HEALTH CARE COST CONTAINMENT COMMISSION MATERIALS

Table of Contents

ductivity among providers would each work to reduce the urgency with which policy is developed for the health care cost problem. Finally, it is clear that all policy measures, even successful ones, are transitory. Other aspects of the problem will arise, or other forces exogenous to the health care system and economy will upset what appears to be a relative success.

It is also useful to consider the nature of the options open to those who would propose either regulatory or marketlike solutions to health care provision and payment problems. The options do not neatly settle into two distinct types. Quite the contrary, there are four fundamental kinds of action that can be taken, and either private or public policy makers are limited to the same four. The first is to reduce the demand side of the market. (I start with the demand curve because many argue that government's entry into health care as a payer in 1965 caused the shift in demand that resulted in the subsequent cost spiral.) Efforts to increase copayments, establish deductibles, and stimulate the use of second opinions in surgical cases are three examples of attempts in both the private and the public sectors to influence the position and shape of the demand curve.

The second policy option is to shift the supply side of the market. In theory, increasing the number of suppliers of services, or changing the nature of supply by inventing substitutes for traditional providers, will cause prices to fall. Again, both the private and public sectors have attempted to affect the supply side. Private actors have developed and encouraged the formation of alternative providers such as health maintenance organizations in an attempt to dilute the power of hospitals to control the market for providing care. The federal government's subsidy of medical schools and other professional training programs was designed to increase the number of physicians as well as physician substitutes in an effort to reduce the price of care. The construction of new hospitals and the replacement of older facilities, again subsidized by government, were intended to increase hospital supply and efficiency.

Interestingly, these supply strategies may backfire, pointing up the importance of agreement on what the fundamental problem is. The oversupply of physicians resulting from expanded training may result in lower unit prices. However, given that as the number of suppliers grows, there is every likelihood that total spending on physicians will increase, making the global cost of care higher. These outcomes were easily foreseen—economic theory suggests that as unit prices fall, suppliers will attempt to sell more units—but were apparently disregarded by policy makers perhaps fixated on wreaking vengeance on physicians.

The third policy avenue is one that in the short run disregards market forces and establishes a transaction price by governmental or other fiat. In this approach, an exchange price is determined by an institutional force, governmental or otherwise. It reflects the ability of one party to essentially impose a price on the market. This role is formally reserved to government through regulatory delegation by the legislature.

The remaining policy option involves improving the efficiency of health care providers and insurers to produce more services for constant or shrinking expenditures.

As suggested, the very words "competition" and "regulation" deserve some explication. They have come to have meanings of mutual exclusivity. As I suggest throughout this paper, however, the operational meaning of the words is not so clear. In the case of regulation, the term has come to be used to describe any government presence whatsoever. But just as government payment programs are not regulatory per se, likewise the absence of government is not a state that can accurately be described as free competition. Indeed, private actors are often observed to consciously manipulate market situations expressly to regulate entry, price, and quality. To the person setting out to establish a monopoly, the market appears dysfunctional in that it does not maximize personal gain. Conversely, antitrust laws bear witness to the role government plays in keeping the market free of private regulation and conducive to competition.

The following example sheds light on the nuances embedded in such distinctions. It is arguable that Blue Cross Plans that advance DRG-based payment schemes are establishing a private regulatory system. The ability of Blue Cross Plans to operate such a regulatory regime on hospitals might relate to their quasi-public tradition; that is, they are permitted to operate as government's surrogate as suggested by the *National Gerimedical* case.[2] Or they may reflect the conscious be-

havior of influential private purchasers behaving in the expected way given an oligopsonistic situation.

The propositions that follow suggest that the regulation/competition paradigm be looked at in a different light. It is hoped that by examining these propositions, I can help elucidate the real issues underlying the debate and, in the process, demonstrate that the dichotomous view of policy options should be discarded in favor of a pragmatic approach to forming courses of action. Such approaches should be tested by their performance relative to a clearly established and widely agreed upon set of goals and not by their compliance with symbols of orthodoxy.

Proposition 1

In the absence of positive empirical evidence on the effectiveness of either government or market action in effecting a different ordering of the system of producing and distributing health care resources, all policy proposals ultimately rest, ipso facto, on economic theory tested in other markets or on naked political-economic ideology.

In complex policy making, in either the public or the private sector, it is difficult to establish with any certainty what the optimum approach to solving a particular problem is. Absent a scientific and predictable link between a given policy step and desired change in the underlying phenomenon, policy makers retreat to a body of theoretical work often called policy studies. By its nature, the corpus of such knowledge, principally based on neoclassical economics, is an aggregation of statements on what appear to be historically established links between given actions, most commonly undertaken by government, and changes in some economic or social phenomenon. Of course, the shortcoming of this approach, at least from the perspective of those schooled in the physical sciences, is that it is difficult to establish causal links, let alone to establish the magnitude of changes in the phenomenon under attack.

Several issues confound the empirical analysis of the effects of government intervention and the effects of the marketplace on given social and economic phenomena. First, simultaneous events exogenous to the model confound the effect being sought. A careful grain subsidy policy, for example, can be upset by swings in international crop or market conditions. Second is the problem of measurement. Unlike the measurement of, say, flows of various types of funds in banking policy or cubic yards of concrete in public works projects, the metrics used to measure the status of a targeted social or economic phenomenon are often too vague to capture secular differences. Third, the nature of theory construction in economics limits action. Economic science proceeds by serially testing the effects of a number of forces on a particular outcome. Thus, certain cause-and-effect relationships cannot be established independent of a specific historic time. The very nature of this limitation forbids the simultaneous pursuit of steps that are deemed theoretically antithetical. A fourth problem relates to the nature of orthodoxy and its application in policy work. Because theory may not allow a particular relationship to exist, many times experimentation is foreclosed altogether. Finally, policy science cannot account for unforeseen shifts in underlying or related phenomena. For example, we are apparently powerless to anticipate major changes in social or cultural values, such as the labor force behavior of women in the 1970s, that affect decisions relating to the use of health care and how it should be financed.

Proposition 2

The competition/regulation debate seems to be more one concerned with who is in charge of change than one focused on achieving optimal performance of the health care system.

It flows from the discussion of the first proposition that because there is a lack of certainty regarding the cause-and-effect relationship between various policy steps and outcomes—a problem that most of those who offer policy prescriptions are aware of—the real argument may well be over who is directing the change in the delivery and financing of health care. One's position on regulation/competition is inexorably related to one's perspective on how effective private or public actors are in guiding the health care delivery and financing system. In generic terms, the question is really one of whether government, through a system of rule making, can force greater efficiencies into the health care system than the system can produce if left to itself in an environment of increased attention to unit prices. Little evidence exists to inform us on the historic ability of either actor to reorder and regulate the health care

system so that it performs in more acceptable ways.

While government has had far greater experience than business until recently, its performance in operating several regulatory programs suggests its limited ability to effect appropriate change in the provision and financing of health care. The federal government's inability to enforce Hill-Burton community care obligations is a telling example of nugatory governmental action.[3] Likewise, federal cost containment efforts under Section 223 proved virtually without impact. Finally, federal health planning legislation may have exacerbated the problem of excess bed capacity that it set out to solve.

Proposition 2 suggests the irreducible ideological nature of the problem. By definition, one expects regulation to emerge in situations where real or perceived market failure exists. Thus, government's presence in health care delivery and finance is, in terms of the debate, regarded as prima facie evidence of regulation. Students of regulation, however, would find the absence of an integrated regulatory delegation including control over market entry, price, and quality suggestive of government's inability to control events. It could be argued that the health industry, in operational terms, has never been subject to effective regulation.[4] Likewise, the alternative, namely, a privately functioning market for care, is historically nonexistent. Much of the health care exchange, notably that taking place in the hospital, was expressly established in nonmarket (eleemosynary) settings.

Thus, one could conclude that although government did not really regulate hospital prices until the advent of the prospective payment system two years ago, neither has there been any sweeping private market experience in the hospital exchange. Absent a broad-based record of action by either the government or the private sector, one's position in the competition/regulation debate may really reflect more one's taste for collective versus private action than a rational choice based on historic performance.

Proposition 3

Government will continue as an important actor in health care delivery and finance because it will always reserve for itself and be given the role of default actor.

Quite apart from perceptions regarding government's ability to effectively reform the health care delivery and finance mechanisms, government will play a regulatory role in the future regardless of the outcome of policy debate. Some regulatory action will attach to its residual role as ultimate payer for certain populations. None of the reforms proposed to date remotely conceives of reducing government's fundamental responsibility for Medicare and Medicaid. Proposals to shift the administration of the programs to the private sector, to increase copayments, and to reorder the delivery mechanisms to favor prepaid or capitation plans over fee-for-service arrangements merely address government aspirations to reduce its fiscal obligations at the margin. Government as a payer will continue to establish performance standards for those accepting public monies for services. These conditions, purely a matter of contract law, are often erroneously characterized as regulation.

In addition to continuing its contractual role, government in the future may well embrace an indisputable and comprehensive regulatory role, that is, one in which it enforces a price regime on all sellers and buyers in the market. Whether government seeks to enlarge its regulatory role will largely depend on the demand for such a role. For example, with increased pressure from insurers to pay providers lower prices for care delivered to patients, it is certain that the burden of uncompensated care will grow even more and that hospitals will insist on increased government payment for care of the uninsured. A greater government presence will result in more regulation if reorganization of the health exchange is not able to protect against the unwillingness of health care purchasers to help shoulder the cost of providing care to the uninsured.

To the extent that patients are being underserved in the interests of cost pressures imposed by competition, or that private insurance mechanisms discriminate against bad risks, or that alternative providers of care (HMOs, PPOs, IPAs, and so on) can no longer demonstrate economic efficiencies relative to traditional providers, the likelihood will grow that government will act to enforce a global regulatory scheme in order to protect a societywide interest. In other words, should developments largely justified on competitive grounds fail to demonstrate true economic advantages, or should the dislocation of high-risk

or uninsured individuals become problematic, government action will be called for.

Proposition 4

The costs of advancing alternative policy options in lieu of traditional practice, even if untried, may appear to be less than the costs of continued pursuit of current policy.

To some observers, discontent with current health care policy, whatever its foundation, is a sufficient condition to compel change, and whatever system takes its place could hardly be less efficient or less equitable than the existing system. To such observers, it may appear that there is little to lose in changing the health care sector.

This proposition reflects the absence of a public policy culture that embraces a critical understanding of what the relationship is between a course chosen and its effect on the problem it was designed to address. A cursory examination of any area of public policy, however, suggests that there is enormous potential for harm in virtually any step that might be taken. Unintended effects abound from ill-considered change, and in some cases the net effect of policy change has been to worsen, not improve, the underlying problem.

Two examples illustrate the point. In the case of national manpower and education policy, government programs were undertaken to improve the operation of labor markets for engineers, high school teachers, and medical personnel, including physicians. In each case, government action, while appearing both timely and appropriate when it was initiated, proved to be overreaching and, arguably, resulted in worsening the problem by producing oversupply conditions.

The second example is airline safety. Government has recently acted to reduce its role and to rely on industry-operated safety programs. This change is founded on the notion that market forces are sufficient to reward safe behavior and punish unsafe behavior. The nature of the market test in this area, however, puts one in mind of Arthur Okun's observation that it is scant comfort to the person poisoned by a defective drug that he or she will be able to choose another manufacturer's product the next time around. Regarding airline safety, there is potential for enormous harm if the policy decision proves to be wrong.

The absence of a critical policy perspective permits proponents of change to suggest relatively radical alternatives. In the instant case, the failure of current government health policies may be seen as calling for an entirely different approach, untried for the most part and outside the government sector. An attempt at another governmental approach may not even be discussed. Thus, once government action is thought to have failed, only private action exists as an alternative.

Proposition 5

The focus of future regulation in the health sector is likely to be quality, consonant with experience in other regulated industries where regulation appears to advance in steps, first attending to entry questions (access), then price, and finally quality.

Regardless of the debate over whether the future will be characterized by either regulation or competition, it is likely that one area in which government's role will increase will be in the assurance of quality care. History suggests that contemporary regulatory action tends to focus increasingly on quality issues, which supersede government regulation of entry and price activities. It can be argued that every new federal regulatory program in the last 20 years (occupational health, environmental protection, and consumer products) has been concerned principally with quality rather than entry or price issues. If competitive pressures in the health care arena result in care of less than optimal levels, it will likely result in demands for government intervention to assure quality standards.

Quality is likely to suffer from increasing pressure to reduce unit costs of care. To the extent that real unit costs are already depressed relative to current levels, providers may be expected, in the short run, to increase the number of units sold. Absent any indication that an absolute number of procedures will "naturally" occur in a given population, and given the provider's ability to influence demand, there is every reason to be concerned that the population could be medically overtreated, resulting in reduced quality.

Pressure to lower provider costs per unit may also result directly in reduced quality. In responding to price pressure, providers may be tempted to reduce the volume and/or quality of input altogether. To the extent that reduced input results in poorer care relative to an acceptable standard,

the impact of cost reduction will affect quality in an adverse way.

In the final analysis, regulation of quality may prove to be the only appropriate regulatory role for government in the health care sector—a function that will be sorely needed if competitive pressures reduce quality below acceptable levels.

Proposition 6

As competition in the health care sector increases, the need for regulation will increase; the two are likely to be as much symbiotic as exclusive phenomena.

Oversight of the health care sector—that is, regulation in the broadest sense of the word—is now spread among federal and state agencies and private payers able to exercise power because of the oligopsonistic nature of the market. Such regulation, or oversight, arguably is necessary because of the nature of the product distributed in the health care exchange. Unlike those markets where consumers have greater control over their taste for a service or a commodity, purchasers of health care services generally defer to the judgment of health care professionals. And, unlike markets where both the quality and price of goods and services are easily discerned, the health care consumer often must make his decisions in the perceived absence of both information on and, in most instances, choice in the grade of care that he purchases. Thus, because the health care sector operates outside the usual market forces, it is likely that as competition increases (in the form of more providers under pressure to deliver services at lower prices), regulatory activities will increase, although not necessarily in proportional terms. Conversely, as regulation increases, competition will decrease.

In the case of Medicare, as the federal government redefines its roles by reducing its fiscal obligations through regulation (the prospective payment system), the locus of public policy will shift to state and local arenas because it is at this level that other payers are governed. In reaction to Medicare reductions, hospitals will attempt to burden other payers with the shortfalls resulting from decreased federal payment. Eventually, as hospitals shift more of these costs to payers that are more responsive to local pressures, there are likely to be proportionally louder calls for regulation at the state level to address the payment imbalance. From a national perspective, where the regulation/competition debate has been focused, it may appear that there is less regulation. But in fact, there may be more—and certainly more diffuse—regulation. Not only will state Medicaid programs exert regulatory pressures, but Blue Cross Plans and other payers may use the private regulatory power associated with oligopsony to establish prices without the consent of providers.

Proposition 7

Because the attribution of success and failure to specific actors is impossible owing to secondary effects, government may as likely be deemed responsible for current procompetitive changes just as market failure is the predicate of government regulation.

In complex policy making, either in the public or in the private sector, it is nearly impossible to establish with any certainty what the optimum approach to solving a problem is. Worse, as pointed out earlier, it is frequently impossible to establish a cause-and-effect relationship between consciously taken policy steps and specific outcomes. This being the case, it is even more difficult to determine what outcome, if it is measurable, can be ascribed to a given actor.

One can speculate, for example, that the current interest in a procompetitive health care delivery system is the result of government having first defined health costs as a major problem. Until about five years ago, by contrast, private sector interest in the issue was largely lacking.[5] Now many of the nation's largest employers have concerned themselves with health care costs. Insurers face growing pressure to reduce premium costs, and employees and unions are encountering demands to bear more of the costs of health care coverage—the so-called give-back phenomenon.

It is important to recall, in the enthusiasm that greets growing private sector interest in health care costs, that it can be argued that the failure of the private health care financing and delivery sector to accommodate the poor and the elderly forced government to enter the arena in the first place. It is impossible to deny the operation of one or the relative supremacy of the other. Indeed, in the final analysis, how our health care system got to where it is today, and how we will find appropriate solutions to access, funding, and payment problems, may continue to elude accurate and fruitful analysis.

Conclusions

This paper suggests the relativism of policy debate, specifically of whether we as a society should pursue a conscious policy of turning to government or to the private sector to improve the workings of the health care finance and delivery system. All such contests, absent solid facts that establish cause-and-effect links between action taken and outcome achieved, necessarily become normative in nature.

In the health care exchange, a fundamental tension exists over whether we as a society want the system to perform more efficiently (like other markets) or whether we want to strive for equitable distribution of the opportunities of care (suggesting the traditional view that government enters into markets to establish rules that override those of strict price distribution; i.e., government enters when the market fails relative to a value that requires a different distribution outcome). It is curious that proponents on each side argue that their solution will achieve both objectives and that the other side is capable of achieving only one.

In many respects, the debate of the day—that, through either more competition or more regulation, the way we finance and deliver health care must be changed—is based on a calculus that is relativistic. Unfortunately, our inclination to change may not rest on the proportionate failure of the present actors in the system. That is, if we are really satisfied with, say, 70% of government's role in financing and directing the system, but discontented with only 30% of what it has done, we seem all too willing to try a completely different approach—namely, a market-driven system.

It could be argued that the competition/regulation debate would disappear if the U.S. government's huge debt—and the attendant pressures to reduce government spending—disappeared, since government's role as spendthrift funder would be reestablished. This suggests the budgetary relativism of the debate.

Notwithstanding the nature of the relativism of the debate, the debate itself, once properly focused, is of great utility in the making of policy. It exists because it mirrors real opportunities to proceed in alternative directions. The tension between the competition and the regulation options in the health care debate is to be encouraged because it makes policy makers mindful that future solutions, as past experiences suggest, will rely on the operation of both the private and the public sectors. In other words, the debate is really one of how large the roles of government and the private sector should be. Thus, the debate is one of proportion. The future seems likely to hold a larger—or at least different—role for the market at the same time that government interest and action will assume a different form. The task must be to recast our vision of how much each actor properly does.

Notes

1 H. J. Aaron and W. B. Schwartz, *The Painful Prescription: Rationing Hospital Care* (Washington, DC: Brookings Institution, 1984).

2 *National Gerimedical Hospital v. Blue Cross of Kansas City*, 101 S. Ct. 2415 (1981).

3 Ellyn L. Brown, "The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor," *Maryland Law Review* 39 (1979): 316.

4 S. Payton and R. M. Powsner, "Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need," *Michigan Law Review* 79 (1980): 203-277. But see B. Biles, C. J. Schramm, and J. G. Atkinson, "Hospital Cost Inflation Under State Rate-Setting Programs," *New England Journal of Medicine* 303 (Sept. 18, 1980): 664-668.

5 H. M. Sapolsky, D. Altman, R. Moore, and J. D. Moore, "Corporate Attitudes Toward Health Care Costs," *Milbank Memorial Fund Quarterly: Health and Society* 59 (1981): 561-585.

