Annual Premium Single Worker	\$4,024	8,024
Total Annual Premium Family Coverage	10,880	10,880
Employee Annual Premium Single Worker	610	
Employee Annual Premium Family Coverage	2,713	2,713
Cost of Care—Medical Loss Ratio of 85%		
Single Worker Premium	\$3,420	
Family Coverage	9,248	9,248
Cap on Cost Sharing Requirement 5% of Income	536	
Cap on Cost Sharing Requirement 7.5% of Income		1,607

Compromise and Complexity

The political give and take that has marked the development of health care policy in the United States has left us with incredible financial complexity in our health system. **Table 2-4** shows the primary federally financed programs, each of which has its own often-changing sets of regulations.

In the Medicaid program, we have at least 52 distinct governmental health care systems, one for each state, Puerto Rico, and the Virgin Islands.



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There are more than 1,100 current waivers of the rules granted to individual state programs to allow expanded coverage and use of managed care approaches. Each state system has its own reimbursement rate, the Federal Medicaid Assistance Percentage, which is based on a complex formula involving income levels in the state. For 2006, this ranged from 50% federal payment in a number of wealthier states to 76% in Mississippi and 73.77% in Arkansas (**Table 2-5**).

Whether a person is eligible for Medicaid depends on the state that he or she lives in, as income eligibility and some coverages vary by state. For example, a pregnant woman may be covered in one state if her family income is at or below 133% of the FPL or 150% in some others, or 166% or 185% or 200% or 250% or 275%, depending on where she is enrolled (State Health Facts, 2007). Those covered by Medicaid may include the following:

- Categorically needy
 - Families receiving Aid to Families with Dependent Children
 - Pregnant women and children under 6 years old with family income up to 133% of the FPL
 - Children ages 6 to 19 with family or caretaker incomes up to 100% of the FPL
 - Supplemental Security Income (SSI) recipients or aged, blind, and disabled persons whose requirements are more restrictive than SSI
 - Individuals and couples living in medical institutions who have monthly income up to 300% of the SSI income standard
- Medically needy individuals whose income or assets exceed those of the categorically needy
 - If a program exists, it must cover pregnant women through 60-day postpartum period, children under 18, certain newborns for first year, and certain protected blind persons.
 - The program has the option of covering:
 - Selected groups of full-time students between 18 and 21 years old
 - Caretakers (relatives and legal guardians) living with children
 - Aged persons over 65 years old
 - Blind persons
 - Disabled persons meeting state or SSI standards
 - Persons who would be eligible if they were not enrolled in an HMO

**TABLE 2-4 Major Federal Programs**

Medicaid is health insurance for the poor and disabled. It can cover pretty much all their medical bills, including nursing home care and drugs. Eligibility levels and services vary by state.

Medicare is health insurance for those over 65, some disabled younger than 65, and individuals with end-stage renal failure. It consists of three programs:

- **Part A** is hospital insurance and is covered by payroll taxes. In addition, it may cover hospice care, some home health care, and brief post-hospitalization nursing home care.
- **Part B** is medical insurance for which the premium due is deducted from one's Social Security check. It pays parts of the physician's and other providers' fees, home health care, outpatient services, medically necessary physical and occupational therapy, and some home health services.
- **Part D** is insurance for prescription drugs coverage. Most participants pay a monthly premium to a private insurer for coverage under a plan-specific formulary.

Dual eligibles are poor disabled or elderly persons eligible for both Medicare and Medicaid. This population accounts for 18% and 16% of the respective beneficiaries of these two programs. Medicare pays for physician, prescription drug, and hospital care, while Medicaid pays the Medicare premiums and cost sharing and covers other health needs such as long-term care. Dual eligibles accounted for 42% of Medicaid costs in 2000.

