U.S. Health Care System: A Look to the 1990s

Health Affairs 4, no.3 (1985):120-127
doi: 10.1377/hlthaff.4.3.120

Cite this article as:
John K. Iglehart

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UpDate is a section that will report developments in health policy issues and scheduled conferences of relevance to the field. In this issue, a report of a discussion of health policy leaders on the future of the U.S. health care system and a summary of a conference on treatment for chemical dependency and mental illness are presented.

U.S. Health Care System: A Look to the 1990s
Cornell University Medical College
New York, New York
March 7-8, 1985

America’s medical care enterprise has entered an era of accelerated change that is being fueled by growing third-party demands that costs be moderated but the quality of care remain high, by an increasing pool of physicians and by the often frenetic efforts of providers and insurers to reconfigure their operations in an attempt to protect their patient bases and market shares. Many burning questions arise from this evolving equation but the most important—given the humanitarian instincts of society and its declared statutory commitments to provide for the less fortunate—is whether the poor will be served in a health care system that allocates its resources increasingly on the basis of marketplace principles.

In the opinion of the vast majority of health policy analysts who gathered March 7-8 at Cornell University Medical College to discuss the “U.S. Health Care System: A Look to the 1990s,” the poor will lose out if medical care is rendered on the basis of price unless policy adjustments are made along the way. While the philosophically disparate group could agree on little else, there was remarkable concurrence around this notion that even included Jeff C. Goldsmith, a hospital consultant and the most outspoken market advocate in attendance, who remarked at one point: “I don’t see the marketplace doing anything for the poor.”

Eli Ginzberg, a health economist and director of Columbia University’s Conservation of Human Resources project, organized and chaired the two-day conference. Ginzberg, a senior statesman of the social policy world, invited thirty-three individuals (see list of participants at the end of text) based on two essential criteria: that they be about forty years old and that they had demonstrated the potential for becoming health policy leaders in the decades ahead or had already reached that station. In the
mix of disciplines represented, there were seven economists, six political scientists, four physicians of mostly an academic flavor, three private foundation executives, two congressional staff members, two hospital administrators, two public administration professors, a private insurance executive, a lawyer, and other assorted backgrounds. Discussions centered on issues raised by five commissioned papers that dealt with policy choices for the 1990s; the growing role of management in health care, the changing hospital, medical technology, and health care financing in the future. But no issue loomed larger than who is going to pay for the medical care of the nation’s poor.

Who Will Treat the Poor?

Robert J. Blendon, a senior vice-president of the The Robert Wood Johnson Foundation, opened the meeting by suggesting that six major questions, which he characterized as “the potentially unresolved public policy issues of the 1990s,” loom ahead: medical care coverage of the poor; who is going to pay for the special “catastrophic” medical problems of the nation’s middle-class; what should the nation do about “the problem of a physician surplus;” what should it do about “the nation’s excess hospital beds;” what should it do about “the nation’s continuing problem of rising health care costs;” and will the nation need to better control the quality of medical care in the future?

Blendon, who believes in government as an appropriate control mechanism, said the United States has developed a three-track system of health care financing in the last twenty-five years: (1) private health insurance for the employed and their families; (2) public insurance for the poor eligible for public assistance, the disabled, and the retired, and (3) a system of governmentally subsidized public hospitals and neighborhood health centers, coupled with a major commitment by some 6,000 nonprofit private hospitals to provide “free” or subsidized care when necessary to the poor or otherwise uninsured.

By the 1990s) Blendon said, “it may become clear that this three-track system is breaking down” because of the multiple pressures of reduced governmental and philanthropic support and the growing business and organized labor disenchantment with continuing cross-subsidies that have often financed medical services for the poor. Blendon concluded: “Viewed together, these trends suggest that the question, ‘Who is going to pay for the care of the poor?’ may be the single most critical issue of the 1990s. Across the country, there are already some signs of the potential seriousness of this problem. In a recent study, one million families reported that someone in their family had been refused medical care for financial reasons. The majority of these were either poor, uninsured, or unemployed.”