DEFINITION OF QUALITY, ACCESS, AFFORDABILITY

A DISCUSSION OF SOME ASPECTS

February 15, 1988

Prepared for:
The Blue Ribbon Commission on Health Care Expenditures

Graham Atkinson, D.Phil.
1449 44th. Street, NW
Washington, DC 20007

A HISTORY OF MAINE'S CERTIFICATE OF NEED PROGRAM

NOTE: A major portion of this report on the history and development of the Certificate of Need program is taken from a paper prepared by Robert Clarke for this committee, The Background and Development of the Maine Certificate of Need Program, October 1985.

Major Influences on the Health Care System from 1945-1975

Health Insurance:

In the 1930's, public health insurance was virtually non-existent and private health insurance was still rare. During the Depression, hospital revenues decreased drastically. From 1929 to 1930, the average hospital receipts fell from $236.12 per patient to $59.26.[1] Out of this crisis, hospitals, in conjunction with the American Hospital Association, developed Blue Cross plans to provide a stable source of revenue for hospitals. (Blue Cross plans are basically group insurance plans which provide payments to hospitals for covered health services in exchange for a monthly subscription fee.)

During World War II, wage ceilings were imposed by the War Labor Board. The labor force was sparse. The wage ceilings prohibited wage incentives from being used to attract the available labor force. Employers turned to non-wage benefits, such as health insurance, to attract the scarce labor force. By 1950, approximately half of hospital revenues were derived from health insurance. Now, in the 1980's, more than 90% of all hospital revenue comes from health insurance.

The result of this dramatic change in the payment system for health care is that the consumers of health care (the patients), the ultimate payors, have insulated themselves from the direct impact of health care costs in a remarkably short period of time.

Government involvement:

During the post World War II era, we also began to see the beginnings of governmental involvement in health care. President Truman had proposed a national health insurance program. The American Hospital Association (AHA), opposed to this plan, suggested a Federal program of grants to support community hospital construction. In 1947, Congress adopted their version of the AHA proposal and enacted the Hill-Burton Act to encourage the expansion of hospitals and to encourage a more balanced distribution of hospital beds across America.

This program provided grants to any hospital who would make their services available to everyone and who would dedicate a specific amount of free care to those unable to pay. Between 1947 and 1974 four billion dollars was given to almost 6,000 hospitals. By 1973, the program had provided approximately one out of every three beds in community hospitals (358,000 beds).

The Hill-Burton Act marked the Federal government's first entry into health care as a major participant and, indirectly, as a guarantor of health services for the poor. But, this was only part of the story. The Federal government also became involved in health care through:

1. Research: Massive investment in medical research, e.g. through the National Institute of Health, has been responsible for many of the advances in medicine in the last 30 years.

2. Medical education: Substantial funds were invested in medical schools and in the subsidy of medical education more than doubling the number of physicians graduating from American Medical schools in 1980 than graduated in 1960.

3. Medicare and Medicaid: Established in 1966, these two programs gave the elderly and poor access to and financial support for a broad range of health care services. These programs increased the demand for health care services. The method of payment used until 1983, retrospective cost based reimbursement, also provided tremendous incentives to increase the costs of medical care. Payments to providers were based on the actual costs incurred, i.e. the charges the providers made for the services. If a provider became more efficient, the payments from Medicare and Medicaid were reduced. If the costs increased, payments increased. The message that the government was sending by the incentives inherent in this kind of payment system was not to decrease costs.

Results:

Over the last 40 years we have seen many changes in the nature and delivery of health services. These changes include:

1. significant advances in medical technology;

2. increase of access to more advanced health care for those least able to pay and for those in remote areas;

3. a period of rapid and dramatic increase in health costs;

4. insulation of the recipient of health care from the direct impact of increased health costs;

5. a weakening of traditional market forces; and

6. major investments and major policy decisions in the health care field by government.

This dramatic improvement in access to and quality of health services was largely the result, directly or indirectly, of the government's actions in the health care field. In 1966, the Federal government responded to these changes by initiating or authorizing "several efforts intended to bring about an orderly and equitable allocation of the newly available resources, to avoid the costly and unnecessary duplication of new services and to assure sufficient but not excessive growth in the capacity of health care facilities."[2]

Precursors to Certificate of Need

In 1966, the Partnership for Health Act, was enacted to encourage creation of statewide and local health planning agencies, which were expected to engage in comprehensive health planning, to moderate rapidly rising health costs, and to involve consumers in the formulation of health policies. This was to be accomplished by the creation of three agencies:

1. a state comprehensive planning agency to carry out state wide health care planning (Maine's Department of Health and Welfare was the designated agency);

2. a statewide citizens advisory council appointed by the Governor, with a consumer majority, to advise the state planning agency; and

3. local or regional planning agencies (5 were established in Maine), with a consumer majority on their governing boards, to develop local or regional plans.

These agencies were given limited authority and limited funding. Accordingly, there success was limited.

In 1974, the National Health Policy and Resource Development Act (Public Law 93-641) replaced the Partnership for Health Act. Its purpose was to address the:

1. rising cost of health care;

2. the maldistribution of resources;

3. the lack of uniformly effective methods of delivering health care;

4. the lack of a comprehensive, rational approach to these problems; and

5. consumer ignorance of proper personal health care and of proper ways to use available health resources.

Again, three kinds of agencies were created by the legislation.

Each state was to establish local or regional health systems agencies (HSA). Each agency was to be a non-profit, private entity with a majority of consumers on their governing boards and was to represent their health service area. Governor Longely designated the entire state as a "health service area" and created the Maine Health Systems Agency, Inc. (MHSA) as its only HSA. This had not been anticipated by the Federal legislation and led to a unique implementation of the Federal scheme. Each HSA, in Maine's case the one state-wide MHSA, was responsible for developing annual health systems plans and annual implementation plans for their respective service areas. Other states had several sub-state plans. Maine had only one statewide plan, developed by its MHSA.

The second agency, the state health planning and development agency (SHPDA), was to take the sub-state plans and combine them into a preliminary comprehensive state wide plan. In Maine, this resulted in two agencies preparing a statewide plan, clearly overlapping in responsibility. SHPDA, which was the newly created Bureau of Health Planning and Development in the Department of Human Services (formerly Health and Welfare), was to submit the plan to the third newly created agency.

The third agency was a state wide volunteer health planning body referred to as the "state health coordinating council" (SHCC). Its responsibility was to take the preliminary state health plan submitted by SHPDA, adopt its own version of it (now creating a third statewide plan) and present it to the Governor for his approval or disapproval.

Once approved, SHPDA would be the state agency responsible for implementing those portions of the approved plan which related to state government.

In addition, the MHSA, SHCC and the Department of Human Services were responsible for reviewing proposed use of Federal funds and specific health services.

The last part of Public Law 93-641 required each state to establish a Certificate of Need program and implement the Federal Certificate of Need review (referred to as Section 1122 review.) Failure to comply with the minimum criteria would result in the loss of substantial Federal funds for health related programs.

SHPDA, the Bureau of Health Planning and Development, was designated by the Governor as the state agency responsible for implementing the Maine Certificate of Need Act and the Federal Section 1122 program. SHPDA would review any projects which required a Certificate of Need review and make its recommendation to the Commissioner of the Department of Human Services. The MHSA would also review the Certificate of Need project and make its recommendation to the Commissioner. The MHSA would hold a public hearing on each project as part of its review. The Commissioner, after considering both recommendations, would approve or deny the project.

In 1978, Maine enacted its Certificate of Need program. A description of the current law is contained in the next major section of this report.

Significant Changes to the Certificate of Need Act

In 1979, Congress amended Public Law 93-641. It increased the minimum dollar amount (thresholds) which set the limit on which projects were reviewed. In addition, Federal funding for the HSA's was reduced considerably.

In Maine, this resulted in staff reductions, a cut-back or elimination of many MHSA activities, and, by 1981, no effective review of Certificate of Need projects.

The Legislature began to look at the Certificate of Need program and how the 1979 Federal amendments had affected it. The Joint Standing Committee on Audit and Program Review study recommended the elimination of the MHSA and transfer of their Certificate of Need related functions to the SHCC. Their proposal was withdrawn in deference to a legislatively created special Certificate of Need study committee. Composed of legislators from the Joint Standing Committee on Health and Institutional Services (now called the Joint Standing Committee on Human Resources), it recommended a change in the threshholds for the state Certificate of Need program and the creation of a Certificate of Need Advisory Committee. The Certificate of Need Advisory Committee would take the place of the MHSA whose days were numbered. The study committee chose not to place those Certificate of Need review functions in SHCC, feeling it would be inconsistent with their role as a statewide health planning organization.

These recommendations were enacted in 1982. The Certificate of Need Advisory Committee was established to hold public hearings on Certificate of Need projects, when requested, and make an independent recommendation to the Commissioner. The Committee was composed of 5 consumers and 5 other members representing hospitals, physicians, the nursing home industry, major third party payors, and, as a non-voting member, the Department of Human Services.

THE MAINE CERTIFICATE OF NEED PROGRAM

In enacting the Certificate of Need Act, the Legislature declared "that unnecessary construction or modification of health care facilities and duplication of health services are

substantial factors in the cost of health care and the ability of the public to obtain necessary medical services." (22 MRSA § 302 sub-§ 1). The purposes of the Act are to:

1. promote effective health planning;

2. assist in providing quality health care at the lowest possible cost;

3. avoid unnecessary duplication in health facilities and health services and ensure that only those facilities that are needed will be built or modified;

4. assure that state funds are not used to support unnecessary capital expenditures made by or on behalf of health care facilities;

5. provide an orderly method of resolving questions concerning the need for health care facilities and health services which are proposed to be developed;

6. permit consumers of health services to participate in the process of determining the distribution, quantity, quality and cost of these services; and

7. provide for a Certificate of Need program which meets the requirements of the National Health Planning and Resources Development Act of 1974, Public Law 93-641, and its accompanying regulations.

Hospitals and other designated health care facilities are required to obtain a Certificate of Need approval for projects which are subject to the Certificate of Need review. Those projects which require a Certificate of Need review include:

1. acquisition of major medical equipment costing $300,000 or more if:
   a. owned by a health care facility,
   b. located in a health care facility, or
   c. used to provide services for inpatients of a hospital;

2. capital expenditures of a health care facility of $350,000 or more;

3. development of a new health service by a health care facility:
   a. which will have a capital expenditure cost of $350,000 or more,
   b. which will have an annual operating cost in 3rd fiscal year of $145,000 or more ($155,000 or more after December 31, 1985), or
   c. which qualifies under the SHCC "Category C" rule;

4. termination of a health service if it will involve a capital expenditure of $150,000 or more;

5. changes in bed complement over a 2 year period which involve more than 5 beds or more than 10% of licensed or certified beds;

6. predevelopment activity of $150,000 or more;

7. construction or development of a new health care facility; and

8. other circumstances specified in the law.

A hospital may apply for, and receive, a waiver of the certificate of need review requirements otherwise imposed if:

1. the project is a new health service involving no capital expenditures or a capital expenditure of less than $300,000 and 3rd year annual operating costs are at least $155,000 and not more than $250,000; AND

2. the hospital agrees not to seek or accept any adjustments to its financial requirements under the Health Care Finance Act. (The significance of this will be explained when the relationship of the Certificate of Need program and the Health Care Finance Commission is discussed.)

An overview of the Certificate of Need law with statutory citations, including the requirements and criteria for a Certificate of Need approval, are contained in Appendix B.

THE CREATION OF THE MAINE HEALTH CARE FINANCE COMMISSION

Factors leading to establishment of MHCFC

It soon became apparent that health care costs were continuing to rise, consuming an increasing share of individual, corporate, and governmental budgets. Retrospective cost based reimbursement was feeding not fighting the increase in health costs and was threatening the financial viability of some health care providers. The prominent question to be answered at the state and federal level was "How much of our resources could we, or should, devote to health care?"

The Maine Health Care Finance Commission Established

In 1983, Maine established a prospective payment system for hospitals and created the Health Care Finance Commission to implement this system.

The prospective payment system requires the determination of the financial requirements of each health care provider and the aggregate amount the provider must charge to meet those requirements. This is determined in advance by the Health Care Finance Commission. If the provider actually spends less to provide those services, it may keep the extra. The next year's financial requirements are based on the previous year's financial requirements, with adjustments, and not on the actual costs. So, the hospital is not penalized for saving by a reduction in financial requirements. Under the cost based system, the hospital would have received its actual costs, which, if less, would have resulted in less revenues for the hospital.

A prospective payment system has incentives that are just the opposite from those of a cost based system. In a cost based system, the more you spend the more you get reimbursed. There is no incentive to save. As noted above, a prospective payment system provides a benefit, if you save. In addition, you are guaranteed reimbursements for your approved financial requirements, your "budget".

The Relationship between the Health Care Finance Commission Act and the Certificate of Need Program

A hospital's financial requirements are based on the costs of existing equipment and programs, adjusted each year to account for inflation and other items. Expenses for Certificate of Need projects (new services, construction, or equipment) could not automatically be added to the financial requirements of a hospital since they would represent new charges not previously associated with their budgetary needs. Hospitals could not collect the costs for these services.

The legislature, at the same time it enacted the Health Care Finance Commission Act, required that all Certificate of Need projects which were approved be automatically added to a hospital's financial requirements. The costs of these services was automatically passed on to the payors under the payment system established by the Health Care Finance Commission Act. This change to the Certificate of Need program provided the link between the Health Care Finance Commission laws and the Certificate of Need Act. Hospital regulation through the Commission would control the costs of existing services. Certificate of Need approval would be the cost containment tool for control for new services, construction, and equipment. It would help control health care costs by requiring a state agency to review each new service, construction project, or purchase of new equipment and grant approval to only those projects which were actually necessary. Existing programs were held to a budget and any new programs added to that budget had to be found necessary or the system would not allow increases to a hospital's charges to pay for that service or equipment.

The two parts of the system, when combined, cover the whole of health care for those facilities subject to cost regulation and Certificate of Need review.

The Certificate of Need Development Account

Also, in 1983, the Legislature enacted the Certificate of Need Development Account. The Certificate of Need program was required to approve every project that was not duplicative or otherwise unnecessary. Neither the Certificate of Need program nor the Health Care Finance Commission addressed the issue of how much of our resources we should devote to expanding our health services. The cumulative financial impact of Certificate of Need approved projects could not be considered. Its cost would be passed on automatically to the payors of health care. The Certificate of Need Development Account established an affordable limit on growth.

The Certificate of Need Development Account established a limit on the total dollar amount of Certificate of Need projects which may be approved in any one year. This amount is established by statute in the first two years under the Health Care Finance Act at 1% of the total hospital operating expense for the state and is set by the Health Care Finance Commission in subsequent years. Legislation enacted in 1985 (PL 1985, c. 347) amended the method in which debits against the account are determined and allowed projects of unusually high cost to be debited against the account over several years.

The Medicare Prospective Payment System for Hospitals

Established by the Federal government, the Medicare prospective payment system for hospital expenses is different from Maine's prospective payment system. Maine's system includes the goal of assuring the financial viability of Maine's hospitals. The Federal system makes no attempt to determine the financial requirements of a hospital and the aggregate charges to offset those requirements. Medicare pays hospitals a fixed amount for each case. Each case is assigned to a diagnostic related category (DRG) and each DRG is assigned a payment amount. This fixed amount is not adjusted (like the rest of Maine's payors amounts are) to reflect the costs associated with approved Certificate of Need projects. Maine payors will bear those expenses. Medicare payments represent from 35% to more than 50% of the total revenues in some Maine hospitals.

The result of Medicare's prospective payment system approach will significantly increase the financial impact of Certificate of Need related costs to Maine's payors.

FROM ADVOCACY TO ALLOCATION

The Evolving American Health Care System

David Mechanic

THE FREE PRESS
A Division of Macmillan, Inc.
NEW YORK

Collier Macmillan Publishers
LONDON

Introduction: A Brief Anatomy of the American Health Care System

THE PURPOSE of this introduction is to present a short, overall picture of the health care system, to provide a fuller context for the chapters that follow. It is difficult to describe in brief the dimensions of an industry involving facilities, goods, and services exceeding $400 billion a year. The size, complexity, and diversity is mind-boggling; the system of care is extraordinarily dynamic; and the high stakes intimately involve hundreds of government agencies, professional groups, business interests, consumer organizations, special interest lobbies, employers and unions, public interest groups, and many others. The health industry has been growing rapidly; some estimate it will reach an expenditure level of $2 trillion and 15 per cent of the gross national product by the year 2000.

Health Expenditure Patterns and the Burden of Illness

The single major component of total health care expenditures is hospital costs, consuming 42 per cent of the total. The second-largest element is physician fees, not already included in hospital budgets,

totaling slightly in excess of 19 per cent. Other major components include: nursing home care (approximately 8.5 per cent); drugs and small medical items (almost 7 per cent); dental services (6 per cent); construction of medical facilities (2.5 per cent); and administration of insurance programs (almost 4 per cent). Restricting consideration more narrowly to personal health expenditures shows that in 1983, 47 per cent of all such expenditures went for hospital care and 22 per cent for physician services. Given the size of the budget, a seemingly small 1 per cent involves expenditures of more than $4 billion.

In 1983, government at all levels accounted for 42 per cent of total health expenditures. The two largest programs, Medicare—a program for persons over 65 and a limited number of others with specific disabilities—and Medicaid—a federal-state matching program for the most impoverished part of the population—accounted for 29 per cent of personal health expenditures. Medicare alone cost $57 billion in 1983, $62½ billion in 1984, and is expected to cost $75 billion in 1985.

The pattern of health expenditures in some measure reflect the burdens of illness and risks of mortality in varying age and other social strata. The elderly and the poor are, of course, at greater risk. In examining the overall profile of mortality, four additional points ought to be considered. First, rates and causes of death vary greatly by sex and age. Women, on average, live more than seven years longer than men, and deaths among children, adolescents, and young adults are relatively low and predominantly due to accidents and self- and other inflicted violence. Second, age-adjusted death rates in the United States have been falling for major diseases with the exception of cancer. The increases in cancer are almost completely explained by smoking patterns. The large drop in age-adjusted mortality from heart disease and strokes in recent years are particularly important gains and account for a significant proportion of the advances in longevity among the American adult and elderly population. Third, while all groups in the population have benefited from downward trends in mortality, the large differentials between males and females and whites and nonwhites persist. Absolute rates have fallen, but the gaps have not significantly closed. Nonwhites and the poor remain at greater risk. Finally, while many biological, environmental, and other factors contribute to the differentials by age and sex, factors associated with behavior clearly have a major role. Cigarette smoking, accidents, excessive drinking, and failure to maintain control

over blood pressure together account for massive increments in sickness and mortality.

More than two-thirds of all deaths in the United States are due to heart disease, cancer, and stroke. In excess of 7 per cent of deaths result from accidents, suicide, and homicide. Other major causes include chronic obstructive pulmonary disease (3.3 per cent), pneumonia and influenza (2.7 per cent), diabetes mellitus (1.8 per cent), chronic liver disease and cirrhosis (1.4 per cent), and atherosclerosis (1 per cent). No other single cause accounts for as much as 1 per cent of all deaths.