- Special groups
 - Medicare premiums, coinsurance, and deductibles may be covered for Medicare beneficiaries with incomes below 100% of FPL and resources below 200% of the SSI allowable. States can also cover groups up to 135% of that level.
 - States may provide extended Medicaid eligibility while disabled persons learn to work and seek employment and as their conditions improve.
 - Individuals with tuberculosis may be covered for tuberculosis-related treatments costs.
 - Women with cervical or breast cancer may receive time-limited full coverage for cancer-related care.
 - Long-term care (institutional and home health) is covered in all states, but eligibility requirements varying by state.

Until very recently, Medicaid covered prescription drugs, but Medicare did not. Medicare still does not cover long-term care.





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TABLE 2-5 FY 2007 Federal Medicaid Assistance Percentage (FMAP) By State and Territory

Percentage Grouping	States and Territories in Category
50.0	California, Colorado, Connecticut, Delaware, Guam, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, Puerto Rico, Virgin Islands
50.01–50.99	Alaska, Nevada, Rhode Island, Washington, Wyoming
54.00–57.99	Hawaii, Michigan, Nebraska, Pennsylvania, Wisconsin
58.00–60.99	Florida, Kansas, Ohio, Texas, Vermont
61.00–64.99	Georgia, Indiana, Iowa, Maine, Missouri, North Carolina, North Dakota, Oregon, South Dakota, Tennessee
65.00–67.99	Arizona
68.00–69.99	Alabama, Kentucky, Louisiana, Montana, Oklahoma, South Carolina
70.00–73.99	Arkansas, District of Columbia, Idaho, New Mexico, Utah, West Virginia
76.0	Mississippi

Data Source: *Federal Register* 2005 Vol. 70, No. 229, p. 71857.

LEADERSHIP AT THE STATE AND LOCAL LEVEL

A state is responsible for health insurance regulation as well as paying up to half the costs of Medicaid. Complexity is increased by the fact that each state has its own system of insurance regulation. Yet this has enabled a wide variety of innovative responses to access and cost issues at the state and local levels. Medicare is often the largest expenditure category in their budgets and is an open-ended commitment. Jurisdictions that rely heavily on property taxes have major problems dealing with such unpredictable expenditures. State and local governments also end up covering most of the acute care costs of the uninsured. The many approaches that they are using are discussed in Chapter 5.




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Insurance regulation is a strong lever for mandating coverage and access and for taxing premiums to cover uncompensated care and fund high-risk pools; The Employee Retirement Income Security Act (ERISA) of 1974, however, exempted self-insured plans from much of state insurance law because self-funded insurers would not have insurance as a primary line of business. Generally, the courts have upheld this law. One exception is a 1995 Supreme Court decision allowing New York State to place a surcharge tax on health premiums, including self-insured plans, to cover uncompensated hospital care.

Park (2000) reported that in 1993 about half the nation's insured workers were in self-insured plans (also called Section 125 plans), mostly in large companies. The exemption allows companies to offer a consistent benefit package to all of their employees in various states and to avoid state taxation of premiums and incurring the costs of regulation, as well as keeping any returns on their capital reserves. A self-funded company takes the underwriting risk for its own pool of generally healthy employees. These plans were most popular in the 1980s and early 1990s, but then lost market share as companies turned to managed care organizations to reduce costs. They are further losing share as companies cut back their plans and offer defined contribution plans, if anything at all.

ERISA constitutes a barrier to states attempting to achieve universal coverage. It leaves each state with two health care insurance systems, one regulated and one not. Other arguments against the ERISA exemption point to the possibility that unregulated plans might fail because of mismanagement, might abuse sick employees, and would put employees at a disadvantage whenever employers discontinue their self-funded plans.

INDUSTRIALIZING STRUCTURES FOR DELIVERY

The terms *industrialization* and occasionally *commoditization* keep coming up in current discussions of how to fix health care (Holstein, 2006). When applied to manufacturing early in the 20th Century, industrialization meant (1) breaking complex tasks performed by individuals down into simple tasks assigned to different members of a team and (2) studying, analyzing, and specifying the best way to do each of those tasks. The result was that work moved from the control and *artistry of the craft person* to a systematic process that was perhaps more efficient and less personal. Specialization in the indus-

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trialized system can imply *deskilling* for some and much higher, but narrower, skill levels for others. Managerial control of the system involves both allocating duties and specifying the right way to do them. Usually management includes two groups: (1) line managers who allocate the work and (2) staff specialists whose job is to specify and improve processes. Where the process is well defined and skill requirements can be reduced, *labor substitution* takes place—routine work is done by less expensive personnel with more limited training and less autonomy. Primary care physicians particularly report the frustration with their loss of autonomy and with the pressures for efficiency expressed as a measure of the number of patients seen (Rastegar, 2004).