A recurring theme articulated by a number of participants was the
erosion of social insurance principles through which much of the care of the poor and other high-risk patients has been financed. Gordon T. Moore of the Harvard Community Health Plan characterized as a “sea change” in attitude the growing unwillingness of third party payers to finance care of the poor through cross-subsidies. As the risk pool shrinks, the system will face breakdown, Moore said, “separating the haves and the have-nots.” Sheila P. Burke, who handles health issues for Senate Majority Leader Robert Dole (R-Kan.), agreed with Moore. “Health insurance is splitting apart as a market.” Noting the conflicting interests of many of the parties involved in this process, Burke said that “people who want Congress to act to protect the indigent are often the same people who say, ‘don’t cap my fringe benefits.’”

Bruce C. Vladeck, president of the United Hospital Fund of New York, a staunch believer in state rate setting, recommended that care for the poor be cross-subsidized through this mechanism by adjustments in the payment structure, but he urged that such allocation of funds not be “called a tax in this climate.” David Nexon, director of health issues for Senator Edward M. Kennedy (D-Mass.) reminded participants that legislation introduced by Kennedy and Representative Richard A. Gephardt (D-Mo.) would provide for such cross-subsidies. Bruce Steinwald of the Prospective Payment Assessment Commission did not buy the state rate-setting concept but he did concede, “the uncompensated care issue is the Achilles heel of the competitive model. It deserves attention. Everyone has a stake in addressing it, even the most hard-core competition advocates.”

While participants clashed over questions on the appropriate balance of market and regulatory mechanisms, there was general agreement that state governments should be the organizational locus for overseeing society’s commitment to serve the poor. The pooling of resources and responsibility at the state level was cited as a reasonable arrangement by participants ranging the philosophical spectrum. The emergence of state administration as a favored instrument represents a major philosophical shift for adherents of a strong central government role. This shift reflects the demise of any real constituency now for national health insurance, the rise to power of a conservative government, and the operation of rate-setting agencies in key industrial states (Maryland, Massachusetts, New Jersey, and New York) that are administering these cross-subsidies in a politically acceptable fashion.

The New Managerial Imperative In Health Care

Lawrence D. Brown, a political scientist who holds an associate professorship at the University of Michigan in medical care organization, argued in his paper that society’s increasing investment in health services has
pressed traditional providers to respond with greater innovation in management styles. “The suddenness and scope of these organizational innovations (hospital responses to Medicare’s new payment scheme, the rise of health maintenance organizations, independent practice associations, preferred provider organizations, ambulatory surgical centers, and for-profit multihospital corporations) are the more intriguing and in need of explanation because they are native, and indeed in many respects unique, to the United States, whose health care system is often described as heavily provider dominated, resistant to change, and immune to all but the smallest and most incremental innovations.”

Brown argued that the basic element in these organizational innovations is neither competition nor the growing corporate presence, though both do play their part, “but rather a gradually building commitment to management that has lately become so intense as to constitute a managerial imperative.” (In the ensuing discussion, Brown put it another way, saying that “innovation does not reflect competition but rather organizations striving to arrest competition and protect turfs.”) “The managerial imperative may prove to be as important in the 1980s as was the technological imperative in the 1970s and the access imperative in the 1960s.” Nevertheless, he urged caution about concluding now that these organizational changes would “prove to be truly fundamental in the future.” In this context, he noted the slow evolution of alternative delivery system development and characterized as “questionable” the notion of market advocates “that the system is developing a healthy competitive constitution.” It is also unclear, Brown maintained, whether price competition will save society money overall, rather than mostly shift costs among sectors of medical activity.

Brown said that he was of the mind that specialization, not competition, was driving much management innovation. To illustrate, he cited the activities of Humana Inc. “Humana performs well on Wall Street, but the average occupancy rate at its ninety hospitals declined from 58.5 percent to 54.4 percent between 1983 and 1984. Presumably its production processes are as well managed as possible and its charges as low as it thinks prudent, and so its response is to develop specialties for itself, notably the heart institute so much in the news lately. To those who understand the managerial imperative, desirable diversification— that is, profits may try to insulate themselves from competition by specializing by area (locating in regions where nonprofit competitors are relatively feeble and rate regulation is weak), patient mix (‘creamming,’ ‘skimming,’ and ‘dumping’), and by medical activities (artificial hearts and the like).”