An alternative way of looking at the burden of sickness patterns is to examine health expenditures in relationship to varying classes of disease. Many diseases causing substantial suffering and disability, and great dependence on the medical care system, do not necessarily result in death. The 10 most costly categories of illness, as measured by expenditures on hospital care, nursing home care, professional services, and drugs, vary from circulatory disease, costing $33 billion in 1980, to endocrine, nutritional, and metabolic diseases, costing almost $8 billion. Intermediate categories, listed in order of importance were: diseases of the digestive system; mental disorders; injuries and poisoning; diseases of the respiratory system; cancer; diseases of the musculoskeletal system and connective tissues; genitourinary disorders; and diseases of the nervous system and sense organs.

The largest costs involve the elderly, who have more chronic and degenerative disorders than younger populations and require more ambulatory, hospital, surgical, and long-term care. These costs accelerate dramatically at the oldest ages and are particularly high in the final year of life. In 1977, per capita health care spending among those 65 and over was $3\frac{1}{2}$ times that of the total population, and the difference has continued to grow since then. In 1978, persons 19 and under had per capita expenditures of $286 while those 65 or older expended $2,026. Seventy per cent of all Medicare payments were on behalf of 9 per cent of the elderly involving an average payment of over $7,000. Reimbursement for the elderly was high during the last year of life, and particularly in the last 60 days before death. The 5 per cent of Medicare recipients who died in 1978 accounted for 28 per cent of program expenditures, which, on average, was $4,527 during the final year of life.

Most of the population have much of their medical expenses cov-

ered to varying degrees by health insurance. More than 90 per cent of the population have third-party insurance, most commonly profit and nonprofit insurance programs associated with the head of household's employment. The elderly are primarily covered by Medicare, and a significant proportion of the poor by Medicaid. It is estimated that in 1985 as many as 35 million people have no private or public insurance coverage. In 1982, nongovernment health insurance programs paid 29 per cent of all health care expenditures while 28 per cent were paid directly by patients. Hospital care and inpatient physician services were predominantly covered by third-party insurance, but coverage is much less comprehensive in the areas of ambulatory care, outpatient diagnostic services, drugs and appliances, preventive care, and dental and other services. Even Medicare, a program perceived as relatively comprehensive, pays only for 44 per cent of total health care costs of the elderly.[1] Out-of-pocket payments by the elderly have increased in recent years, and this population now pays a larger proportion of their total income for medical care then they did prior to the enactment of the program. Per capita out-of-pocket expenditures for the elderly are estimated to rise from $1,683 in 1985 to $2,395 by 1990. They receive, of course, much more medical care than before.

It is commonly noted that the number of poor aged has declined over time, making this age group comparable in economic status to other age categories in the population. While many elderly people have avoided poverty in large part due to social security and other public programs, a disproportionate number of aged persons live close to the poverty line and could become impoverished with cutbacks in federal programs. Moreover, the elderly group is heterogeneous. While some are affluent, many are poor. Some analysts speak of the "two faces" of aging, emphasizing that significant segments of the aged are greatly disadvantaged and face special burdens when sick. In 1981, for example, while elderly persons on average paid 13 per cent of their incomes for out-of-pocket health expenditures, the black elderly paid 23 per cent and black elderly women 27 per cent of their incomes for such out-of-pocket costs. Also, because of the inadequacy of long-term care coverage and complex eligibility criteria for Medicaid coverage, an elderly person may be required to become impoverished before the spouse can receive needed subsidy for essential long-term care. These areas continue to be important challenges for future policy formulation.

THE FOREGOING is necessarily brief since my intent is to establish a context for what follows and not to summarize this large arena. Thus, I now turn to a description of the basic components of the system: physicians, nurses, and other health care personnel; the organization of primary medical care and first contact facilities; innovative system approaches such as HMOs (health maintenance organizations); the hospital sector and related institutional facilities; tertiary care and the sophisticated teaching hospitals; and research and development in health and health care.

Health Workers

Physicians dominate the health sector although they constitute only a small minority of the many millions of health workers. At the beginning of the century there were two health workers per physician, but the present number is more like 15 to 1.[2] There are approximately one-half million physicians in the United States, a ratio of more than 1 for every 500 patients. This reflects an increase from 1.4 physicians per 1,000 patients in 1950 to 2.2 in 1985. The increasing supply reflects the substantial expansion of medical education between 1960 and 1980. In 1960–1961, American medical schools graduated somewhat less than 7,000 doctors. In recent years, they have been graduating between 16,650 and 17,400. As a consequence, we anticipate an excess future supply. The Graduate Medical Education National Advisory Committee (GMENAC), established to advise the secretary of the Department of Health and Human Services, anticipated an oversupply of 70,000 doctors by 1990 and 145,000 doctors by the year 2000.[3] The concept of oversupply is, of course, a fairly arbitrary one. In one sense, the number of doctors one needs depends on the willingness to pay for services. Much evidence supports the belief that the nation is reaching a ceiling in its financial commitment to continuing growth in the medical care sector relative to other social priorities.

Though the total supply of physicians is estimated to be in excess, some specialties are expected to be in short supply, while others are seemingly in great abundance. Areas of anticipated undersupply include general and child psychiatry, preventive medicine and emergency medicine, and physical medicine and rehabilitation. Areas expected to have large oversupply include general surgery, obstetrics-

gynecology, and many of the medical and surgical subspecialties such as nephrology, rheumatology, cardiology, endocrinology, pulmonary medicine, neurosurgery, and plastic surgery. Estimates of oversupply are uncertain to some degree because many subspecialists facing inadequate specialty work loads fill in their time doing general medicine,[4] because of unanticipated changes in science and technology, and because there are alternative ways of coping with excess supply, including cutbacks in medical school enrollment, retraining doctors for needed clinical areas, expanding the boundaries of medical work, and migration of physicians to underdoctored areas. Yet when all is said, it seems evident that physician supply will be very large as compared with prior decades.

Physicians are primarily organized in relation to three major dimensions: specialty, type of group organization, and form of remuneration. All of these are in a dynamic state, and it is difficult to clearly predict future trends. A major distinction is between doctors engaged in primary care as compared with those primarily practicing specialties and subspecialties. Most typically, the primary care disciplines are defined as family practice, general internal medicine, and general pediatrics. Despite many efforts on the part of government and private foundations to encourage primary care training and practice, the trend continues toward specialty training, with a very substantial growth of medical subspecialists. On average, generalists see many more patients than specialists, charge less for each encounter, and are less likely to order complex and expensive medical procedures and laboratory tests.

Physicians have traditionally worked in office-based solo practice, and rarely in large single-speciality or multispecialty groups or other organizational settings, but the trend is clearly toward larger practice groups. In 1983, excluding physicians employed by hospitals or government, approximately half of U.S. doctors practiced by themselves, but those practicing in groups of five or more increased from approximately 17 per cent in 1975 to 23 per cent in 1983. More than three-quarters of doctors in 1983 were self-employed, varying from 87 per cent in the surgical specialties and 83 per cent in general and family practice to 68 per cent in other specialties. Older doctors are more likely to be self-employed, varying from more than four-fifths among physicians older than 56 to 61 per cent among those younger than 36. While prepaid practice is growing at a rate of 18 to 21 per cent each year, it still only serves approximately 6 to 7 per

cent of the population, and thus relatively few doctors work exclusively in such settings. A much larger proportion of doctors at least have some patients covered by prepayment plans, and such coverage is becoming increasingly common. Younger physicians and women are more receptive to practice in HMOs than their counterparts.

Most doctors receive their income through fees charged for visits and specific services and procedures performed. Third-party reimbursement for doctors' fees increased from 17 per cent in 1950 to 62 per cent in 1981. In 1983, three-quarters of all doctors' patients were covered by Medicare (21 per cent), Medicaid (9 per cent), Blue Shield (23 per cent), and other private insurers (23 per cent). In 1983, doctors reported that while Medicaid covered only slightly more than half their usual fee for a follow-up office visit, Medicare paid 68 per cent and Blue Shield 77 per cent.

Even doctors working in private settings have increasingly incorporated themselves for tax and other advantages, such as limiting their financial liability. Such incorporation increased from 31 per cent of physicians in 1975 to 54 per cent in 1983. More than half of physicians working with colleagues received their remuneration in the form of a salary, while approximately a third are paid on a fee-for-service basis. Approximately 10 per cent receive a proportion of either net or gross billings. These data reinforce an important but not widely appreciated point: how practices charge patients and insurers, and how physicians within these practices are paid, are two separable matters.

The Medicare program reimburses approximately 26 per cent of office visits and almost 31 per cent of all hospital visits. Thus, Medicare, and how it pays doctors, is of crucial importance to physicians and they feel very much threatened by impending changes. Medicare is particularly important for the medical specialties accounting for 44 per cent of all visits. Average net physician income before taxes in 1983 was $106,000. It varied a great deal by specialty from a low of $68,500 for family and general practitioners to $148,000 in radiology. Incomes were lower in nonmetroplitan areas and among those who were employees as compared with those self-employed. Both the youngest and more elderly doctors earned the lowest incomes, with income highest in the 46 to 55 age group.

In summary, doctors have done rather well in the context of growing government involvement in medical care, and particularly in the context of the Medicare program. Their current status, how-

ever, is unstable due to the vigorous efforts by the government to control expenditures for medical care, reduce the federal deficit, and contain increasing costs at the state level. There is little doubt that this is an area of impending tension and acrimony, and physicians' incomes are likely to erode to some degree.

In 1980, there were about 1.3 million active registered nurses (RNs) in the United States, one for about every 145 people. The availability of RNs more than tripled since 1950, reflecting not only population changes and the increased importance of hospital care, but also the growth of technology and intensity of treatment characterizing inpatient care. Approximately two-thirds work full time and one-third part-time. Nursing is primarily based in hospitals, where two-thirds of all nurses are employed. Although most do general nursing, in recent years there have been significant increases in more specialized roles—for example, clinical nurse specialists, nurse clinicians, nurse practitioners and midwives. While very important in leadership roles in clinical settings, their number remain relatively small. In 1980, there were about 8,000 nurse clinicians, 16,000 nurse practitioners and midwives, 18,000 clinical nursing specialists, and 14,000 nurse anesthetists. Other major settings for employment of registered nurses include nursing homes, public and community health agencies, physicians' and dentists' offices, and student health services.

Nursing has become increasingly professionalized, and while in earlier eras most nurses obtained three-year diploma degrees and two- and three-year associate degrees, most nurses are now educated in colleges and universities. While in 1980 only a third of all practicing nurses had baccalaureate degrees, a major goal of nursing is to eventually require the baccalaureate for entry into practice. Many nurses are also going on for graduate degrees as well.

Unlike physicians, nurses are primarily employees, paid through hospitals and other institutional or agency settings. Nursing salaries have been traditionally low, often on a par with secretaries and other female workers, but lower than teachers and social workers. While salaries vary to some extent depending on supply and demand for nurses and the ability of nurses to organize and conduct effective collective bargining, nursing salaries are constrained both by the large potential supply and the cost pressures on hospital budgets. Nurses, despite their crucial importance to the sophisticated care of the critically ill, earn between one-fifth and one-sixth of physicians' in-

comes. Of even greater import is the absence of income-graded career structures in clinical nursing, allowing little income differentiation between the young starting nurse and the more experienced nurse. While various aspects of the economics of nursing are hotly debated, it seems clear that many nurses leave nursing or reduce their level of participation because of relatively low pay. This, in combination with responsibility for important on-the-spot clinical judgments but with little clinical autonomy, and gruelingly hard work, makes nursing less attractive to many talented and ambitious people who see better alternative career prospects, or to older nurses who may drop out as they find the physical and psychological demands too heavy for the rewards they receive.

While nursing care provided by RNs are the key to high-quality patient care in hospitals, their efforts are supported by large numbers of licensed practical nurses and nursing aides and orderlies. In 1978, half a million licensed practical nurses and 1.1 million aides and orderlies supplemented registered nursing. Hospitals in 1978 also employed 240,000 laboratory personnel, 104,000 workers in radiological services, 80,000 in medical records, 52,000 respiratory therapy workers, and innumerable others carrying out such varied functions as billing, speech therapy, physical therapy, dietary services, etc. Even a cursory examination of the range of hospital employees conveys the enormous complexity of hospitals, their technologies, and their managerial responsibilities and challenges. Dentistry constitutes a separate system to a considerable extent, but it is worth noting that by 1980 we had in excess of 144,000 dentists and 230,000 dental hygienists, assistants, and laboratory technicians.

The Hospital

With the emergence of intensive and sophisticated surgical and critical care technologies, the hospital has become the central focal point of the medical care system. Not only does the hospital provide the context, technology, and specialized personnel for a broad array of medical applications, it also often serves as the core element in a system that includes ordinary primary care services, specialized ambulatory clinics, home care programs, affiliated nursing homes, rehabilitation programs, and a wide array of other services. In 1983, there were 6,888 hospitals in the United States, accounting for

1,350,000 beds, almost 39 million hospital admissions, and more than 270 million outpatient visits. While the numbers of hospitals has not changed much in several decades, and the number of beds has been reduced by several hundred thousand in the past 20 years, the hospital's sophisticated capacities have accelerated rapidly, making the institutions of the 1950s and those of the present vastly different. As previously noted, two-fifths of all medical care expenditures—approximately $160 billion in 1984—are for hospital services.

The most typical component of the hospital system is the 5,789 community hospitals, acute short-stay institutions accounting for almost 900,000 beds in 1983, somewhat in excess of four beds per 1,000 persons in the population. Most of these hospitals have between 50 and 200 beds, although 613 hospitals have in excess of 400 beds. Because of both technology and the need for economies of scale, the average size of community hospitals has been growing, increasing from an average of 153 beds in 1972 to 176 beds in 1983. Other hospitals, in 1983, included 342 federal hospitals and 703 special hospitals, such as long-term care institutions, psychiatric hospitals, chronic disease hospitals, and hospitals for respiratory diseases, alcoholism, mental retardation, and so on.

In 1983, on any given day, there were 750,000 patients in community hospitals, an occupancy rate of 73.5 per cent, staying an average of 7.6 days. With aggressive cost-containment efforts, hospital admissions and length of stay have been falling, with occupany rates dropping to 68 per cent by mid-1984. The average cost per day of providing inpatient care in 1982 was $369, of which more than half went for personnel other then interns, residents, and other trainees. Intensive and coronary care beds are about 6 per cent of all beds, but cost $2\frac{1}{2}$ times the regular bed charge. In 1982, the average cost for an intensive care bed was $408 a day in contrast to $167 for a regular bed.[5] Averages, of course, hide extraordinary variations among institutions by geographic area, size, patient mix, type of sponsorship and control, as well as many other factors.

Although data beyond 1983 are limited, admissions to voluntary hospitals declined from 1983 to 1984 from more than 36 million to approximately 35 million, a drop of almost 4 per cent. Average length of stay also decreased from 7 to 6.7 days among the nonelderly population and from 9.6 days to 7.4 days among patients covered by Medicare. Despite a reduction in hospital beds, occupancy rates declined to about two-thirds of capacity, a rate sufficiently low to in-

duce great alarm among hospital administrators. While it is too early to fully assess this trend, or to provide an adequate empirically substantiated explanation, one major change has been a shift in surgical procedures from the hospital to ambulatory surgi-centers. A major strategy of for-profit industries and major suppliers is to put emphasis on surgical procedures that can be used in ambulatory settings, thereby avoiding the necessity of hospitalization. American Hospital Supply, for example, has developed lasers and a special new eye lens that allows cataract removal on an outpatient basis. Such transfer of technologies from the hospital, involving several days of inpatient care, to outpatient settings has dramatic cost implications since cataract surgery is one of the most commonly used surgical procedures with the elderly population.

There is much speculation about the recent drop in hospital admissions and length of stay. While some attribute the effect to the initiation of a diagnostic-related group (DRG) methodology under the Medicare program, the drop preceded its implementation and is unlikely to explain the change. It is more likely that impending cost constraints in general, anticipation of DRGs, the tougher activities of peer review organizations that assess the necessity for hospital admission, and the overall influence of increased cost-consciousness have all contributed to a more thorough scrutiny of the necessity for inpatient care. Moreover, the profitability of ambulatory surgery and other technical procedures for health companies and physicians must be taken into account. Medicare data for the years 1977–1982 show astronomical increases in the numbers of services and procedures performed, ranging from routine urinalysis, blood sugar tests, and examination of the feces for occult blood to EKGs and their interpretation. Understanding changes in hospital patterns requires examining the changing mix between services provided in hospitals and in ambulatory settings.

Hospitals have traditionally been owned and operated by a variety of governmental, community nonprofit, religious, and proprietary organizations. The dominant form has been the voluntary not-for-profit hospital, organized under the auspices of community groups, religious orders, and a variety of other groups—for example, unions and industrial organizations, cooperatives, and organizations such as the Shriners. A small segment of the industry has been owned by individuals, partnerships, and investors seeking profits and there has been a long and continuing debate about the contributions and

costs of having a proprietary sector in health care. This debate has very much accelerated in recent years with the aggressive entry of large multihospital corporations and other large investor-owned facilities. Contentions vary greatly: some argue that these developments bring new services to populations presently lacking them and force greater efficiencies in hospitals specifically and the health industry more generally; others contend that these profit-oriented ventures "cream" the profitable illnesses and patients, leaving higher risk patients and those with nonprofitable conditions to the public sector. They also argue that the powerful profit motives of medical care corporations, and their potential influences over practitioners, will significantly alter the way medicine is practiced and decisions are made in the future.[6]

The debate will continue. One fact, however, is clear: profit corporations in health care operations are growing at a rapid rate. As of 1982, approximately 10 per cent of hospitals were owned and 4 per cent were managed by profit chains; another 5 per cent were independently owned proprietaries.[7] These numbers are less impressive than the fact that the number of hospitals owned or managed by for-profit chains doubled between 1976 and 1982 and such corporations are aggressively acquiring existing hospitals, constructing new ones, and taking over small proprietary enterprises. In 1985, Hospital Corporation of America (HCA), the largest such chain, owned or managed 431 hospitals accounting for in excess of 60,000 beds. In 1983, HCA had operating revenue of almost $4 billion and earnings per share that have increased for 15 straight years, yielding a compound annual earnings per share growth rate of 25 per cent.[8] In 1984, HCA had net income of almost $300 million on net revenue of $3.5 billion and was devoting considerable resources to acquire and build more hospitals. As of 1983, Humana Corporation averaged growth in earnings per share of 41 per cent, and American Medical International 26 per cent. In sum, as Richard Rosett has put it, whether or not these corporations "are doing good, they are certainly doing well."[9]

In addition to the growth of chains of institutions, known as horizontal integration, there are increasing efforts by the health industries to increase their span of involvement over the entire array of health services, facilitating greater control over their markets, sources of supply of patients and products, and interorganizational relationships. In April 1985, a merger was proposed between HCA and

American Hospital Supply Corporation, the largest source of medical supplies, which makes and distributes 130,000 products. The combined revenues of these companies in 1984 totaled $7.6 billion.* HCA as of 1985 owned 17 per cent of shares in Beverly Enterprises, the largest nursing home chain, and it is anticipated that the continuation of vertical integration will proceed by acquiring companies manufacturing drugs, medical technologies, and ambulatory services and products. Humana, the third largest hospital chain, is marketing health insurance—Humana Care Plus—which provides a patient population for the facilities they own. While mergers and integration of programs and facilities are a response to the changing and more constrained economic environment, and an aggressive effort to take advantage of new opportunities, it also characterizes the new and influential constellation of forces in the health care arena.