Clayton Christensen has expressed the industrializing view most strongly.

In health care, rather than replicating the expensive expertise of Mount Sinai Medical Center or Mass General Hospital, or replicating the expensive expertise of doctors, we have to commoditize their expertise. That comes through the precise ability to diagnose the diseases that people have. Our ability to diagnose diseases is moving ahead at a breathtaking pace, but regulation and reimbursement are trapping the delivery of rules-based medicine in high-cost models.

Referring to the mastery of consumption he argued,

You had tuberculosis there, at least three types, and you had pneumonia. We thought it was all one disease. So the care had to be left with doctors because they were the ones with the training and judgment, but once you could precisely diagnose the cause of the disease, you could then develop a cure. It was so rules-based that you didn't need a doctor any longer. Today a technician can diagnose those diseases and a nurse can treat them (Holstein, 2006).

Other symptoms of industrialization in health care include the following:

- More physicians employed (under management) rather than partners in practices
- Institutional emphasis on process development, including evidence-based medicine and continuous quality improvement
- External exchange of information on relative experience, outcome quality, and prices and costs
- Emphasis on process conformance and transparency, including preauthorizations, carve outs, utilization review, and clinical pathways
- Increasing labor substitution



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- Development of focused factories that specialize in a limited range of procedures, such as specialty hospitals and ambulatory surgery centers
- Increasing fragmentation of patient care with offsetting efforts aimed at coordination and teamwork
- Increasing substitution of capital for labor
- Less of a personal relationship between the server and the served.

Managed care has become a major form of organization for care delivery. Practices and institutions have merged or sold out to a wide array of health care organizations. Physician incomes, especially those of specialists, have dropped rapidly. These are all symptoms of the industrialization of what had been a cottage industry organized along craft lines despite being 14% to 15% of our country's economic activity.

Figure 2-3 suggests one way of thinking about industrialization and the various process requirements that analogy suggests. Two dimensions are identified: Type of Case: Simple to Complex and Knowledge Base: Science-based (Codified) to Art (Tacit). The drivers of industrialization in health care have been the expansion of the science base of medicine and the codification of

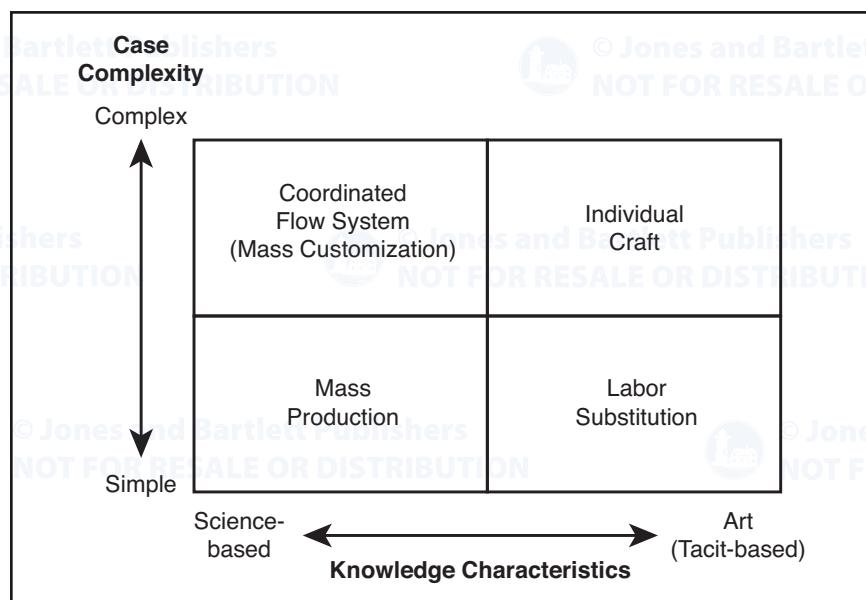


FIGURE 2-3 Suggested Impact of Case Complexity and Knowledge Characteristics on Process Choices in Health Care