Participants were divided on the potential significance of the business activities engaging many providers and insurers as they move to do battle
in a price-competitive market. Opinion broke down largely on the basis of an individual’s belief in the utility of market principles for medical care; several believers (Goldsmith and Neilson Buchanan) regarded current activities as the dawning of fundamental change while skeptics viewed these movements as incremental and of questionable long-term consequence. Many easterners (Vladeck, Blendon, Jo Ivey Boufford, Lynn Etheredge, Ginzberg, Thomas W. Moloney, Marilyn Moon, James Morone, David Nexon, Deborah Stone) were more pessimistic, expressing the view that market-driven medicine would slight the poor, punish the hospitals which provide them care and not recognize the contributions of states that over the years have financed more generous benefits for the uninsured and other disenfranchised individuals. Another subset of participants–Moore, Robert J. Rubin, Steinwald, Gail R. Wilensky, all to one extent or another believers in the market, were of the view that unless government fashion policies that maintain services to the poor and supports graduate medical education, price competition could be found wanting as a viable long-range strategy.

Although participants could not all agree on whether current market-driven activities represented fundamental change, there was consensus that the increasing size of the physician pool would greatly influence the process and pace of change. Moore said that the difficulty health maintenance organizations once had recruiting physicians is history. Wilensky, agreeing with Moore’, said the “one overriding factor fostering change” will be the increasing physician supply. There also was general agreement that the mounting tensions already evident between primary care and specialty physicians would intensify. “Organized medicine will become disorganized medicine,” Berenson said. Joseph Lynaugh of Sanus Corporation Health Systems said: “We are witnessing a reversal of the pecking order between specialists and primary care doctors” as the latter are placed at some degree of financial risk for specialty referrals under various patient gate-keeper schemes. At another point, Bernard Tresnowski of the Blue Cross and Blue Shield Association said: “The managed care produce is the product of the future.”

The Changing Role Of The Hospital

Goldsmith, a management consultant who made his publishing mark with a 1981 book entitled, Can Hospitals Survive? rendered an opinion in the next paper of “yes, many of them,” but in a restructured form Goldsmith cited “a variety of forces” that have resulted in declining inpatient demand: the reform of Medicare and Medicaid hospital payment mechanisms; the redesigning of private health benefit packages with more consumer cost sharing required and greater ambulatory care coverage; an increasing willingness of employers to question physician decision mak-
ing in management of the patient; significant changes in medical technology, which have eroded the hospital’s inpatient franchise; and an explosion in freestanding emergency facilities. “Taken together . . . these developments over a period of years appear to have the potential for stripping away a significant fraction of routine inpatient hospital utilization. . . . Ultimately, hospitals that cannot support their capacity from market demand will be compelled to close, unless they are somehow subsidized by the government.”

Speculating on the future shape of the hospital system, Goldsmith said he envisioned a highly fragmented, decentralized system (he noted that the largest hospital management enterprise, Hospital Corporation of America, generates revenues of about 1 percent of total personal health services dollars) with “a drastically reduced inpatient hospital capacity. . . . Hospital facilities will house primarily intensive care services, highly complex diagnostic and therapeutic modalities and medical resources for treating the most seriously ill patient. The financial management of these facilities will probably be an economic nightmare. Reimbursement for services provided in them will probably not equal their cost. As a consequence, hospital services will be cross-subsidized by net revenues generated by the system in other forms of health-care delivery.” Goldsmith’s model is built essentially on private-sector actions, but he conceded that the role of public policy making could loom large. “Whether government seeks to shape the behavior of these new arrangements through incentives or to supersede their development through direct regulatory approaches will also have a major bearing on the future shape of this system.”