It is difficult to forecast future developments, but generally two rather different scenarios are predicted for the future. Some anticipate accelerated development of profit-oriented ventures with corporate chains taking over many more hospitals and other types of health care facilities, integrating them into systems, and setting the tone for the medical care marketplace overall. It is suggested that in a decade or two, six or seven large corporations will dominate hospitals and much of the industry, and physicians significantly will be proletariatized. Alternatively, others believe that such firms will control a stable segment of the market, but not dominate it, preferring to invest in selected areas where opportunities are more promising of profits in an environment increasingly characterized by cost-consciousness and cost-regulation.

Ambulatory Medical Care

Ambulatory medical care is carried out in a variety of settings including doctors' offices, clinics, hospital outpatient departments, single-speciality and multispecialty group practices, prepaid group practices, independent practice organizations, health centers, and emergency rooms. A variety of factors affect where people come for care including the availability and accessibility of providers, ability

*The proposed merger between HCA and the American Hospital Supply Corporation failed when Baxter Travenol, a hospital supply company, offered a higher price for AHSC stock. Pressures from stockholders resulted in acceptance of the Baxter offer.

to pay and insurance status, attitudes and knowledge, and personal taste. There is broad agreement that it is desirable that patients have a primary care service that monitors their continuing needs for care, provides basic services, and makes referrals when necessary. This service should provide most basic preventive and acute care, coordinate whatever specialty care is used, and serve as patients' ombudsmen, helping them negotiate the complexities of the system.

Only some ambulatory care settings provide primary care in the sense described. Many are simply points of first contact, making an initial assessment of the patient's complaint and referring the patient as needed. While the patient may or may not come back to this setting, the physicians involved do not necessarily view themselves as the patient's personal physician or has having responsibility for continuity of care. Other services of first contact, such as outpatient departments in hospitals or emergency rooms, typically provide episodic care with little continuity and with little assumption of the role of personal physician for coordinating the patients' medical needs. Patients using such sources of care may see different doctors each time or may be treated for a single condition with little attention to other problems and needs they may have. While such care may not be optimal, even patients having alternatives sometimes choose to seek care from these settings, suggesting the variability and complexity of patient preferences.

Some settings are organized to provide primary medical care services more consistent with the definition stated earlier. Among physicians, the specialties of family practice and general internal medicine espouse such philosophies, and for children and adolescents, many pediatricians typically take similar responsibilities. Among organized practices, those emphasizing a "gatekeeper" role for the physician of first contact, such as prepaid group practice and independent practice organizations, often have highly developed approaches to primary care, although much variation exists in how broadly the physician of first contact construes his or her responsibilities and the degree of continuity of care with a physician who knows the patient. In many large health maintenance organizations, for example, continuity of care may be more developed in theory than reality, and patients with a need for acute care may commonly see an "urgent care" physician other than their designated primary care doctor.

The National Ambulatory Medical Care Survey (NAMCS)[10] pro-

vides data on encounters with office-based physicians. Office-based general and family practitioners account for about one-third of all visits and internal medicine and pediatrics for approximately another 25 per cent. Specialists also provide much general care in addition to care in their special domains. Using estimates from NAMCS, the average patient made 2.6 office visits in 1981, varying from 2.1 visits among those under 15 years to 4.3 visits for those 65 and over. Women made more visits than men. Somewhat more than a third of the visits were for acute problems, 28 per cent for routine chronic problems, and about 18 per cent for nonillness care. Other major reasons were for flare-ups of chronic conditions (9 per cent) and postsurgical or postinjury care (9 per cent). The vast majority of patients seen were previous patients (86 per cent) with old problems (64 per cent). Twenty diagnoses accounted for two-fifths of all care. The five most common were: essential hypertension (4.9 per cent); normal pregnancy (4.3 per cent); health supervision of an infant or child (3.2 per cent); acute upper respiratory infection (2.5 per cent); and general medical exam (2.4 per cent). Other frequent diagnoses included ear infections and diabetes mellitus. The above data are based on diary studies completed by office-based doctors. An alternative approach is to survey the population to assess their access to and use of health services. Data collected in 1982 indicate that 90 per cent of those surveyed report a usual source of care, and 80 per cent saw a physican at least once in the previous 12 months.[11]

The data described earlier relate to visits in doctors' offices, but patients see doctors in other contexts as well. In 1981, 69 per cent of all visits with doctors were in their offices, 13 per cent were in hospital outpatient departments, and 12 per cent of consultations were over the phone. Using a broader definition of visits, including these three types, the average number for the population was 4.6, and was highest among children under six, the elderly, and women.[12] The most common complaints seen, of course, vary by specialty.[13] Among family practitioners, for example, the five most frequent reasons for a visit (examination, acute upper respiratory infection, hypertension, prenatal care, and diabetes mellitus) accounted for almost one-fifth of all visits. The five most common complaints seen by a gastroenterologist accounting for a comparable proportion of visits included chronic enteritis and ulcerative colitis, functional disorders of the intestines, diseases of the esophagus, cirrhosis of the liver, and ulcer of the duodenum.

Health Maintenance Organizations

Health maintenance organizations (HMOs) still serve only a small minority of the population, but they are growing rapidly and are commonly seen as a prevalent model for the future. A major advantage to consumers is its prepayment feature and the availability of comprehensive services with little or no out-of-pocket costs. Government advocates see the HMO as an attractive model because of its implicit incentives to maintain a low rate of hospital admissions. At last count there were almost 17 million enrollees in HMOs, and enrollments have been growing yearly at a hefty 18 to 21 per cent. Between June 1983 and June 1984, HMO membership increased by 21.2 per cent. In 1984, there were 28 plans with 100,000 or more subscribers, as compared with 19 plans in 1982.[14] As of June 1984, these plans accounted for 58 per cent of total HMO enrollment. Average (mean) plan size, in contrast, was just below 50,000 members as of 1985. The majority of plans are relatively small in membership but are expected to grow substantially in future years. HMOs develop more rapidly in large urban settings characterized by mobility of population, and have become particularly well established in California and the Northwest and in various Northcentral states, particularly Minnesota and Wisconsin.

HMOs come in a great variety of forms, making the term itself somewhat misleading. Though they all have prepayment in common, almost every other dimension varies from one to another. While traditional established plans, such as Kaiser-Permanente and the Health Insurance Plan (HIP) of New York, were organized around group practice—hence the rubric prepaid group practice—many independent practice associations have doctors providing services to enrollees in their private offices. Even among traditional prepaid practices, some, Kaiser-Permanente for example, build, own, and operate their own hospitals, while others, such as HIP, use community hospitals. Physicians in prepaid groups are organized as staff employees in some HMOs, while in others they constitute self-governing groups that contract with the health care plan. Some large prepaid groups almost exclusively serve enrollees, while others mix prepaid and fee-for-service patients. While many HMOs are nonprofit organizations, for-profit HMOs are now a growth industry. In short, knowing that an organization is an HMO conveys relatively little about its philosophy, structure, functioning, or quality.

Hospital Use

Rates of admission to hospitals vary enormously from one area to another and cannot be explained by the populations served or patterns of need, illness, or disability. Criteria for hospital admission and length of stay are commonly ambiguous and depend as much on the experience and judgment of the individual physician and local practices as they do on established professional norms. Tougher criteria for hospital admission, earlier ambulation following surgery, reduced length of stay, and performance of many types of surgery on an outpatient basis, all attest to the ability to substantially change customary practice with few negative effects and often positive medical as well as economic benefits.

A major use of hospitals is for surgical procedures; in 1979, almost 30 million procedures were performed on almost 19 million patients in short-stay hospitals.[15] The most common surgical procedures, each performed at least half a million times were: episiotomy, diagnostic dilatation and curettage of the uterus, endoscopy of the urinary system, bilateral destruction or occlusion of the fallopian tubes, cesarean section, tonsillectomy, and repair of inguinal hernia. The average length of stay of patients receiving procedures was 7.2 days in 1979, with the hospital stay varying by type and number of procedures.

Surgical rates vary by age and sex, with the highest rates among the elderly and women. Young males under 15 have more surgery because of accidents and injuries, but in the age group 15 to 44, the rate among females is approximately four times that among men. Even if obstetrical procedures are excluded, the rate among women far exceeds that among men, largely due to procedures related to the female reproductive system. In the age group 45 to 64, the female rate is still higher but much closer to the male rate (1,746 as compared with 1,509 per 10,000 population). In the age group over 65, male rates are considerably higher (3,056 versus 2,256 per 10,000 population). These differences reflect the higher prevalence of procedures for men relating to the respiratory and cardiovascular systems. Older men also have more procedures than women affecting the urinary system. Procedures related to obstetrics or the reproductive system account for two-fifths of all female procedures, while male procedures predominate in the areas of the digestive system, the musculoskeletal system, and the urinary system.

Diagnostic procedures performed on inpatients are frequently performed on outpatients as well, and thus understate the total prevalence. In 1979, 2.4 million biopsies and endoscopies were performed on inpatients. Other common procedures were radioisotope scans, arteriography, myelograms, and intravenous pyelograms. In 1979, there were almost 200,000 CAT (computerized axial tomography) scans on inpatients; the frequency of such scans seem to be increasing rapidly as this type of radiography becomes a fairly conventional hospital technology. Such units are also increasingly available in offices of large medical practices.

Wennberg and Gittelsohn[16] have documented large variations in available resources and the amount of care given from one locality to another. In one analysis of variations among 13 hospital service areas in Vermont, for example, they documented extraordinary differences by area in hospital discharges (from 122 per 1,000 to 197), surgical procedures (from 36 to 69 per 1,000 population), available hospital beds per 10,000 persons (34 to 59), hospital personnel per 10,000 people (68 to 120), and so on. Their work suggests the importance of establishing clear norms within the medical profession describing reasonable ranges for resource need, hospital admission, and surgical intervention. Geographic, economic, and social differences would lead us to expect some variability, and uncertainty in medical practice is a reality we cannot wish away, but it is difficult to believe that with careful planning, education, and peer review we cannot more effectively limit the enormous range of these discrepancies. Some areas may have too few resources and fail to provide all the care needed, but most knowledgeable observers believe that these variations in large part reflect excess hospital beds, an overabundance of physicians and surgeons in particular areas, and incentives that encourage additional procedures and interventions at the margins.

Long-Term Care

The long-term care industry and nursing homes as its dominant institution are not new, but they grew rapidly in response to the infusion of funds that followed the implementation of Medicaid in 1966. In 1960, only $500 million a year was expended in nursing home care, approximately 2 per cent of total personal expenditures

for health care. In 1983, the comparable numbers were more than 9 per cent and approximately $29 billion. As of 1980, there were an estimated 23,000 facilities fitting the description of a nursing home, with approximately 1.5 million beds. As of the same year, the Government Accounting Office estimated the availability of 1,373,300 licensed nursing home beds.[17] Nursing homes are relatively small; the average in 1980 was 66 beds. Medicare only covers short-term skilled nursing and rehabilitative care and, in 1979, contributed only 3 per cent of nursing home expenditures. Medicaid, in contrast, has substantially become the nation's long-term care financing mechanism, contributing 45 per cent of all nursing home expenditures in 1979. In 1977, Medicaid supported to varying degrees between 48 and 75 per cent of all nursing home patients. Slightly less than half of all nursing home expenditures are privately financed.

The vast majority of nursing homes in the United States are proprietary institutions; of the 18,900 facilities included in the National Nursing Home Survey of 1977,[18] 14,500 were owned by private groups. These vary from the small "mom and pop" type operations, which are believed to constitute about 40 per cent of the total, to large corporate chains. For example, Beverly Enterprises as of 1985 owned 908 nursing homes. In 1984 Beverly earned almost $47 million on revenues of $1.4 billion.

The vast majority of patients in nursing homes are old and infirm and require assistance in many of the activities of daily living. In 1977, almost 600,000 patients had difficulties with incontinence, more than 400,000 required assistance in eating, and a majority required assistance in walking, in using the toilet, in dressing, and in bathing. Patients most commonly suffer from diseases of the circulatory system and mental disorders and senility. In 1977, only 4,200 facilities provided registered nurses on all shifts, and an additional 2,400 had registered nurses on duty for two shifts. Many institutions depend heavily or even exclusively on licensed practical nurses or even nurses' aides. While most institutions have an arrangement with a person who fills the title "medical director," most physicians spend little or no time in these institutions and the quality of care depends almost exclusively on the competence level and quality of the nurses who work there.

As they get older, the elderly are at much greater risk of institutionalization. The aging of the American population, and particularly the large increases in the population over age 85, suggests that

we will need many more nursing home beds or must develop vial home care and other community alternatives if we are to escape s nificant expansions of the existing nursing home industry. Importa alternatives are to convert unused or excess hospital bed capacity f long-term care; to develop grades of supervised housing in the co: munity with adequate nursing, medical, and social service backu and to develop and expand programs to enhance social functioni among the aged, to assist families who assume much of the ongoi care, and to remedy the social isolation of many frail elderly peop In coming years, long-term care considerations will increasing dominate the nation's health and social services agenda.

Systems Within Systems: Federal Health Services

In addition to financing much of the public's health care, the fede government also owns, operates, or provides for relatively comple systems of services for veterans (Veteran's Administration), arm forces personnel and their dependents (Department of Defense), a American Indians (Bureau of Indian Affairs). This is not the conte for any detailed discussion of these systems, but it is useful to pr vide some sense of their magnitude and scope.

The VA medical care system was originally developed to aid ve erans with service-connected problems and disabilities, but over tim the system expanded to serve many others. In 1981, 84 per cent VA patients were treated for health problems unrelated to milita service. As of 1983, the VA operated 172 hospitals, 226 outpatie clinics, and 99 nursing home units.[19] Its department of medicine a surgery alone employed 194,000 persons. During 1981, the VA serv approximately 1.3 million inpatients, 42,000 nursing home patient and provided almost 18 million outpatient visits. Its expenditures f 1983 were almost $8 billion, and large future increases are antic pated with the aging of our veteran population. The VA has dev oped a blueprint for meeting anticipated needs that would requi increases of personnel by 70 to 150 per cent by the year 2000. Wi growing concern about government health budgets, various propo als have been made to integrate the VA system into our larger me ical care system, to cut back on the scope of services offered veterans with nonmilitary-related health problems, and to screen p tients more carefully on the basis of their ability to pay their ow

medical care expenses. While some cutbacks and changes in service patterns are possible, veterans' groups constitute a powerful and effective lobby that have successfully thwarted such initiatives in the past.

The Department of Defense (DOD), in contrast, directly serves existing military personnel and provides for core dependents under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which authorizes care in non-DOD facilities when necessary services are not easily available in DOD installations. CHAMPUS operates like an insurance program with cost-sharing between the DOD and the recipient. It is estimated that the DOD provides service for 9 million persons, including both active and retired military personnel, their dependents, and survivors. In 1983, the DOD operated 161 hospitals and 310 clinics in the United States and abroad. Its medical care expenditures in 1982 were almost $7 billion, including the estimated provision of almost 900,000 hospital admissions and more than 51 million outpatient visits. The Indian Health Service, a considerably smaller program, operates 47 hospitals and 172 clinics for American Indians and Alaska natives.

The Health Care Research Establishment, American Medical Schools, and the Teaching Hospital

The federal health research establishment, concentrated in the National Institutes of Health (NIH), and intimately linked with research efforts in medical schools, teaching hospitals, and universities is one of the most admired achievements of our national government. It has received sustained support from the public and the Congress, and the NIH alone has a budget in excess of $5 billion. In addition, extensive research and related efforts are supported by the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), consisting of three institutes relating to mental health, alcoholism, and drug abuse.

The NIH is organized around 12 bureaus and institutes that range widely over categorical disease areas and health concerns. The largest institutes include the National Cancer Institute, the National Heart, Lung and Blood Institute, and the National Institute of Arthritis, Diabetes and Digestive and Kidney Disease. The other institutes vary from broad general areas—such as aging, child health and devel-

opment, the environmental health sciences, and general medical sciences—to more specific concerns—such as allergy, and infectious disease and dental research. Much of the basic and applied medical research in universities and medical schools is supported through the NIH extramural research program, involving a process where investigators submit requests for grants that are then evaluated by committees of peers rated on the basis of scientific merit. Proposals receiving the best priority scores are funded consistent with the availability of funds. In 1982, NIH contributed 20 per cent of all national basic research support, 37 per cent of all such federal support, and 48 per cent of all basic research support to universities and colleges.[20] The NIH also operates a vigorous intramural research program and supports research training and other research-related programs. More than half of all NIH funding goes to medical schools, and most of that goes to a relatively small group of elite institutions. In 1982, the top 20 medical schools accounted for half of all NIH support, and the top 10 for about one-third of all NIH support.

There are 127 medical schools in the United States. These schools have affiliation agreements with approximately 1,000 hospitals, but 100 of these hospitals account for about half of all residents trained. Thus, there are very major differences among institutions designated as teaching hospitals. Sixty-one hospitals share common ownership with medical schools, and for most purposes can be viewed as components of the same institution. Medical schools and major teaching hospitals also play an important part in the education of nurses, dentists, pharmacists, and other health professionals, and are important centers for research and training. The total effort is often given the title of Health Sciences Center.

Medical schools and teaching hospitals expanded rapidly in recent decades with the infusion of large sums of research support from the NIH. Seen as on the cutting edge of medical science, new technology, sophisticated patient care, and an investigatory mode, this perspective encouraged increasing specialization and subspecialization and a high dependence on the clinical laboratory and newly developed diagnostic procedures. Because of their sophistication, many teaching hospitals attracted a sicker and more complex mix of patients, and the process of training students and residents in these institutions contribute to a more expensive pattern of care than that found in the typical nonteaching community hospital.

As efforts are made to constrain expenditures for hospital care through rate regulation, diagnosis-related group methodologies, and other devices, there is growing concern among medical educators that new forms of reimbursement will not adequately pay teaching hospitals for their complex and sicker mix of cases, for their crucial role in training future generations of medical students, residents, and other health professionals, for the magnitude of uncompensated care they provide for the indigent without insurance, and for the intangible costs associated with maintaining sophisticated research operations. Our key teaching hospitals are a major national asset, and the way of reimbursing them fairly for their varied service, educational, and research functions are difficult issues. Balancing the preservation of their unique role in our health care system on the one hand, but also avoiding unnecessary costs on the other, will probably only evolve through a process of trial and error. We probably require a much more sophisticated classification of teaching hospitals, since many have only a modest teaching and research role.