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product definitions and process specifications. For more about art (tacit knowledge) versus science and product and process improvement trajectories in general, see Victor and Boynton (1998). Their applicability to health care is discussed in greater detail in McLaughlin and Kaluzny (2006).

The craft/guild system attributed to medicine before World War II implied that medicine was primarily an art lacking decisions rules that could be communicated effectively (tacit knowledge) (Ferdows, 2006). With more and more scientific and/or codified knowledge, it was possible to differentiate between simple and complex cases. Where activities were simple, they could be turned into mass production systems that repeated the same process over and over. If the knowledge was still pretty much an art but the case simple, the work could be delegated to less experienced or less trained personnel (like in the old *apprentice* system in which much of the simpler work was delegated to others, but the master craftsman maintained control and handled the trickiest parts). Part of the training process was learning what not to treat and what to hand off to appropriate experts. Where processes are codified but the cases are complex, and hence varied, they need to be processed in a coordinated flow between provider subsystems, a process referred to today as *mass customization*. The modern hospital can be visualized as such a process, with patients (all or in part) moving from the bed tower to the X-ray department to the blood laboratory to surgery to the intensive care unit to the step-down unit and back to the bed tower. However, we all witness the consequences of matches and mismatches between situations high in art that fit with craft (apprenticeship and job costing or fee-for-service) and those high in science that fit with industrialization (bundled payments, use of clinical pathways, length-of-stay controls).

Mass production does exist in areas such as cataract surgery and other “centers of excellence,” but there is a widespread desire to avoid mass production of medical services. That desire is legitimate given the high inherent variability in patient anatomy, physiology, and psychological needs and preferences. Mass customization is the logical end point for this process. Health care is a mixture of art and science; however, health care differs from classic mass production in the sense that patients present themselves with both simple and complex problems (multisystem problems or comorbidities). Problems that have a clearly optimal treatment regimen and those for which medical knowledge is limited can appear simultaneously in the same individual.

What has kept this from being a well-coordinated process has been the absence of development of process codification and inadequate investment in information technology, as well as a lack of provider commitments to share knowledge and to abide by specified process parameters. This is often attributed to lack of sufficiently aligned professional and institutional incentives.

Ownership of Intellectual Capital

As work is industrialized, work methods are specified by the organization rather than the individual artisan. In health care, we have historically assumed that intellectual capital resides with the professional. This stems from an assumed inability of the public (including lay administrators) to understand the technical processes of health care. This notion is the underlying foundation of medicine's claims of professional autonomy, but that autonomy is threatened by recommendations such as those of Einthoven and Tollen (2005), who argue for reliance on integrated delivery systems for cost control. They argue against provider-level competition and for system-level competition because integrated delivery systems:

- Can better motivate and hold accountable clinicians to use best practices
 - Do a better job of achieving coordination and continuity of care, especially for the chronically ill
 - Are more likely to invest in and implement interoperable information technology
 - Are more likely to adopt and successfully implement "large scale efficiency measures"
 - Are more likely to compete directly with each other on quality and price
 - Are more likely to be selective among providers than loose and inclusive provider networks serving most insurers in a community.
- These authors want employers to offer employees a choice of carriers to motivate insurers to avoid providers of low quality and high costs. Haislmaier (2006) argued that a key innovation of the Massachusetts reforms was the "Connector" exchange system, which allows individuals insurance portability and enables them to change carriers without reunderwriting.