Medical Care And Medical Technology

William A. Knaus, an associate professor of anesthesiology and clinical engineering and codirector of the intensive care unit at George Washington University Medical Center, discussed the changing world of medical technology. Knaus argued that it has vastly increased the number of facts that can be determined about a patient’s condition, but he noted there are few comparable studies providing physicians with estimates of the actual value of these factors for the treatment of disease.

In recent years, medical research has concentrated on the explanation of mechanisms of disease and human biology, and the clinical goal of prediction has been slighted, Knaus said. That is one reason why, at every level of clinical practice today, the use and evaluation of therapy is beset by controversy, dissension, and doubt, he added. To increase research in clinical outcomes, Knaus recommended creation of an Institute for Clinical Research within the National Institutes of Health that would be charged with sponsoring and coordinating studies on prognos-
tic factors and outcome from acute disease. He concluded: “Just as the
development of a new medical technology depends on the tedious and
inefficient nature of scientific research, so guidance on using it must come
from a rigorous search for the truth. It cannot be found in short-term task
forces, expert opinion surveys, or consensus conferences. All of these
efforts are limited by a fundamental lack of predictive ability and
understanding.”

Knaus noted the changing nature of societal attitudes regarding the
interests of some patients and their families to stop short of exercising all
clinical options in the face of impending death. One reflection of this
change is the enactment of thirty-seven state right-to-die statutes. Another
reflection, he said, is “people in my practice have changed from saying
‘do everything possible’ to, ‘where there’s no more hope, please stop.’”

Asked what he perceives to be the basis of these changing patient atti-
tudes, Knaus responded, “to avoid suffering.” Lynn Etheredge, a former
(1978-1982) health branch chief of the President’s Office of Management
and Budget, suggested that doctors would increasingly be faced with mak-
ing tough resource allocation judgments because “politicians don’t want
to decide who shall live or die. When that tough question is put before a
political body, it comes out with laws like the Baby Doe statute,” a new
federal law designed to protect the rights of infants regardless of their
physical or mental state.

Health Care Financing In 1990

Participants conceded that the rapid rise in the cost of medical care,
from $75 billion in 1970 to $400 billion in 1985, cannot be sustained,
but no consensus emerged on what spending trends will look like in the
future. Etheredge, a senior researcher at the Urban Institute, set out four
scenarios for the future in the concluding paper, a solid reflection of his
uncertainty (and that of most other participants) about the likely direc-
tion of events.

The first two scenarios described alternative approaches to slowing the
growth of costs—one would introduce vigorous, price-cutting competi-
tion, the other was based on a proliferation of state rate-setting agencies
and tighter regulation of physicians’ fees. The third and fourth scenarios
suggested that the powerful economic, political, cultural, and technologi-
cal forces which built “the medical-industrial complex” are far from hav-
ing run their course. Indeed, they envision a health system in which the
full extent of its growth lies ahead. These scenarios stressed the funda-
mental weaknesses of payers which have prevented them from taking
effective actions in the past to control costs.

Tresnowski said that “scenario planning is a favorite pastime of strate-
gic planners. The latest scenario around Blue Cross is that Number 1
(vigorous price-cutting competition) will play out.” He said that if society follows this road, it will involve “tremendous lead times” and the “fall-out” of the poor, the uninsured, and elderly people who need long-term care. “Horror stories will begin to surface. The critical policy question at that point will be how to respond.”

The conference left no doubt that the health system, the nation’s third largest industry with some eight million workers, is being buffeted by change that no single interest controls. Congress and private third parties are demanding that costs be moderated, but they want no slow down in the pursuit of better medical technologies and treatments. Ginzberg’s concluding comments did not necessarily represent the consensus of the group, but it did reflect the frustration of many participants. “We have an absolutely insoluble proposition on the table. People want it all, but are unwilling to pay for it, and this includes the government. We don’t know what the political reconstellations will be but they must come because the architects of policy are talking about trying to circle a square that simply can’t be squared, given the assumptions they are operating under.”

John K. Iglehart
Editor, Health Affairs