There are those who believe that the technical orientation of our teaching hospitals, and their emphasis on the more rare and complex diseases, distort medical education and the health care system. They argue that the teaching hospital should play a larger and more central role in preventive medicine and primary medical care, assisting in better preparing young health professionals for the typical problems they are likely to confront in practice,[21] and teaching practice strategies that prevent illness and disability and promote functioning among the chronically ill. While these are all goals of much importance to our medical care system, it is unlikely that teaching hospitals will take a primary role in meeting these challenges; nor is it obvious that they should do so. Teaching hospitals serve a unique function in caring for the very sick, as well as expanding our knowledge of how to do so more effectively.

Medical care in America requires a better balance between prevention and treatment, promotion of function and cure, and educational as compared to technical approaches to care. We should not, however, confuse the need for a more sober balance with denigration of the search for more sophisticated treatments and better understanding of disease processes. It is the combined agenda of balance and scientific sophistication that offers us the greatest potential for a system of effective medical care for the future.

References

1. Aiken L, Bays K. The Medicare debate—round one. N Engl J Med. 1984; 311:1196-1200.
2. Ginzberg E. Allied health resources. In: Mechanic D, ed. Handbook of health, health care, and the health professions. New York: Free Press, 1983:479-494.
3. U.S. Department of Health, Education and Welfare. GMENAC staff papers: supply and distribution of physicians and physician extenders. Washington, D.C.: Government Printing Office, 1978.
4. Aiken L, et al. The contribution of specialists to the delivery of primary care. N Engl J Med. 1979; 300:1363-1370.
5. Congress of the United States, Office of Technology. News release, Nov. 29, 1984.
6. Starr P. The social transformation of American medicine. New York: Basic Books, 1982.
7. Gray B, ed. The new health care for profit: doctors and hospitals in a competitive environment. Washington, D.C.: National Academy Press, 1983:2.
8. Wohl S. The medical industrial complex. New York: Harmony Books, 1984.
9. Rosett R. Doing well by doing good: investor-owned hospitals. University of Chicago: Michael Davis Lecture, Center for Health Administration Studies, Graduate School of Business, 1984:3.
10. National Center for Health Statistics. Patients' reasons for visiting physicians: national ambulatory medical care survey, U.S. 1977-78. Hyattsville, Md.: National Center for Health Statistics, 1981. (DHHS publication no. 82-1717, Series 13, No. 56.)
11. Robert Wood Johnson Foundation. Special report, update on access to health care for the American people. Princeton, N.J.: Robert Wood Johnson Foundation, 1983, No. 1.
12. National Center for Health Statistics. Health—United States, 1983. Hyattsville, Md.: National Center for Health Statistics, 1983. (DHHS publication no. [PHS] 84-1232:137.)
13. Robert Wood Johnson Foundation. Special report, medical practice in the United States. Princeton, N.J.: Robert Wood Johnson Foundation, 1981.
14. National Industry Council for HMO Development. The health maintenance organization industry ten-year report, 1973-1983.
15. National Center for Health Statistics. Surgical and nonsurgical procedures in short-stay hospitals: United States, 1979. Hyattsville, Md.:

National Center for Health Statistics, 1983. (DHHS publication no. [PHS] 83-1731, Series 13, No. 70:3.)

16. Wennberg J, Gittlesohn A. Small area variations in health care delivery. Science. 1973; 182:1102-1108.
17. U.S. General Accounting Office. Constraining national health care expenditures: achieving quality care at an affordable cost. Sept. 30, 1985.
18. National Center for Health Statistics. The national nursing home survey: 1977 summary for the United States. Hyattsville, Md.: National Center for Health Statistics, 1979. (DHEW publication no. [PHS] 79-1794, Series 13, No. 43.)
19. Veteran's Administration. Caring for the older veteran. Washington, D.C.: Government Printing Office, 1984.
20. National Institutes of Health. NIH data book. Bethesda, Md.: Office of Planning and Evaluation and the Division of Research Grants, June 1984.
21. Lewis I, Sheps, C. The sick citadel: the American academic medical center and the public interest. Cambridge, Mass.: Oelgeschlager, Gunn and Hain, 1983.

Bibliographic Note

For the purposes of this introduction it is superfluous to document each of the figures or trends noted. Only occasional references are given. Much of the data in the chapter can be found in the following general data sources: National Center for Health Statistics, *Health—United States, 1983,* Washington, D.C.: U.S. Government Printing Office, DHHS Pub. No. (PHS) 84-1232, Dec. 1983; *Health—United States, 1984,* Washington, D.C.: U.S. Government Printing Office, DHHS Publ. No. (PHS) 85-1232, Dec. 1984; Center for Health Policy Research, *Socioeconomic Characteristics of Medical Practice 1984,* Chicago: American Medical Association, 1984; Daniel Waldo and Helen Lizenby, "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984," *Health Care Financing Review* 6:1-29, 1984; National Center for Health Statistics, *Patients' Reasons for Visiting Physicians: National Ambulatory Medical Care Survey, United States, 1977-78,* DHHS Pub. No. (PHS) 82-1717, 1981; National Center for Health Statistics, *Surgical and Nonsurgical Procedures in Short-Stay Hospitals: United States, 1979,* DHHS Pub. No. (PHS) 83-1731, 1983; National Center for Health Statistics, *The National Nursing Home Survey: 1977 Summary for the United States,* DHHS Pub. No. (PHS) 79-1794, 1979; Eli Ginzberg, "Allied health resources," in David Mechanic (ed.) *Handbook of Health, Health Care, and the Health Profes-*

sions, New York: Free Press, 1983, pp. 479–494; Eugene Levine and Evelyn Moses, "Registered nurses today: a statistical profile," in Linda Aiken (ed.) *Nursing in the 1980's,* Philadelphia: Lippincott, 1982, pp. 475–494; National Center for Health Statistics, Annual Summary of Births, Deaths, Marriages and Divorces: United States, 1983, *Monthly Vital Statistics Report* 32, No. 13, Sept. 21, 1984; American Hospital Association, *Hospital Statistics,* Chicago, 1983; American Hospital Association, *Hospital Statistics,* Chicago, 1984; U.S. General Accounting Office, *Constraining National Health Care Expenditures: Achieving Quality Care at an Affordable Cost,* Sept. 30, 1985.

PLANNING FOR THE NATION'S HEALTH

A Study of Twentieth-Century Developments in the United States

GRACE BUDRYS

Contributions in Medical Studies, Number 19

GREENWOOD PRESS
New York • Westport, Connecticut • London

9

Conclusions

After reviewing the record of health planning in the United States over the twentieth century, what I find most striking is the high level of consensus present among the majority of those concerned (consumers, providers, vendors, evaluators, and such) regarding the need for major changes in current health care delivery arrangements. Equally striking is the complete lack of consensus past this point when it comes to identifying the problem and its solution. This situation is clearly illustated by public survey data showing that a majority of the public considers the health care system to be in a state of crisis and that there is little consensus regarding the aspects that should be changed. In my estimation, the persistent perception of a health crisis stems from society's lack of confidence in the social control arrangements governing the activities of the health sector in recent years; what is worse is that the public is confused about who should be entrusted with the responsibility for planning the nation's health (Mead 1977). The primary reason for the confusion is the paucity of information to assist in altering the current situation (Ermann 1976). This is not to say that the relevant information does not exist; however, the existing information is poorly organized, inaccessible, and uneven. In actuality a great deal of information is being generated, but it is often disseminated in a way that adds to the public's sense of confusion (Evans 1983).

This chapter consolidates a portion of the vast amount of information available in the hope of reducing some of the confusion surrounding current discourse regarding the problems affecting the health sector. (For another perspective see the APHA Presidential Address, Addiss 1985.) The discussion presented here begins with a review of the topics addressed in preceding chapters. Outlined is the sequence of steps responsible for the design of the health care delivery system that now exists. Then the evidence available on the performance of the mech-

anisms associated with each of the social control arrangements experience date is discussed. Next, the special features of the health sector and the eff that these characteristics have had on continuing efforts to plan for the natic health are considered. This portion of the discussion serves as the backgro against which to examine the strengths and weaknesses of the three avail systems of social control. Finally, my own opinion regarding the best appr to social control is offered.

THE OVERVIEW OF PLANNING FOR THE NATION'S HEALTH

Based on the historical overview presented in earlier chapters, we can see the central focus of health planning shifted several times. During the early of the twentieth century, health planning efforts were primarily directed tow improving the quality of health care. This goal remained intact until the na experienced nearly a decade of post–World War II reconstruction, at which p society began turning its attention to internal social problems, especially existence of social inequity. Accordingly, the health planning goal was alte to encompass equal access to health care services. The pursuit of high qua in the delivery of health care remained an integral part of the goal. By the 19 the goal was again redefined to include the aim of delivering health care reasonable cost. Within a few years this portion of the goal was revised to fo on a more ambitious objective—cost containment. By 1980, the goal was alte for the fourth time during the twentieth century. Now the new component not given a commonly agreed-upon label. However, it is clear that what is be demanded at present is improved efficiency, specifically, managerial efficien Thus, the goal currently serving to guide the activities of the health sector inclu the following components: (1) the highest quality of care possible, (2) access health services for everyone, and (3) cost containment, (4) which is to be achie by encouraging or, if necessary, forcing the health sector to incorporate principles of managerial efficiency.

The timing involved in these shifts is significant. Note that the initial go quality, set forth early in this century was not altered for approximately decades and that the three new components were added between the mid 19 and the early 1980s. The fact that the goal of quality remained unaltered for long indicates that society was reasonably satisfied with this health care objec and with the leadership provided by the medical profession in attaining it. logical corollary of this observation is that the subsequent alterations indic persistent social dissatisfaction with the performance of the health sector.

We must look to the "social climate" prevailing during particular periods time to find the best single explanation for shifts in satisfaction with the hea care system over the course of the twentieth century. To illustrate, during era when the pursuit of quality gave the health sector its primary purpose number of other matters emerged to capture society's attention, namely, t

world wars and a major economic depression, overshadowing for periods of time society's concern about health care. At the same time, the course that medical progress was taking matched prevailing social values holding scientific/technological progress and expertise in high regard. Accordingly, the medical profession received the credit for the progress that was being achieved by the health sector. The shift in social values that occurred during the early 1960s came in response to the recognition that the sense of well-being and prosperity that followed World War II did not extend to all Americans. Society responded by launching into action on a variety of fronts (in addition to an expanding military front in Vietnam). Such newly recognized social problems as poverty, social inequality, the plight of the elderly, and the financial devastation caused by prolonged illness provided the agenda for social action. The reluctance of the medical profession to embrace the solutions being developed at this time was responsible, at least in part, for planting the seeds of social dissatisfaction with the prevailing health sector arrangements that had been governed without interference by the medical profession for so long.

Two added factors, to which the emergence of social dissatisfaction can be attributed, are rooted in the increase in funding plus the rise in expectations about personal health status that accompanied the newly identified social priorities of the 1960s. The massive influx of federal funds produced well-known effects—the overall expenditures on health care increased, health care facilities and services multiplied, the pool of health care workers expanded at an unprecedented rate, the technology employed by the health sector became more sophisticated and expensive, and so on. In combination, the ready availability of government monies plus a strong sense of social support for the development of the health care sector attracted a high level of investment in terms of personal energy and private funds. (To illustrate, expansion occurred among the following: medical schools, medical specialty societies, across the allied health occupations, health administrators, quasi-government agencies, third-party payers, equipment manufacturers, hospital supply companies, contractors of services to health care institutions, plus the vast array of special-interest consumer groups.) It is important to recognize, however, that those who developed a vested interest in this sector did so in response to prevailing social values and incentives. That this high level of involvement would pose a problem in time was not anticipated. Nevertheless, the fact that so many diverse groups developed vested interests in the health sector indicates that these groups also have reason to protect their respective interests and investments.

Even so, the large number of parties involved would be less problematic if not for the apparent inability of the health sector to make much headway in addressing the problem of rising costs. The situation has now come full circle. Commonly agreed-upon problems have become increasingly more difficult to resolve because so many different interest groups have become involved, each holding vastly different ideas regarding the solutions to address those problems. Even those who agree on a general approach to a problem differ on the specifics

when their respective vested interests are threatened. Clearly, the large number and the diversity of interested parties is now exacerbating the situation.

Thus, while the shifts in health care goals over the past few decades are related to the increasing complexity of this sector, it is the continuous rise in health costs that is primarily responsible for the idea that the health sector is growing in an uncontrolled and poorly managed fashion. This assessment coexists with the recognition that the rate at which medical knowledge is being advanced is awesome. Not commonly acknowledged, but possibly of greater significance to the effort to achieve greater control over the health sector, is the fact that no one devoting time and energy to the pursuit of medical knowledge or its application is willing to abandon this work without a fight. Nor are any of the other members of organizations whose livelihood depends upon the continuity of health sector pursuits prepared to step aside. The consumers of health care services are certainly not ready to accept any reductions when their own health care is involved. Yet, we as a society are now being pressed to confront choices which will inevitably affect negatively some category of participants if health care costs are to be curbed to any extent.

The enthusiasm with which institutions in the health care sector have taken steps ostensibly intended to increase efficiency would seem to indicate that a consensus has been reached regarding the preferred means to use in addressing the complex health care goal as it is currently defined. However, I anticipate that the most recent approach introduced, the market system of control, will provide only a relatively temporary solution, at least in its current form. The sudden interest in this approach coincides with the shift in social values signaled by the election of Ronald Reagan. We are now in a period during which the pursuit of self-interest is being advocated as the best means to attain collective goals (Thurow 1985). Reducing the role assigned to government in favor of an increased role for the private sector, a trend currently known as "privatization," is a central feature of this approach. The reason this approach may not turn out to be a long-lived solution is that a steadily growing faction of persons who favored this approach are shifting their loyalties as their own jobs are eliminated in the competitive marketplace (for example, farmers, steelworkers, auto workers, bankers). Commentators speaking about problems associated with the national economy point to the Reagan administration's inability to deal with the national deficit and its impact on an entire range of social priorities. The fact that this approach has not been as successful as its advocates promised it would be is certain to rekindle unresolved debates about the value of regulatory versus market controls in some sectors, the health sector in particular (Vladek 1985). This assessment should not be interpreted to mean, however, that I am advocating that any of the newly introduced mechanisms aimed at curbing health care costs should be abandoned. After all, one of the major lessons learned from the experience of health planning is that the performance of control mechanisms improves over time and with experience. We learned this as we learned to carry out the evaluation procedures themselves. It is to the literature that I now turn.

EVALUATIONS OF HEALTH PLANNING PERFORMANCE

While an historical overview allows us to consider health planning over the entire twentieth century, the literature evaluating its performance is largely a product of the past three decades. In effect, health planning, as practiced over the first half of this century, the era during which the medical profession was basically responsible for planning society's health care, has not been scrutinized in the same way that it has been over the last thirty years, nor have we had enough time and experience with the market approach to health planning to have accrued comparable data on its performance. In fact, what we have is a considerable amount of information on the successes and failures of one approach to social control, the administrative approach. As a result, any effort to draw comparisons across the three systems of control, which is of central interest to the discussion presented in this book, must be treated with caution. With this caveat in mind, let us examine the data available.

The health planning literature of the past thirty years provides two sets of answers to the question: What have we learned from our experience with health planning? One branch of this literature is concerned with health planning outcomes, measured in terms of cost savings. The other branch focuses on the planning process but is primarily interested in the issue of participation. From the perspective of those who are primarily interested in planning outcomes, health planning attained little success in containing costs during the early years of administrative planning (the mid 1960s through the mid 1970s). However, there is evidence to indicate that substantial savings were being attained just at the time when administrative control was about to be superseded by the market system of control (the late 1970s and early 1980s). The researchers who focus on planning outcomes offer two main reasons for this. First, gains in experience attained by planning agencies over time resulted in increased effectiveness; second, it was determined that earlier findings indicating poor results in containing costs were based on premature and faulty data. The second answer regarding what we have learned comes from the portion of the health planning literature focusing on the process of planning. This portion of the literature states that the problems surrounding participation in the planning process were never satisfactorily resolved.

The case study findings presented here offer a third perspective. I am not suggesting that the findings revealed by a single case study can be treated as if they apply to all or, for that matter, any other health planning agency. The case study does proceed, however, from a foundation laid by the existing literature; and, to that extent, the conclusions found in the existing literature serve as a framework for considering the case study findings. The primary contribution that the discussion based on the case study makes is to introduce a previously neglected dimension, the structural dimension, into discussions aimed at evaluating the success of health planning efforts.

To the extent that the case study attempted to address questions stimulated by

the existing literature, the conclusions found in the literature on the proce health planning were found to be only partly applicable. Because one o earliest hurdles that the health planning effort encountered revolved aroun termining who should participate in the planning process, this became an legislative concern as well. Health planning participants were viewed as men of two separate categories—providers or consumers. Legislative measures aimed at increasing the influence of consumers, an aim consistent witl prevailing belief that one of the primary problems confronting health plan at that time was provider domination. The division of participants into categories was built on the assumption that consumers and providers woul themselves as members of two distinct groups, who would also embrace respective identities assigned to them and behave accordingly in the health p ning forum. In effect, the portion of the health planning legislation that with participation was based on a two-party decision making model. In the of the Urban HSA, the expectations inherent in this model were not fulfill

While coalitions based on shared political interests did emerge among Urban HSA participants, they did not fit the two-party model, at least not in way the designers of the legislation which created HSAs had anticipated. C sumers and providers united to form coalitions around community bounda In the Urban HSA area, community interest was synonymous with racial/et community interest, which, in turn, generally approximated geographic c munity boundaries. A number of coalitions of this kind evolved to oversha the anticipated consumer-provider split.

This is not to say that the differences between the interests and agendas the consumers and providers, respectively, brought to bear on the Urban H planning process were irrelevant. There were readily identifiable difference the way that members of these two categories saw the basic problems that w presented before them as well as the expectations they had regarding what t hoped to accomplish. Generally, these differences closely reflected an indiv ual's familiarity with the workings of the health care delivery system. The m experience an individual had, the more comprehensive were the changes t the individual thought were necessary. The less familiarity an individual brou to the process, the less extensive were the changes envisioned. This expla why the consumers, who were generally less knowledgeable about the worki of the health care system, could express a higher level of satisfaction about t Urban HSA's achievements.

The case study was not specifically designed to confirm or reject the findi presented by the literature, particularly the outcome-oriented literature, much which is concerned with the problems inherent in measuring cost savings. Ho ever, the general discussion found in this portion of the literature includes ric descriptive analyses of the difficulties agencies encountered in attempting achieve savings, in which so many varied problems are mentioned that at lea some of them apply to the Urban HSA situation. Furthermore, the most general agreed-upon conclusion found in this literature fits the Urban HSA case ve

well, namely, that greater cost savings were attained as the participants and staff gained experience. The major reservations expressed in this literature regarding the difficulty of analyzing data to support such a conclusion apply in this case equally well. Much of the difficulty stems from the fact that the conditions under which the health planning agencies were operating were themselves undergoing change over the period of time under consideration. For example, the law governing health planning was revised; an economic recession made capital funding more difficult to obtain, which had an impact on the capital expenditures hospitals were willing to undertake; a shift toward ambulatory care was just beginning to gain momentum with its own effects on costs and so on.