As competition increasingly depends on the implementation of evidence-based practices by an institution and rapid dissemination and adoption by practitioners, organizational rather than professional learning



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becomes the focus. That raises new questions about the provider–management conflicts (often called *suits versus coats*), the role of continuing graduate medical education, and access to clinical records and research outputs. Professionals must be prepared to take leadership in issues around developing, disseminating, and compensating for intellectual capital or lose even more autonomy.

The Professions

One interesting aspect of the U.S. medical system is that it did not industrialize under either corporate or government control. Many U.S. services industry sectors have concentrated into large corporations emulating the oligopolistic model of dominant multinational firms. Starr (1982) discussed how the medical profession gained control of health care and maintained it in the presence of pressures to consolidate into corporate forms of organization. The cover of his book, *The Social Transformation of American Medicine*, states that it is about “the rise of a sovereign profession and the making of a vast industry.” Writing in the early 1980s at the height of the interest in HMOs, he foresaw rapid growth in the corporate form of care delivery.

Much of the ebb and flow of employer, insurer, and government attempts to solve health care system issues flows around issues of industrialization and corporate delivery of medical care. Starr (1982, pp. 229–231) cited five structural changes in American medicine before World War II that strengthened the sovereign position of physicians in health care and enabled them to avoid working in a corporate structure. They were as follows:

1. An informal control system based on dependence on colleagues for referrals and hospital privileges
2. Formal control of labor markets through the licensing process
3. Transfer of many of the overheads and investments that a typical private corporation would make should it provide medical services to societal organizations such as hospitals, public health departments, and educational institutions
4. A lack of countervailing organizations that could choose to challenge the political and economic influences of the medical profession
5. Few attempts to develop integrated care organizations that would attempt to rationalize the highly fragmented, but insulated delivery system.



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In 1934 the American Medical Society claimed that “all features of medical service in any method of medical practice should be under the control of the medical profession.” Elsewhere in the world the response to that assertion is that control should rest with the government. In the United States, we increasingly hear that it should rest on “consumer sovereignty.”

Is there something inherently different about health care? Nobel economics laureate Kenneth Arrow addressed this question in his influential 1963 article entitled “Uncertainty and the Welfare Economics of Medical Care.” He argued that some functions, such as insurance, exhibit typical market behavior, but he also observed that the buyer is not a rational optimizer in a perfect market, but is a vulnerable, trusting patient who seeks information in an uncertain world from a physician who is also dealing with many uncertainties. He emphasized elements of uncertainty and market failure such as the following:

- Inequality of information (today called *information asymmetry*)
- Inequality of resources, especially income
- Professional ethic demanding that treatment be independent of ability to pay
- Importance of trust to the effectiveness of the care
- Vulnerability and psychological state of patients
- Longer term implications of the ongoing physician–patient relationship.

Arrow pointed to a number of the unique structural elements of the health care marketplace such as professional licensure, nonprofit institutions, sliding fee scales, and government intervention as responses to these elements. He argued that much of the uncertainty could be handled through insurance and government intervention. His postscript concluded,

The failure of the market to ensure against uncertainty has oriented many social institutions in which the usual assumptions of the market are contradicted. The medical profession is only one example, though in many respects an extreme one.... The economic importance of personal and especially family relationships... is based on non-market relations that create guarantees of behavior which would otherwise be afflicted with excess uncertainty.... The logic and limitations of ideal competitive behavior under uncertainty force us to recognize the incomplete description of reality supplied by the impersonal price system.
(Arrow, 1963, p. 967)

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Criticisms of Arrow and of how that article is interpreted are many, but it remains very relevant and very influential. Sloan (2003, p. 58) argued that the article is used by those who oppose markets and argued that “an alternative approach—in my view, a much more fruitful one is to recognize the market imperfections and devise various interventions to empower consumers. . . . Consumer ignorance should not be taken as a given.” Rice (1998) raised 15 questions about the assumptions of the competitive market model applied to health care, such as lack of externalities, fixed preferences, absence of monopoly, complete and accurate information availability, and rational decision making. Henderson (2002, pp. 109, 111) accepted the market failure examples but counters normatively,

On the other hand, no credible evidence supports government remedies as the answer to the perceived inequities either. Markets may fail, but governments may be just as prone to failure. And correcting government failure is inherently more difficult than correcting market failure. . . . Criticism directed at market failure without at least admitting the possibility of government failure is dishonest, or at minimum naïve.