One of the most important observations to be made about the health planning literature is that it grew out of two separate disciplinary bases—economics and political science—and that the two disciplines have had no particular need to speak to each other on this topic. While their respective conclusions have been moving toward a common ground, there has been little effort to integrate them. The attempt to do so yields an interesting, logical by-product which deserves some consideration. Consider, first, the fact that the outcome of health planning, measured in terms of cost savings, was, in the final analysis, judged to be a positive one, the consensus being that increased experience contributed substantially to bringing about this outcome. If, however, the major conclusion of the other branch of the literature is that participation in the process of planning was never satisfactorily resolved, whose growth in experience should be credited for the successful outcomes that eventually resulted? It seems we are left with only one conclusion—it was the HSA staff that benefited by the gains in experience. The Urban HSA case study data lend some support to this interpretation.

The Urban HSA participants used the term "streamlining" to explain how the staff in recent years had begun to manage the enormous amount of paper that participants were expected to read. Over time the staff reduced the amount of paper being sent to participants by reducing the number of original documents and expanding the staff summary portions of the mailing. As the staff members became more experienced in interpreting the law and codifying the abstract goals, the agency became more efficient.

It is difficult to know, of course, where the natural course of this trend toward increased efficiency would have led had funding and social support for the administrative approach been continued. The classic sociological literature on organizations leads us to expect increasing formalization, organizational entrenchment, greater adherence to rules, and more reliance on an impersonal approach to complicated issues, that is, a bureaucratic operating format. As it is, the Urban HSA's future is in doubt because its funding has been steadily declining and its mandate whittled away. Under these conditions it is not surprising to find that interest in its own survival is moving to the forefront of the Urban HSA's list of concerns.

The more closely one scrutinizes the workings of this or any other health planning agency, the larger the number of organizational problems associated

with the administrative approach to control one is likely to find. Howev different but equally problematic organizational problems should be expectec appear if either of the other two available systems of control were to replace administrative control system.

It is interesting, therefore, that current debates about the superiority of mechanism of control versus another are often based on empirical data do menting the flaws of the administrative approach, while the salutary effects t can be expected from as yet untested mechanisms associated with the mar approach are grounded in promises. Even more interesting is the fact that st debates generally proceed without objections raised by anyone regarding unevenness of the bases on which the argument is constructed.

In short, each approach for imposing greater control available to us bri with it its own strengths and weaknesses. Before discussing these, however would like to point out that any approach to control we select must oper within the context provided by the special features of the health care deliv system. It is to the relationship between these characteristics and health planni efforts that I now turn.

HEALTH SECTOR CHARACTERISTICS

It seems that everyone who comments on the workings of the health sec points to one or another aspect which makes it difficult to achieve greater or or control over this sector. There also are those whose primary purpose is describe the characteristics of the health care system. Few go on to draw co nections between the two. Consider the relationship between the characteristi of the health care sector and the effort to bring order to it. Although the exerci of describing these features could easily serve as the main topic of a lengt volume, my purpose is more circumscribed. I direct my attention to a limite number of characteristics, those I believe pose the greatest constraints: (1) t size of the health sector, (2) its institutional structure, (3) the nature of the go involved, (4) the factor of continuous change, and (5) its financial potential.

Size

That the health sector expanded rapidly and is now very large are facts th are mentioned often in passing. The indicator that is most commonly used referring to the size of the health sector is the percentage of the GNP (Gro National Product) that is devoted to health. This figure troubles most those wl are fully cognizant of the meaning of the GNP (the measure of all goods an services exchanged in the society). The public seems to view the rising level the GNP devoted to health as far too distant from its personal purse to caus concern (Altman and Blendon 1984). In recent years, however, another portic of the GNP for which the government bears sole responsibility, defense, h also been growing. The fact that the proportion devoted to both is increasing

Table 5
Fiscal Trends in the National Budget

Year	National Health Expenditures	National Defense Expenditures
1950[1]	4.4	4.7
1960[2]	5.3	9.7
1965	6.1	7.7
1970	7.6	8.4
1975	8.6	5.8
1980	9.4	5.2
1981	9.7	5.5
1982	10.5	6.1
1983	10.8	6.5
1984	10.6[3]	6.7

[1]U.S. Bureau of the Census, Statistical Abstract of the United States, 1985, 105th ed. (Washington, D.C., 1984), pp. 96, 331.

[2]Ibid., 1984, 104th ed. (Washington, D.C., 1983), pp. 102, 343.

[3]Health United States, 1985, U.S. Department of Health and Human Services (Washington, D.C., 1986), p. 128.

a source of great concern to those who have reason to be interested in the national budget. Consider the trends exhibited in Table 5.

The significance of the continued expansion in the size of the health sector requires little interpretation. The larger and more dispersed an enterprise is, the more difficult it is to coordinate and direct the efforts of that enterprise in a systematic manner. Understanding the relationship among the structures through which it operates is essential if greater order and control are to be achieved (Ermann 1976).

Institutional Structure

One especially important feature of the health care sector is one which is also not readily apparent, namely, the absence of centralized institutional structures that might represent the interest groups involved. This is not to suggest that such structures would not have serious drawbacks were they to come into existence. However, the lack of centralized structures makes discussion among the parties involved disorganized and inefficient. There are, of course, a number of organizations that play central roles within the health sector. The AMA quickly comes to mind as the organization which speaks for the medical profession. However, as I have pointed out previously, if only 30% of practicing physicians are enrolled, can it truly be said that the AMA represents the whole medical profession? The American Hospital Association (AHA), by contrast, does represent the vast majority of hospitals. However, the constituency it represents is highly heterogeneous, including small rural hospitals, major medical center hospitals, privately owned chains of hospitals, and so forth. Thus, like the AMA, it must maintain a stance which is not highly specific in order to satisfy

its wide-ranging membership. There is also the organization representing f profit hospitals, the Federation of American Hospitals. Not surprisingly, its ai do not always coincide with the aims of other groups within this sector. T public, for its part, has no single representative, and the special interest consun groups who do have organized representation generally do not attempt to ordinate their efforts. Nor can the companies whose profit margins are clos connected to developments taking place in this sector turn to a single rep sentative organization. In short, a multitude of unrelated organizations can identified representing the interests of virtually everyone with a stake in t sector, but there is little interaction among them. In the meantime, the individ redress of perceived injustices is pursued via the courts with increasing frequen and with steadily escalating awards.

Clearly the disadvantage in this arrangement is that a consensus regardi changes in the policy and practices governing the delivery of health care servic is difficult to achieve. This is true not only because differences in opinion inevitable, but there is no single place to hold a discussion to address th differences. Nor does a recognized set of representatives exist that is limited manageable numbers and legitimated through any of the traditional means, su as election to office in a representational organization. On the other hand, t fact that little effort has been made to alter these arrangements suggests that t advantages of this inefficient arrangement outweigh the disadvantages for mar if not all, concerned. The advantages include the freedom to address proble at the level where they occur, generally at the juncture where the providers health services and the consumers of those services interact. A radical alterati in these arrangements is unlikely unless several categories of participants d termine that there are advantages in unification. If, however, one coalition we to emerge that threatened to unbalance the current situation in which the pow to affect changes in the structure of the health care delivery system is broad diffused, then other coalitions could be expected to develop in rapid successio

There are some signs that the coalition formation process may have begu When it was recognized that the attempt to tighten the federal budget was causi the burden of costs to be shifted to the private sector, the private insuran industry responded with tighter controls of its own. Furthermore, it is general expected that the DRG reimbursement schedule, which currently covers Medica patients only, will be extended to cover all categories of patients. In fact, DR scales of payment are already being phased-in to cover Medicaid admissions a number of states. As third party reimbursement evolves toward increas uniformity, few avenues except unified resistance will be left to those provid of health services who feel that some part of the reimbursement schedule is t restrictive or inappropriate on other grounds. Thus far, physicians have responde individualistically by reducing their participation or joining groups willing assume the responsibility for negotiating payment with third-party payers. Hov ever, judging from the experiences of other countries which have imposed strict controls over reimbursements (for example, the Canadian provinces, especial

Ontario and Quebec, as well as the United Kingdom), we should not be surprised if the medical profession takes steps to unify its forces in order to negotiate from a position of strength (Woods 1986).

The attempts of hospital administrators to arrive at a unified response to government efforts to tighten controls have been complicated by the fact that some hospitals are sustaining significiant financial losses while others are prospering. This is not to say that hospital administrators have been passive (Zuckerman 1983). The past five years have witnessed the emergence of hospital chains on both the not-for-profit as well as the for-profit sides of the industry; urgent care and ambulatory care centers have sprung up everywhere; vigorous marketing has suddenly become commonplace, and so on. The internal organization of hospitals also has been undergoing some change. Although conflicts between administrators and physicians remain, an increasing number of hospital boards of directors and executive boards have been inviting physicians into their inner circles. It would seem that if efforts to contain health care costs continue to be as vigorously implemented in the future as they have in the past year or two, some hospital administrators and doctors will be readier to acknowledge that they have a shared interest in combining their efforts to ensure the viability of their hospital's future (Shortell, Morrisey, and Conrad 1985).

It is interesting to consider the irony in this situation. When health planning was organized around an administrative approach to control, one of the built-in assumptions was that the providers would act in response to a sense of "consciousness of kind." This assumption did not materialize. Now that the health sector has moved toward a market system of control, the prevailing assumption is that providers will be motivated to compete with one another rather than to join forces. However, if providers perceive themselves to be competing for a limited number of dollars and constricted by a fixed schedule of reimbursements, then it should not be too surprising if they develop a characteristic usually associated with groups: a recognition of the existence of shared interests which stand in opposition to the interests of those who control third party payments, thereby creating clear boundaries dividing "them" from those who will now see themselves as "us."

THE NATURE OF THE GOAL

The third characteristic of the health sector with which any system of control must contend is the nature of the goal involved. Consider what we as a society want to set forth as the ultimate goal toward which we expect the health care delivery system to work. To date we have identified a four-part goal: improving the quality of health care, ensuring that all persons in the society have access to health care, containing the ever-increasing costs of care, and making certain that health care is being delivered in the most efficient manner possible. It is worth noting that improving the health of society is not one of the goals we have set forth for ourselves. Of course, it has always been the ultimate goal we hoped

to achieve. Improving the health of society is, however, far too abstract objective to function as a stated goal. It is too difficult to measure, especi in the short run; one can never be sure that one's current efforts will bring ab the desired results in the future; at the very least, one cannot guarantee the b avenue for arriving at the final goal is being followed. For these reasons int mediate goals have been identified. In practice, however, the four intermed goals now guiding the efforts of the health care sector suffer from some of same problems from which the ultimate goal of improving the nation's he suffers.

Much of the current confusion about goal attainment revolves around measures that the government should take in support of one step or another. T confusion stems from the fact that discussion is invariably introduced with promise that the measure in question will improve the delivery of health c for all. Which step is, in fact, the best is unclear because all the measu recommended are of necessity based on theoretical assumptions and promi which can only be tested via implementation in the arena where people's hea and attitudes about health care will be directly affected. For obvious reas those in a position to influence action are wary of risking a miscalculation. present, this is largely the province of our representatives in the federal gove ment because the government pays the largest portion of the nation's health c bill. In order to achieve support for their respective agendas, each set of advoca is appealing to the public, urging the public to register directly or indirectly support for that particular measure with its political representatives. Thus, have a situation where a variety of interested parties is appealing to the publ each with its own agenda, criticisms, and alternative objectives. The result apparent when the public is surveyed regarding its views on the health c delivery system. The consensus is that there is something seriously wrong w the system, but it is not at all clear exactly what the problem is or what shou be done about it. Obviously, there would be far less confusion about the prefer solution to the problem if the problem was more clearly identifiable. The reas it is not is that so many different parties are offering competing interpretatio In short, the nature of the goal guiding the activities of the health sector exe a powerful influence on the operations of this sector. If the goal were less abstr and ambiguous, it might be easier to arrive at a consensus regarding an operation measure to gauge our performance in moving toward that goal. As it is, the vig with which competing interpretations are being promoted is likely to continue b cause of the size of the stakes involved, including such traditional rewards money, individual as well as institutional autonomy, status and power.

CONTINUOUS CHANGE

The fact that the health care delivery system operates in an atmosphere continuous change is a fourth factor making the effort to bring order to th sector difficult. Although planning under conditions of change is not an unusu

operating constraint, the rate of change combined with the scope of health care sector endeavors mean that this characteristic deserves special attention. I will focus on three dimensions of change particularly troublesome now: (a) demographic trends, particularly the aging of the population, (b) the rate of expansion in technological capability, and (c) the impact of changes in social values.

(a) The effects that the aging of the population is having on the health care sector are well known. With increasing age, individuals are more likely to suffer chronic illness, increase their visits to physicians, spend more days receiving in-patient care, and so on. This increased use of services translates into increased costs. Since government programs (Medicare and Medicaid) provide coverage for anyone over sixty-five years of age, the steady expansion of this population has been reflected in a growing bill for health care. The sense of urgency about addressing this problem is being spurred on by two other factors in the list of changing conditions—the rapid expansion of medical technological capability and changing social values with regard to the elderly on the one hand, and medical technology on the other.

(b) Increasing technological capability means that health providers are able to select among a much larger range of techniques, especially life-sustaining techniques, and use them to benefit the portion of the population which is the fastest growing portion and exhibits the highest utilization rates.

At the same time, the ability to sustain life at the other end of the life cycle, in the case of seriously ill and impaired infants, is adding to the sudden and unprecedented increase in the number of critically ill persons who use the most expensive forms of health care services. While the benefits this increasing technological capability has brought along with it in terms of expanded medical knowledge are being greeted with awe and gratitude by medical researchers and members of society at large, the problems associated with the same advances are impossible to ignore. We have here a perfect example of "cultural lag." Our technological capability in this instance has far outpaced our ability to integrate that technology into the culture. We have not developed the norms necessary to govern the application of the new forms of highly sophisticated technology or the values that give meaning to the effects produced by the technology.

(c) The third arena of change that affects the functioning of the health care sector is formed by the point at which social values intersect with financial costs. As medical technological capability increases and the population affected continues to expand, questions regarding the cost versus the benefit of administering state-of-the-art treatment are intruding into discussions in a growing number of cases.

There are few commonly agreed upon guidelines to assist either the providers of care or the families of seriously ill persons in determining how extensive treatment should be. This is because we do not have a fully developed set of values and norms which would come into play under such circumstances. To illustrate, most people espouse the idea that death with dignity is a highly valued

social good. Yet, if there is some doubt regarding the point at which de occurs, then it is also not clear when life sustaining equipment stops sustain life and begins to prolong dying. We are not sure whether we should say ourselves that employing heroic measures in cases where death is inevita causes unnecessary suffering to the person and detracts from the peace i should come when a life is ending, or if we should say that hope should ne be abandoned if there is even the slightest chance that death can be forestall The former position is sometimes supported by the argument that resources being wasted because physicians wish to aggrandize their egos by assum godlike control over life-and-death decisions. The argument states that medi resources could be better used to prevent illness than to intervene after it is cl that death is inevitable. The alternative stance lends itself to arguing that a c could be discovered at the last minute and the course of the illness reversed j in time, and that all life-saving efforts should be made under virtually all c cumstances because there is nothing more precious than a human life. Final since no one has the right to play God, no one has the right to withdr technological support even if the person is only surviving with the assistance machines.

Those who espouse the latter stance generally dismiss the issue of costs inconsequential in contrast to the value of human life. This leaves those w oppose what they see as excessive technological intervention in a far m difficult position. In stating that the costs of employing heroic measures are high and that there are better uses for those resources, this faction is put in position of having to identify preferable ways of using those funds. The m commonly proposed alternative is that funds should be shifted away from ac care to benefit preventive care, not a particularly controversial idea. Howev while many may agree in principle that there might be some value to this id a major shift in this portion of expenditures is not likely because there is much vested interest in the segment of the health sector involved in deliver acute care. The discussion becomes more threatening when the statement is m that our health care resources are not unlimited. If scarcity is acknowledg then the question of distribution moves to the forefront of the discussion. long as we as a society refuse to admit that scarcity is an issue, we can av the need to confront sensitive discussions concerned with distribution. Howev this topic is cropping up with increasing regularity. If there is a shortage organs, who should be the first to receive one? Should heroic (that is, expensi measures be used to save people whose life expectancy is very short in any c (that is, the aged)? This leads to the question of how old is too old to be sa using heroic measures? Should extraordinary efforts be made to save the sever damaged child of a poor, unwed, inadequately educated teenaged mother, who ability to care for the child is doubtful once the child is released from the hospit In short, are some people's lives worth more than others'? Should life-worth entered into a cost-benefit equation? How else can we allocate scarce resourc Few models are available from which to choose.

According to Henry Aaron and William Schwartz (1984), the British resolve these questions by allowing physicians to allocate scarce resources at their own discretion. Their decisions are not questioned because everyone shares the basic values that govern decisions in this area, including the fact that after a certain age, say fifty-five, one should not expect to receive as large a share of the resources in this sector as a younger person. In Great Britain, such understandings have evolved quietly without the need to examine them openly and publicly. Even though the results are not the same, understandings about these matters have developed in the United States as well. Our understandings are, however, that each of us should expect that "everything possible will be done," even if the chances are very small that "everything possible" will have any beneficial effect (Aaron and Schwartz 1984). None of us is ready to accept less for ourselves or those who are near and dear, nor is it likely that providers could or would even be interested in introducing other standards on their own, given the prevailing value system and the expected response, starting with private protest and escalating to the threat of legal suits plus public outcry. Thus, any attempt to restrict services must lead to statements specifying the case in opposition to the benefits of treatment. Greater savings in the delivery of health care could be achieved if criteria outlining who should receive maximum care and who should not were determined. In this society such decisions will surely lead to a public debate.

Because specifications regarding who should receive a greater share of health sector resources in the form of more extensive treatment cannot be objectively derived, discussions on such matters require exposition of particularly sensitive values. Few are willing to take the responsibility for initiating discussions stimulating public debate regarding values that are at the heart of the social fabric of this society. Such debate certainly risks pitting the younger generation against the older generation; risks blaming the victims of certain types of illnesses for contributing to their own health problems; and risks arguments about social worth involving the moral quality of a person's life, the value of the person's social contribution, innate intelligence, and so on. As long as most of us are not prepared to enter into such discussions or to entrust others to make decisions for us on these matters, one major avenue for achieving savings in the delivery of health care services will remain closed.

THE HEALTH SECTOR FINANCIAL PICTURE

The final characteristic which has played a crucial role in determining the design of the health sector in recent years involves the financial prospects for the future it projects. From one perspective the national economy has been well served by the steady expansion of the health sector for the last ten to fifteen years. Whether the massive medical–industrial complex that has evolved during these years should be greeted as an exciting investment opportunity or as a cause for serious concern regarding potential negative consequences depends on the

perspective from which one views this development (Relman 1980). In c
case, there is good reason to take seriously the notion that the medical-indu
complex succeeded in the position previously occupied by the military com
(see Table 5). The rise in military expenditures in recent years without any l
that the rate of health expenditures will slow down is at the center of the nat
budget crisis now plaguing the nation and which, in turn, is responsible fo
pressure to cut health care costs.