Starr interpreted many of the social institutions that Arrow cited not as social responses to uncertainty but as steps that organized medicine used to establish its monopoly control over health care and stave off industrialization and cites examples of them increasing uncertainty.

Why has it remained a cottage industry? The medical profession has been very protective of its control over health care. Yet there have been a number of moves in the direction of consolidation and corporate structures. Starr (1982, p. 420) suggested five dimensions likely to change should the practice of medicine move toward a more typical American corporate structure. They are:

1. Change in ownership and control
2. Horizontal integration into multi-site organizations
3. Diversification and public restructuring with holding companies and subsidiaries with differing product lines
4. Vertical integration involving multiple stages and levels of care
5. Industry concentration of ownership and control of services.



Interestingly, all of these have been taking place, albeit slowly and selectively. In fact, many of the implemented proposals and experiments have accomplished aspects of each of these and created efficiency, effectiveness, and wealth. They have each had their day, yet they have not stemmed the inflationary trends nor overwhelmed the smaller operators. Hospitals and corporations that bought up physician practices in the 1990s experienced problems in recouping their investments. For-profit hospital chains have had their ups and downs. Integrated health systems do dominate in many specific areas, but have not been terribly successful in replicating their approach elsewhere.

Status of Professions and Professionals

It may seem odd to think of professional status as a variable to manipulate in establishing health policy; however, professional roles are not immutable. New professions emerge as technology changes and others lose ground. Professions are a combination of knowledge, political power, and custom. It is the public that either accepts or denies one group's dominance over a knowledge domain and the delivery of services.

Health workers existed long before the modern medicine era. Most societies have had shamans, birth attendants, and indigenous healers. Before 1850, physicians did not seem to enjoy any consistent status in the United States. With the advent of modern science and modern medicine, governments became alarmed at the amount of quackery going on. They cooperated with the medical profession and conferred on the profession a near monopoly, which has been buttressed by our system of licensing and credentialing.

Starr (1982) traced in detail the parallel political and social development of monopoly power by American physicians. Freidson (2001) saw the professional model as a third alternative to the hierarchical (corporate) model and to "free market autonomy." In the professional model the professionals maintain considerable control over (1) the information and (2) the means of delivery in their domain; however, as we see in Chapter 5, many proposed and implemented alternatives have the effect of weakening the existing status of health professionals. This is a natural result of the emphasis on market mechanisms and an informed consumer, as well as the vastly increased access to information that the public now has, especially through the Internet.



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Given that professional status and credentials offer privileges with economic value, health policy analysts must consider how that value and power might be allocated to serve the public interest. The literature suggests a number of issues of interest related to professional status decisions:

- Labor substitution
- Outsourcing
- Rising educational barriers
- Disintermediation
- Consumer-centered care based on quality report cards, etc.
- Incentive systems for quality, cost, and access

As potential policy alternatives, all of these warrant further consideration.

Labor Substitution

Despite the monopolies offered by licensure and credentialing, many health care tasks can be done by more than one level of health care worker. For example, there were midwives before there were obstetricians. That function nearly disappeared in the United States but is undergoing a resurgence. Nurse practitioners and physician assistants now are the first level of care for many patient encounters. In many psychiatric practices, the psychiatrist handles the patient's medications but delegates most other care activities to psychologists, social workers, and other counselors. Pharmacies now use pharmacy technicians as well as pharmacists. Dental practices have their own dental hygienists and technicians working in parallel with the dentists. Primary care physicians perform procedures once limited to specialists. The key to further substitution is whether the alternative type of worker is qualified for the problem at hand and whether their unit cost is less. The main drivers for labor substitution are availability and cost. Most substitutions were initially proposed to overcome a shortage of personnel in one area, but after the experiment has worked, more and more organizations adopt it to increase access and reduce cost.