An obvious solution to this problem has been identified by the nation's
icymakers, and attempts are currently underway to implement it, namel
transfer some portion of the government's share of current health expendi
to the private sector. However, this solution has not been easy to achiev
reasons associated with the size and complexity of this sector. The scer
which has resulted is the following one. The elderly, and others whose h
care bills are of catastrophic dimensions, are growing in number; the cost of
type of care constitutes a substantial portion of the government's health care
and no one who finds himself or herself in this situation is willing to ac
restraints on his or her use of services or increased cost-sharing without a f
Because so many of those in this situation are both politically aware and
represented, their resistance is formidable. Similarly, the private health insur
industry refuses to assume the burden of cost shifting without making ce
its clientele is told that cost shifting from the public portion to the private po
of the health care bill is responsible for the increase in premiums, and r
employee benefit packages are being revised as a result. Thus, while the
to control rising costs is a real problem, no one—neither those who cons
health services, nor those who deliver health services, nor those who pla
intermediate role (providing insurance, supplies, and such)—is willing to ac
cuts in his or her particular stake in current health care arrangements. Ad
this the difficulty we seem to be having in confronting the fact that a substar
share of the explanation for rising costs is attributable to factors that do
readily lend themselves to the effort to impose cost controls, namely, the gro
in the number of persons who utilize health services, the expanded rang
medical interventions that are available, and the fact that more seriousl
persons are being treated (Scitovsky and McCall 1976; Scott, Flood, and F
1979).

In recent years we as a society opted for a control system which does
require us to confront these realities. We have chosen to reduce rising he
care costs by supporting an approach that would lead to improved efficienc
the operation of the health sector. No one can argue with the goal of redu
inefficiency. To what extent this approach succeeds remains to be seen.
process of selecting measures of success to satisfy the majority of those w
have an interest in this sector will be particularly interesting to follow.
illustrate, to the extent that there is a consensus about the steps that will lea
cost savings without risk to health, a reduction in in-patient procedures is with

doubt the leading contender. Accordingly, the mechanisms put in place, particulary DRGs, include incentives to encourage the substitution of out-patient care for in-patient care or, at the very least, shorter in-patient stays. (It is interesting that Sloan and Valvona [1986] have concluded that the recent decline in length of stay is due to factors other than the mechanisms associated with market competition.) The effect of the changes taking place has been rapid and extensive enough to have dramatic effects on hospitals, which are undergoing a period of extensive reorganization; some have closed, others have merged, many have entered into contracts with hospital management firms, and so on (Institute of Medicine 1983; Kelly and O'Brien 1983). Although the evidence is not available yet, we should not be surprised if the hospital portion of the health bill, which is the biggest single item, declines. However, the question that must be answered is: Does evidence that this portion is declining, or at minimum not increasing, constitute success? Or is the size of the whole health care bill a better indicator? There are those who argue that it is the "little ticket items" (diagnostic tests) that should be scrutinized (Fineberg 1979). The shift from in-patient to out-patient care may not have a strong effect on this portion of the health care bill. There is also some suspicion that the emphasis on out-patient care may produce increased utilization of out-patient services well beyond the level that could be expected as a result of the shift away from in-patient care, which is to say, increased marketing of out-patient services may induce an increased demand for such services. Whether the increased use of out-patient services is interpreted as desirable depends on whether it is appropriate. Obviously, those who are interested in measuring the effects of recent trends inspired by mechanisms intended to produce cost savings do not face an easy assignment in selecting measures of success that will please everyone.

It will be some time before a consensus can be reached regarding appropriate measures of cost-saving success as well as evaluation techniques to be employed in order to determine the impact that the most recent changes in the organization of the health care delivery system have had. During this time, it is very unlikely that health will decline in worth as a prized social commodity. Accordingly, there is little reason to expect that either personal energy or financial investment will be redirected. In effect, the image this sector projects is imbued with the promise of opportunity in the future. As long as this is true, and as I have said at present there is no reason to believe that this will not be true in the future, investors will continue to put their dollars on what appears to be a safe bet, and individuals will continue to invest their energies in pursuing careers in this sector. As long as this scenario is perceived to be accurate, the health sector will continue to function as a crucial segment in the backbone of the nation's economy. In effect, the nation's economic stability is being buttressed by the confidence that society has in the continued financial viability of the health sector. If this is true, then a severe decline in health expenditures would have negative consequences for the economy as a whole. Perhaps a decline in total health expenditures is

not the measure of success we should be using. Perhaps we should be def cost containment success as reduction in the federal government share of l care costs rather than reduction in health costs as a whole.

DECIDING ON A SYSTEM OF SOCIAL CONTROL

The analogy that comes to mind to illustrate what has been happening i health sector over the past few decades is that it has fallen into a deep cir rut from which we are now having difficulty extricating it. The circulari this rut is caused by the following pattern: as each new health sector pro is identified, a mechanism (that is, an agency, incentive program, or suc created to address it; a sizable number of people become involved in the ations of the mechanism; after a short period of time some faction of obsc begins pointing out its shortcomings and proposing alternatives; however, involved in the operations of that mechanism have a stake in defending i do so; the rhetoric escalates; those involved in the mechanism's operations tually start to become demoralized and move into other parts of the health sc the mechanism begins to wither away from lack of support; meanwhile problems that came to light while the mechanism in question was operativ thought to be even more pressing; and a new mechanism is introduced basc the presumed urgency of the need for it, which brings another wave of partici whose interest in the operations of the newest mechanism become quickly ve And the circular rut begins anew! The rut continues to grow deeper, of co with the increased weight of each new wave of participants. Finding a wa of this rut, obviously, does not become any easier with delay.

Throughout this discussion I have maintained there are only three options which to choose in seeking a way out. I will outline the strengths and weakn of each, but the list is necessarily short because there are only a few point which most of us can agree.

According to the literature on organizations, the greatest concern with re to the administrative approach is its tendency to spawn lumbering, impers and inefficient structures that defeat their own original purposes. In the cas health planning, as is often true of other bureaucratic endeavors, one of primary purposes is representation of the public interest, which is at risk of b jeopardized by widespread inefficiency. The picture painted of the professi system of control includes equally unattractive features. We are told that pr sional control systems have a tendency to evolve to benefit the members of profession. The professionals, in this case physicians, can be expected to de a large portion of their energies to protecting their rights to perform certain t of work for which they are then in a position to charge high fees. Furtherm the evidence from the past indicates that there has been little room in this appro to accommodate measures to address the special situation of the poor, wh health is generally worse but who are unable to afford all the health care t need. The flaws in the third approach to control available to us, the ma

approach, revolve around two basic features. First, the most basic tenet of the market system requires that unprofitable units of an enterprise be identified, and if their profitability cannot be improved they are to be abandoned. The fact that some people depend upon the services provided by such unprofitable units is considered unfortunate but not the responsibility of institutions operating according to market principles. Second, the market approach is based on the idea that consumers are capable of making informed choices, which some critics argue is improbable.

Thus, we are faced with choosing among three approaches to control over the health care delivery system, each of which is clearly imperfect. On the other hand, each also has certain strengths to be considered. The administrative approach is undoubtedly in the best position to assess the overall distribution of health care resources. For one, it is generally agreed that data on the distribution of resources, utilization of services, and perceptions about the availability of health care services are necessary to do planning of any sort; and everyone, except those who are politically conservative in the extreme, agrees that the government should accept primary responsibility for collecting such data. For these reasons, the contribution made by the administrative approach cannot be disregarded.

The most significant characteristic of the administrative approach to control, its stance regarding the role the public should have in determining the kinds of services that will be available, must also be considered. The professional approach is basically silent on this point. The market approach does support the public's right to have a say about the services that will be available; however, the mechanisms it favors differ substantially from those employed by the administrative approach. In a system based on the administrative approach, the public is provided with an open forum where information is shared and options are debated by its representatives. The problems associated with finding appropriate public representatives is where this mechanism falters, as is clear from the literature reviewed in preceding chapters. Those who advocate a system based on market control use this point of weakness to argue that the market approach is superior because it is, by its nature, sensitive to consumer preferences which are expressed as demand for particular kinds of services. Whether one believes this is a superior or inferior mechanism depends on whether one believes that:

1. increased demand will result in an increased supply and ultimately depress the cost of certain services; or
2. that dependence on demand will reduce the access of those who are unable to pay for services that an increasing demand will produce because scarcity rather than an increased supply will be the most likely result. At the heart of this argument is the matter of physician-induced demand and its natural limits.

The key feature of the market approach to control is its emphasis on utilizing practices developed in the private sector intended to increase operating efficiency.

It is interesting that in the relatively short period of time that this appro control has been in effect in the health sector, it has had sufficient imp result in evidence that obvious differences between the not-for-profit an profit operating styles are no longer apparent. There are some who would that this is due to the fact that the profit motive may not have had as explanatory power as it has been generally credited with by the popular w and by economists (Pattison and Katz 1983; Register, Sharp, and Bivin Sloan and Valvona 1986; Watt et al. 1986).

Less attention has been directed in recent years to the advantages the p sional system of control has to offer. However, one of its undeniable stre is its commitment to the development of medical science and its applic While advancement in this sector, as in other scientific arenas, can be fo by directing more funds for research toward one set of research problems than another, no one outside of the health sector, or more specifically the m profession, is in a position to advance medical knowledge because no on is in a position to verify the benefits of new developments in medical know in practice. In effect, because an equivalent level of knowledge and exper required to evaluate or extend the work of others who are developing m science or applying it in practice, the medical profession has a singular advan The health planning legislation (PL 93–641) passed in 1974 provides a p ularly good illustration of this. In spite of the fact that the legislative inten to reduce the influence of providers and increase the influence of consum health planning agencies, the authors of this legislation nevertheless ha alternative but to turn to professional expertise in developing the standard became the regulatory guidelines for evaluating the CON proposals.

THE RHETORIC OF DEBATE

Beyond the fact that the information helpful in clarifying the choices fronting us has not been well organized and readily available is the rheto style of current debates about health sector problems and their resolution (I bilet, Weinstein, and McNeil 1986). The rhetoric of criticism that characte such debates, however, should not be taken too literally. This is becaus many of the critics who comment on prevailing health care delivery arrangen start by identifying the flaws found in a single mechanism of control and con sounding as if all current arrangements are flawed and should be aband While some critics do intend to convey this message, many more probabl not. Whether they intend this or not, however, is a separate issue fron function of the debate itself. Consider the opportunities involved.

If one views the debates about the superiority of one set of mechanisms another dispassionately, then one can see that the health sector provides a ticularly interesting forum for intellectual debate as well as experimentation. mechanisms that are the products of these debates have a good chance of b implemented and tested in the real world. Thus, it possible to have a pa

tinkering with social control mechanisms on a grand scale by creating massive field experiments.

If such a dispassionate view does not strike one as intellectually stimulating but as callous and disruptive, even if not always detrimental to the nation's health, then a revision in the incendiary rhetorical style currently employed by the critics of the mechanisms being used by the health sector might be the first step. The next step might be to identify points of consensus regarding the steps leading to workable solutions. To date far more energy has gone into criticizing alternative approaches and providing a platform for advocating a favorite control mechanism, which has, in turn, more to do with advancing a particular intellectual predisposition, than resolving the problems confronting the health care delivery system.

While it is clearly the business of scholars to engage in vigorous intellectual debate, the consequences of such debates for the operations of the health sector have not been entirely beneficial. The major consequences include a significant loss of public confidence in the health sector, a considerable amount of confusion about alternatives, and the perception that the problems of the health sector are of crisis proportion.

In the end, the rhetoric of criticism realistically can only aim to discredit alternative approaches to control in order to gain an incremental margin of control rather than total control over the health sector. In essence, it is time to acknowledge the fact that all three systems of control are now operative and must continue to coexist in order for the health sector to function.

In sum, we as a society have been reluctant to confront two crucial facts as they relate to the health sector, namely, that no system of control is flawless and that the resources that can be devoted to this sector can no longer be treated as if they were unlimited. Any approach to control that attempts to contain costs in the health sector will of necessity have to confront questions regarding the allocation of resources. However, because each approach takes a different view of this challenge, we must take into consideration the functions each of the three approaches was originally mandated to perform and develop a higher level of consensus regarding the strengths and weaknesses of each before opting for changes in current health care delivery arrangements. To date we have employed an expensive and disorganizing policy of trial and error. This pattern has provided us with certain by-products that have a value in their own right, particularly the sophisticated array of evaluation techniques that have accrued. If it were not for the expense and disorganization involved, we could continue to design and construct massive social experiments and watch them evolve. However, for the sake of the ultimate goal involved—improving the nation's health—it seems to me that it is time to move toward a more cooperative stance focusing on ways to use to best advantage the contributions to planning for the nation's health that each of the three approaches to social control over the health sector can contribute rather than continuing to argue about their failings.

5.

1

Controlling the "Uncontrollables": Budgeting for Health Care in an Age of Megadeficits

Allen Schick

On the next to last day of its 1972 session, Congress completed action on an omnibus social security bill that (among its many provisions) entitled victims of kidney failure to Medicare benefits. The provision was added to the bill by a Senate floor amendment, without prior committee hearings or review and without any consideration of the issue in the House.[1] When it adopted the amendment by an overwhelming 52–3 margin, the Senate had no reliable cost estimates and only a fuzzy notion of how expanded Medicare coverage would affect future budgets. During brief floor debate, Senator Vance Hartke, the amendment's sponsor, implored the Senate to put health care ahead of budgetary concerns: "How do we explain," he asked, "that the difference between life and death is a matter of dollars?"[2] Hartke estimated that the new benefits would cost $75 million in the first year and perhaps $250 million in the fourth. Annual expenditures turned out to be much higher—about $1 billion by the end of the 1970s. By then, however, the entitlement of kidney patients to Medicare was inscribed in law, and the budget routinely labeled these expenditures as "uncontrollable."[3]

A decade after this measure was enacted, Congress once again attached changes in Medicare to omnibus social security legislation. In March 1983, Congress converted the reimbursement of hospitals for Medicare services from a retrospective basis to a prospective payment scheme based on a fixed price for each of 467 "diagnosis-related groups" (DRGs). Congress adopted this far-reaching change with unusual speed. The DRG system was approved by the House Ways and Means Health Subcommittee just two days after it was proposed by the White House. The full committee marked up the bill in a single day, and within a week the social security package to which the DRG scheme was attached was passed by the House. The Senate also acted quickly, and only a month elapsed between the start of congressional

consideration and approval of the measure.[4] Within this compressed time framework, Congress had little inclination to think about the impact of DRGs on the quality or availability of health care. Its overriding concern was to ease financial pressure on Medicare. Although DRG was supposed to be "budget neutral" at the outset (it would not immediately change federal spending on Medicare), there was a strong expectation that the new arrangement would substantially lower the program's cost.

The 1972 and 1983 Medicare actions were products of vastly different legislative and budgetary environments. The expansion of Medicare to victims of kidney disease was enacted during an economic and program expansion. When the economy was producing sizable increments, major program initiatives were often undertaken with little regard for their budgetary effects. The economy would take care of the budget, so the reasoning went, and the government would take care of those who could benefit from its programs and assistance. In this environment, legislation was considered in terms of the good that government could do by opening its purse to those in need. Moreover, beneficiaries were often vested with rights to governmental assistance, shielding them from annual budgetary scrutiny. Budgeting and legislation operated on separate tracks that converged from time to time, such as when budget makers had to estimate the next year's cost of entitlements provided in law. But neither the budget nor the appropriation bills were the instrument for making or changing these policies, though financing for some programs (such as Medicaid) was provided in these annual decisions.

The 1983 legislation reflected a reversal in the relation between legislation and budgeting. Whereas in the past the budget was driven upward by program decisions, now program costs were being forced downward by budgetary pressure. In the 1980s, legislative debate on health care and many other issues has been "fiscalized," as concern about spiraling costs, chronic deficits, and effects on future budgets crowds out consideration of the medical needs of the elderly and others. "The only Medicaid debate taking place this year," one observer of the legislative scene wrote in 1984, "will be a budget debate."[5]

When Congress considered the DRG system in 1983, a leading health industry lobbyist urged Congress to act quickly, "so that we do not once again have to face the annual charade of tinkering with the present reimbursement system."[6] This hope was not realized, however. The 1983 legislation was not an isolated case but one in a series of congressional enactments designed to pare the burgeoning costs of federally financed health services. In fact, as the following summaries

show, cost-cutting changes have been made in Medicare or Medicaid in every year since 1980.

1980: A budget reconciliation bill—the first time this type of measure was enacted—yielded an estimated $2 billion in Medicare savings. The legislation tightened cost controls, permitted lower payment rates for care provided in skilled nursing facilities, and provided for the federal government to recover previously disallowed Medicaid costs by subtracting equivalent amounts from payments to the states. While the cutbacks were quite modest, this measure set the stage for deeper cutbacks in subsequent years.

1981: The Omnibus Budget Reconciliation Act made far-reaching changes in numerous domestic programs, including Medicare and Medicaid. Congress rejected a cap on Medicaid payments to the states proposed by the president and instead chose several changes that gave states incentives and flexibility to reduce the program's costs. The changes included an option for states to waive "freedom of choice" rules that gave recipients the right to choose their health care providers; repeal of the "reasonable cost" basis for hospital reimbursements and allowing payments sufficient to ensure "reasonable access to services of adequate quality"; and across-the-board percentage reductions in payments to the states. The principal Medicare provisions raised the deductible paid by beneficiaries for both Part A and Part B coverage. At the time, it was estimated that the Medicaid and Medicare changes would save almost $6 billion over a three-year period.

1982: The Tax Equity and Fiscal Responsibility Act—a reconciliation bill—made an estimated $14 billion in cuts over the next three fiscal years. Most of the savings in Medicare were due to new limitations on hospital reimbursement. The legislation established a target reimbursement rate under which payments would be increased by no more than 1 percent above the change in the hospital wage and price index. Congress considered but did not adopt proposals to cap doctors' fees. In Medicaid, states were given permission to charge nominal fees for certain services. The measure penalized states for high error rates.

1983: Congress adopted the DRG prospective payment system, to be phased in over a three-year period. A freeze on physician payments was incorporated into that year's budget reconciliation bill, but Congress failed to complete action on the measure.

1984: The Deficit Reduction Act imposed a fifteen-month freeze on Medicare charges by doctors, raised Part B premiums, and limited increases in hospital reimbursements. These and other provisions were estimated to reduce Medicare outlays (or increase program revenues) by approximately $6 billion. The legislation did, however, expand Medicaid coverage for children and pregnant women.

1985: The House and Senate passed reconciliation legislation that would have cut Medicare costs by limiting reimbursements to doctors and hospitals. But the two houses were unable to reach agreement in conference, and the reconciliation bill was not enacted. Congress did, however, approve a temporary extension on the existing freeze of Medicare reimbursements.