Outsourcing

This is a relatively new phenomenon in health care, but is driven by the same factors as labor substitution. A shortage of radiologists in rural areas has led to networking arrangements in which radiologists in urban areas read the images from rural hospitals in their offices or homes without going to the patient. Technicians produce the images and radiologists read them off site. After the information is digitized, it can be read anywhere in the



world and it is not unusual to find that U.S. imaging and electrocardiograms are farmed out to Asian locations where salaries are much lower. More and more patients who lack adequate insurance coverage but have reasonable incomes are choosing to have elective surgery done in reputable overseas hospitals where the cost is much lower. Pharmaceutical companies are also moving medical research and clinical trials offshore to reduce costs.

Rising Educational Barriers

The force that runs counter to labor substitution is the pressure within each profession to raise the bar that one must clear in order to achieve professional status. The biggest suppliers of nursing labor in the United States are the community colleges, which have programs that do not always end up with a baccalaureate degree; however, nursing leadership has argued for the need to have more, if not all, nurses with 4-year degrees. At the same time, nursing subspecialists proliferate, requiring master's level degrees. The pharmacy schools that once offered pharmacy bachelor degrees now produce Pharm. D. recipients. All of these moves require more training and in turn constrain the supply of personnel in a field and seemingly justify higher wages and greater professional status. One casualty of this trend in the university is the use of cross-disciplinary faculty to teach in the health professions. Rather than training in common or using common faculty from other departments to teach their anatomy, pharmacology, and behavioral science, for example, they increasingly insist on having it done by individuals with doctorates in their own field. In-sourcing all of the teaching increases the demand for their own doctoral-level graduates.

Disintermediation

The term *disintermediation* means removing the person in the middle, the intermediary. One prime example is the recent emphasis on direct-to-consumer pharmaceutical advertising. Ten years ago, companies selling efforts focused entirely on the prescribing physician. That has changed markedly. Ad after ad suggests a treatment, syndrome, disease, or risk factor that the patients might not even be aware of (i.e., hypercholesterolemia, acid reflux disease, toenail fungus) and urges them to ask their physician about the branded treatment. This advertising bypasses the physician initially and, given the availability of imported drugs, may bypass the physician entirely. **Table 2-6** shows situations in which primary care physician control of medical information and/or of the means of delivery of care are being bypassed today.



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TABLE 2-6 Disintermediation Activities Affecting the Primary Care Physician

Actor	Activities Affecting Information Control	Activities Affecting Transaction Control
Pharmaceutical Companies	Direct-to-Consumer advertising (DTCA) Web sites	Moving patent-expired drugs over the counter (OTC)
Screening Centers	DTCA Direct patient reporting	No referral required Direct patient pay
Nurse Practitioners Physician Assistants	Independent practice	Independent practice
Psychologists	Independent practice	Gaining prescribing authority
Insurers	Deep portals for enrollees Case management	Forcing drugs OTC Case management
Case Management Firms	Taking over patient management Self-care advice	Patient advocacy in community
Pharmacy Benefits Management Firms	Formulary feedback to patients	Multi-tiered copays
Employers	Educational programs and web portals	Screening programs
Academic Medical Centers	Newsletters/Web sites Telemedicine programs	Telemedicine programs
Government Agencies	Web sites/Advertising Screening recommendations Case management	Preferred drug lists Screening programs
Patient/disease Advocacy Groups	Web sites/Advertising Screening recommendations	Screening programs
Pharmacists	Counseling centers	Screening programs
Hospitals	Protocols share with patients and their families Formularies	Formularies Screening programs

Source: Table 1, p. 72 from C.P. McLaughlin et al., "Changing Roles for Primary-Care Physicians: Addressing Challenges and Opportunities." *Healthcare Quarterly*, Vol. 8, No. 2, 2005 Copyright Longwoods Publishing Corp.

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The primary care provider is not the only intermediary that can be targeted. The decentralized and disjointed nature of the health care industry has allowed the rise of an array of middlemen who have profited greatly by aggregating the demand of small actors and obtaining discounts or who have achieved at least a temporary knowledge advantage that has enabled them take advantage of the market (sometimes called *arbitraging*). The *Wall Street Journal* ran a series of articles on these highly profitable intermediaries in 2006, focusing on pharmacy benefits managers, billing consultants, catastrophic case care managers, Medicaid HMOs, nursing home pharmacy firms, and insurers (Wessel et al., 2006). Large self-insured employers have been attempting to get them to make their operations more transparent or eliminate them entirely.

Consumer-Centered Care Based on Quality Report Cards, Etc.

Quality reporting is relatively new in health care. Diagnosis-related groups, introduced in the 1980s, classified hospital services in 467 bundles of care. A parallel relative value scale system was also developed to evaluate professional fees. It had not been possible to adjust cost data for severity and patient characteristics nor to maintain quality control records until those product definitions were established and widely adopted. After data on costs could be associated with specific diagnoses and compared across cases, providers, regions, and institutions, the tools began to fall in place for a corporate-level analysis, allowing a more industrial approach to health care management.

Incentive Systems for Quality, Cost, and Access

Once cases could be assessed for process quality, outcomes, and costs, payment could be based on overall experience rather than on the inputs utilized in the specific case (fee for service). We discuss pay for performance more extensively in Chapter 3.

MEDICALIZATION OF SOCIETY

A 2006 study showed that white, middle-aged British patients reported better health status than Americans, despite spending much less per capita on health care. Some attribute the differences to high U.S. stress levels; however, an alternative point of view is that the high rate of expenditure on medical care, especially the amount of screening taking place and the constant barrage of health-care-related advertising, has resulted in a reduced



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perception of wellness. In essence, the greater the proportion of our economy that goes into health care-related activities, the more “sickness” we experience (Welch et al., 2007). This goes back to the definition that we have heard attributed to any number of sources—that a healthy person is one who has not been sufficiently examined by a physician. Consider, for example, comparisons of high blood pressure and high cholesterol levels in U.S. and British 40 to 70 year olds. Americans self-reported more of these problems; however, measured blood pressures were the same, and Americans had lower cholesterol levels. Some attribute lower levels of reported illness among Britons to the fact that British primary care physicians do much less routine screening (Hadler, 2004; Kolata, 2006a). Some see the U.S. screening penchant as a transfer of scarce medical resources from the sick poor to the worried, insured well and as a logical outcome of the medicalization of life together with the industrialization of medicine (Heath, 2005).

Other issues related to the medicalization of U.S. society include the dependence of the economy on the growth of this sector. A 2006 cover story in *Business Week* asserted that two sectors, construction and health care, accounted for all the growth in private sector employment over the preceding five years and that growth in health care employment was the greater of the two. “Since 2001, the health care industry has added 1.7 million jobs. The rest of the private sector? None.” (Mandel, 2006, p. 55). Career choices and educational offerings have changed in response to the perceived demand.

Health issues have received increased emphasis in news reporting, television programming, television advertising, and recreation facilities. We have had visitors from other countries ask, unprompted, why we have so much medical and pharmaceutical advertising. There are pluses and minuses to this increasing presence of health care issues throughout our society. We are not arguing that it is good or bad; however, the analyst must take this trend into account when making recommendations. Overall, medicalization tends to increase both the political and economic risks of rapid or radical change to our health care system.

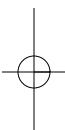
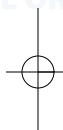


CONCLUSION 57

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This chapter examines the status of the American health care system in terms of access, technical management, management of interpersonal relationships, and costs. It offers comparisons of per capita expenditures, GDP, life expectancy, perinatal mortality in many countries. It also outlines the linkages between these variables or lack thereof. With such data available, the educated citizen can join the debate about where the United States wants to go.

Other concerns in such a debate could include the impacts of changes and trends in the professional environments of health care. Two related constructs discussed in this chapter are the industrialization of health care and the medicalization of American society.

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