1986: The president's fiscal 1987 budget proposed cutbacks in Medicare spending and increased charges that would contribute almost $5 billion to deficit reduction in the first year and a projected $50 billion over the next five years. The budget also proposed changes in Medicaid to lower federal costs by $1 billion in the first year and by an estimated $17 billion over a five-year period. Congress enacted the reconciliation bill developed in the previous session. It pared several billion dollars off Medicare spending by cost and reimbursement controls.

These synopses of recent legislation reveal that health care has been subjected to repeated cost-cutting efforts. The next part of this chapter examines two main factors in the change from program expansion to budgetary contraction—the fiscal condition of the federal government and financial pressures in the health sector. The chapter then discusses ways in which health care policy has been made by the budget process. Both formal and behavioral aspects of congressional budgeting are considered. The chapter concludes with reflections on whether health care financing will be as turbulent in the years ahead as it has been in the recent past.

The Fiscal Condition: From Economic Growth to Budgetary Stress

On the last day of the 1972 session—just one day after it approved Medicare coverage for victims of kidney disease—Congress established a joint committee to recommend improvements in its control of federal spending and deficits.[7] This committee's proposals led to the Congressional Budget Act of 1974, which set up budget committees in the House and Senate, provided for Congress to adopt two or more

budget resolutions each year, and created the Congressional Budget Office (CBO) as a staff agency of Congress.[8]

The budget process was partly a product of worsening economic and budget conditions. Inflation and unemployment were somewhat higher in the early 1970s than they had been a decade earlier, though they still were quite modest compared with the levels that would be reached later. "Guns versus butter" was a troublesome issue, as the government faced program expansion at home while engaged in a war overseas. Congress and the president fought over the impoundment of funds, and they blamed one another for budget deficits and spending increases. Although the 1974 Budget Act did not resolve these economic and budget issues, it established the procedures by which Congress could make fiscal policy, set budget priorities, and control presidential impoundments. The act did not prescribe balanced budgets or spending cutbacks, perhaps because the early 1970s were still a period of confidence in the strength of the economy. There was talk of the "peace dividend" that would be available after the Vietnam War to augment domestic programs without unbalancing the budget.

This confidence was shattered by the OPEC oil boycott and the shocks that rippled through the U.S. economy in the first years of the budget process. The jobless rolls added 3 million workers in the act's first year, and the unemployment rate soared from 5.5 percent to almost 9 percent. While subsequent recovery ameliorated unemployment, it did not bring the rate back down to earlier levels. In the decade prior to the 1974 Budget Act, unemployment never rose above 5.8 percent; in the decade that the act has been in operation, the annual rate has never been below 5.8 percent. Table 1–1 shows that other measures of economic performance also deteriorated during the first decade of the budget process. The annual rise in the consumer price index averaged 5 percent in the pre-budget-act decade compared with almost 8 percent afterwards. Although interest rates were substantially higher after the act than before, economic growth and productivity gains were much lower.

Adverse economic conditions were reflected in deepening budgetary stress. When it was developing the budget act, Congress was troubled by deficits that (for the 1970–1974 years) averaged barely 1 percent of gross national product. In the next five years, deficit spending surged to 3 percent of GNP, and in the five years after these the deficits rose again to more than 4 percent of GNP. Congress also was beset by the creeping rise in spending as a share of GNP—almost 20 percent in 1970–1974; 21 percent in 1974–1979; and 23 percent in 1980–1984.

TABLE 1–1

SELECTED MEASURES OF ECONOMIC AND BUDGETARY PERFORMANCE, FIVE-YEAR AVERAGES, 1970–1984
(percent)

	1970–1974	*1975–1979*	*1980–1984*
Unemployment rate, annual averages	5.3	6.9	8.2
Real GNP growth, year over year	2.8	3.5	2.5
CPI increase, year over year	6.1	8.1	7.3
Outlays/GNP[a]	19.6	21.3	23.2
Budget deficit/GNP[a]	1.2	3.0	4.2

NOTE: Calendar years for economic measures; fiscal years for budget measures.
a. Includes off-budget outlays.
SOURCES: Budget of the United States Government for the 1987 Fiscal Year and Economic Report of the President.

TABLE 1–2

INCREASES IN MEDICARE, MEDICAID, AND TOTAL OUTLAYS, 1971–1986
(percent increases over previous three years)

Fiscal Year	*Medicare*	*Medicaid*	*Total Outlays*
1971	42.9	86.3	18.0
1974	45.6	73.1	28.2
1977	100.7	69.7	51.9
1980	65.9	41.3	44.4
1983	63.9	36.0	36.7
1986 (est.)	30.5	30.0	21.2

SOURCE: Budget of the United States Government (FY 1986), *Historical Tables*.

Subsequent improvements in economic conditions have not significantly eased budgetary pressures. In fiscal 1986—the fourth year of sustained growth—deficits still exceeded the $200 billion mark. They are likely to persist at this high level, CBO has projected, unless further sizable reductions are made in federal programs or additional revenues are generated through tax increases. Few in Washington (other than true supply-siders) view massive deficits as cyclical problems that can be remedied by a vigorous economy. Rather, these deficits are perceived to be structural imbalances between spending demands on

the one hand and the willingness of the government to generate revenues on the other. The Gramm-Rudman-Hollings law passed by Congress in 1985 manifests preoccupation with budget deficits. The law compels reductions in federal spending if the deficit were estimated to exceed target levels.

It is unnecessary for purposes of this paper to consider whether the Reagan administration has contrived big deficits as a means of exerting pressure for cutbacks or whether it has simply exploited a situation over which it has had little control. Regardless of the motive, deficits are the number-one fact of contemporary budgeting. They are propped up by the updrift in interest charges and social security payments (the two largest uncontrollable accounts), by White House success in obtaining more money for defense, and by its steadfast opposition to tax increases. Because of current and prospective deficits, there is hardly any support these days for program enhancements. Interest groups—including those active in health policy—call it a victory if they ward off one round of budget cuts, even though they know that the battle will be renewed next year.

Health Care: From Providing Benefits to Cutting Costs

Despite fiscal stress, some sectors of the federal budget have continued to grow while others have held their own. In addition to highly publicized increases in defense, some programs serving the elderly and poor have fared quite well in the 1980s. There have been spending increases in supplemental security income (SSI) and in the women, infants, and children program (WIC). Social security experienced some cuts in the 1983 rescue package, but it has staved off further reductions since then.[9] Medicare and Medicaid, as the year-by-year summary at the start of this paper shows, have been subjected to repeated cutbacks. To explain their predicament, we must turn from the overall condition of the budget to the financial status of these major health care programs.

In the course of two decades, Medicare and Medicaid have occupied a progressively larger niche in the federal budget. In each of the periods for which data are presented in table 1–2, the increase in Medicare expenditures has substantially outpaced the rise in total outlays. Although Medicaid grew faster than the totals in its first decade, it has kept pace with the overall budget trend during the past ten years. As a result of sustained, steep spending escalation, Medicare outlays soared from $6 billion in FY 1970 to an estimated $66 billion in FY 1985. During the same period, Medicaid grew from less than $3 billion to more than $22 billion. The combined Medicare/

TABLE 1–3
COMBINED MEDICARE-MEDICAID OUTLAYS AS A PERCENT OF OTHER MEASURES, 1970–1985

Medicare-Medicaid as Percent of	*1970*	*1975*	*1980*	*1985*
National health expenditures[a]	11.9	14.8	18.5	20.0 (1984)
Total outlays	4.6	6.1	7.8	9.3
GNP	0.9	1.3	1.8	2.2

a. National health expenditures computed on a calendar-year basis; all other measures are based on fiscal years.
SOURCES: *Health Care Financing Review,* and Budget of the United States Government (FY 1987), *Historical Tables.*

Medicaid share of the budget doubled from 4.6 percent of total outlays in 1970 to 9.3 percent in 1985.

Table 1–3 reveals that these programs also account for a larger proportion of national health outlays and national output. Medicare and Medicaid financed 20.0 percent of national health expenditures in 1984, up from only 11.9 percent in 1975. Their share of GNP more than doubled from less than 1 percent to more than 2 percent. Projections of future health care trends by the Congressional Budget Office and the Hospital Insurance Trust Fund indicate that although Medicaid will stabilize as a share of GNP, the Medicare percentage will steadily rise and might exceed 6 percent of GNP by the year 2040.[10] These projections assume no change in the prevailing federal health care financing policy. Even without program enhancements, therefore, Medicare might triple as a percentage of GNP during the next half century.

Two other trends alarmed Congress. First, inflation in the provision of health care regularly outran increases in broader price indexes. Congress felt that much of this excessive inflation was due to open-ended reimbursement schemes, which permitted providers of health services to pass all cost increases to the federal government. Second, the surpluses built up by the hospital insurance trust fund during the early years of Medicare were substantially drawn down by the early 1980s. In their 1982 report, the board of trustees projected that the fund would be depleted by 1987 and that the gap between expenditures and receipts would progressively widen in future years. Moreover, in 1983 CBO Director Alice Rivlin warned that the supplementary medical insurance fund (which finances doctors' ser-

vices) would also run dry and that without new revenues its outlays would have to be cut by $28 billion over a four-year period.[11]

The Medicare "time bomb" was ticking in the early 1980s, and there was widespread concern that the financial problems would be more severe than those that had impelled Congress to enact a social security tax increase–benefits cutback package.

Cutback Budgeting: Rules and Behavior

Budget stress and skyrocketing health care costs have spurred Congress to cut Medicare and Medicaid. The development of its own budget process gave Congress the means to do so. But it took time for Congress to forge the process into an effective and politically viable cutback mechanism. To become an effective cutback instrument, congressional budgeting had to be reshaped from an accommodation to a control process.

Phase I: Accommodative Budgeting. On paper, the 1974 Budget Act hardly changed Congress's fragmented budget procedures. Authorizing committees retained jurisdiction over substantive legislation, including entitlements that mandated the expenditure of funds. The appropriations committees continued to produce more than a dozen separate spending bills each year. Although the act equipped Congress with an assortment of cost estimates and scorekeeping reports, it limited the instances in which legislation could be stopped because it breached congressional budget policy.[12] The budget resolutions were to serve as internal guidelines for Congress; they had no statutory effect. Congress could neither levy taxes nor authorize expenditures in budget resolutions. These basic legislative functions were retained by older congressional committees. The incapacity of budget resolutions to make (or change) law meant that they could not alter spending prescribed by entitlement legislation. Uncontrollables continued to be beyond the purview of congressional budgeting.

Because Medicare and Medicaid were entrenched in permanent law, their expenditures could not be determined by budget decisions alone. Regardless of the amount budgeted for the health function, actual spending on Medicare and Medicaid was determined by exogenous factors, principally utilization and inflation rates in the health care industry. Inasmuch as three-fourths of the federal health dollar was spent on these two programs during the early years of the budget process—their share has steadily climbed and is now about 90 percent—Congress found that uncontrollables largely determined the health budget.

Prior to the FY 1981 budget, Congress periodically sought to curtail entitlement programs by assuming that "legislative savings" would be achieved through changes in law. The assumed savings were mentioned in the reports of the budget committees, but not in the budget resolutions. Hence, Congress adopted the budget resolutions without having to vote on the assumed changes in law. One such occasion occurred in FY 1978, a year during which President Carter was vigorously promoting hospital cost containment legislation. The report of the Senate Budget Committee assumed that about $700 million would be saved in the first year and $13 billion over a five-year period by enactment of such legislation:

> The Committee recognizes an urgent need for Congress to move quickly to curb the severe inflation in medical care costs, endorses legislation to reduce this inflation, and estimates outlay savings in the health function to reflect enactment of such legislation.[13]

The budget committees, however, did not have legislative jurisdiction over the programs targeted for savings. Because the committees that had jurisdiction did not produce the savings, legislative inaction triumphed over budgetary action, and the hoped-for cutbacks were not attained.

Lacking legislative power of their own, the budget committees had to accommodate the demands of others on Capitol Hill. While the terms of accommodation varied among policy areas, the health function was one in which the budget committees were relatively weak. Most health expenditures were governed by law, not budget decisions, and those subject to annual decisions were strongly influenced by the appropriations committees. Senator Warren Magnuson, the ranking Democrat on Senate Appropriations (and its chairman in 1978), headed the Labor-HEW appropriations subcommittee for many years. When the budget process was established, he was appointed to the budget committee; and, though Magnuson rarely participated in its deliberations, he usually got what he wanted for health programs. Here is the way the Senate Budget Committee set health spending for FY 1976:

Muskie:	Now Senator Magnuson's letter—where is that—on this function is to recommend [$]31 billion in total health outlays.
Beall:	[$]31 billion?
Muskie:	[$]31. That is [$]100 more than mine.
Mondale:	I move that Magnuson figure . . .
Beall:	What does that suggestion include?

Muskie then reread a paragraph from the letter, which expressed Magnuson's concern "that the president's budget does not reflect the high priority Congress has given to the health needs of our citizens."[14] After rejecting a motion for a lower target, the committee voted 11–2 to accept Magnuson's figure. The pattern was repeated two years later, this time with Magnuson present; he wanted $48.2 billion in budget authority and $44.6 billion in outlays:

Muskie:	Are you proposing that?
Magnuson:	Yes, I am proposing that. That is a little lower than the Appropriations Committee wants to go.
Hollings:	Old Silas Marner.
Chiles:	You had to talk to yourself on that.
Muskie:	It is the most effective one-man negotiation I have run into in a long time.[15]

After the committee turned down Chiles's try for a lower figure, it adopted Magnuson's recommendation.

Phase II: Spending Control. Over time, the budget committees gained greater independence and legitimacy in health and other policy arenas. The passage from the congressional scene of Magnuson and other "giants" as well as increased fragmentation in Congress enhanced the coordinating role of the budget process.[16] The key step in this development was the conversion, in 1980, of reconciliation into a process for bringing existing law into conformity with current budget policy.[17] Reconciliation gave Congress a means of compelling legislative committees to recommend program cutbacks. Reconciliation instructions attached to the budget resolution designate the committees that must report savings, tell them the amounts they must cut, and give them a deadline for producing the required legislation. The cutbacks recommended by various committees are then packaged into a reconciliation bill and (in some years) expedited through rules that limit floor amendments in the House and bar filibusters in the Senate.

Not surprisingly, reconciliation was introduced during a particularly difficult economic period. In 1980 the annual increase in the consumer price index exceeded 13 percent, and the prime rate topped 20 percent. Threatened with economic panic, Jimmy Carter withdrew his own budget and hammered out a more austere version in top-level negotiations with congressional leaders. To implement the cutbacks agreed to in these negotiations, the budget committees attached reconciliation to the first resolution for the next fiscal year.

Congress does not have to use reconciliation to retrench programs and expenditures; the 1983 adoption of DRG, for example, was

enacted as part of social security legislation, independent of the congressional budget process. But reconciliation and this 1983 legislation have several common features that go far to explain why the former is a politically attractive vehicle for enacting cutbacks. Both reconciliation and social security legislation were enacted in packages that balance various political and spending concerns; both entail high-level political negotiations; and both avoid the fragmentation of the ordinary authorizations-appropriations processes. Both, therefore, shield rank-and-file members from some of the political heat of voting for cutbacks and insulate them from some interest-group pressures. These political advantages can be understood by examining the reconciliation process.

Cutback through reconciliation. Reconciliation is a two-stage process that conforms existing law to new budget decisions. The first stage consists of instructions placed in budget resolutions; the second stage entails the enactment of one or more reconciliation bills. Without reconciliation, budget decisions might move in one direction but actual spending in another, as happened in the 1970s when Congress assumed but did not produce legislative savings.

Reconciliation is usually triggered by a presidential proposal for spending cuts and is carried out through budgetary negotiations between congressional leaders and White House aides. When the president asks for cutbacks in his budget, he defines the environment within which Congress operates and spares members from having to take their own initiative. Cuts in health care financing have been proposed in every recent budget, and these have set the stage for subsequent congressional action.

Moreover, in most recent years—1981 was the notable exception—political negotiations have been conducted in an effort to get legislative-executive agreement on the amounts or programs that were to be trimmed. In 1980, congressional–White House agreement on cutbacks led to the first successful use of reconciliation. Political negotiations were attempted in 1982, but policy differences between the Democratic House and the Republican White House thwarted an agreement. In recent years, Senate leaders and the White House have tried, through discussion, to forge a Republican position on the budget.

Although the president usually takes the lead in proposing specific cuts, Congress does not have to accept his recommendations. During the Reagan years, Congress has refused to enact some of the severe cutbacks sought in Medicaid, but it has been somewhat more accommodating in curtailing Medicare. By seeking deep cutbacks, the president enables members of Congress to behave as the "good

guys," even when they make some reductions. Congress is the place that beneficiaries and interest groups go to block some of the proposed budget cuts.

The 1983 DRG legislation was a notable exception to this pattern. Congress took the initiative in ordering the administration to devise a prospective payment scheme for Medicare. When the administration submitted its plan, Congress rushed to enactment without allowing affected parties to mobilize in opposition. One can surmise that Congress was so alarmed by the projected bankruptcy of Medicare that it behaved in an atypical fashion.

Reconciliation instructions. Instructions are the first stage of the reconciliation process. These instructions do not mention programs, only money. This preserves the basic division of labor in which the budget committees are concerned with financial matters and the legislative committees retain jurisdiction over substantive policy. This division of labor means that Congress does not vote on program cutbacks when it approves the instructions. If it fails to follow up the instructions with legislation, the targeted cutbacks will not be made.

The budget committees do not have to spell out what they have in mind when dollar savings are proposed. The instructions thus reinforce the tendency of Congress to see cutbacks as a financial rather than a programmatic issue. "Save money; don't cut programs" is the soothing orientation of reconciliation's first stage. Nevertheless, the instructions are not a pig-in-the-poke exercise. As already mentioned, the president is likely to have recommended cutbacks in his budget. Legislative committees often comment on proposed cutbacks in their "views and estimates" reports submitted to the budget committees. These reports are usually the first concrete indication of Congress's willingness to make reductions. The affected committees, however, are not bound by their views and estimates; they can adopt a different budget posture later in the year. Moreover, many committees hedge their bets by not revealing how they would distribute cutbacks among the programs in their jurisdiction. For example, the fiscal 1981 views and estimates report of the House Ways and Means Committee endorsed savings without mentioning which cuts would be made: "The Committee anticipates that it will make legislative changes which result in savings in Medicare equal to the savings resulting from legislative changes proposed in the Reagan budget."[18]

The budget committees do not have a consistent practice for identifying the savings assumed in their budget resolutions. They sometimes refer to key elements such as "caps" and "freezes," but on other occasions they point to specific cutbacks. The Senate Budget Committee recommended more than a dozen Medicare and Medicaid

cutbacks in its 1981 reconciliation instructions. But it also acknowledged that

> each committee that receives a reconciliation instruction is free to make the required savings in any manner it sees fit. The itemization considered by the Budget Committee does not have to be observed so long as each committee reports savings in an amount equal to the reconciliation instructions.[19]

Although these recommendations do not lock in the committees of jurisdiction, they exert a strong influence, if only because affected committees have to devise their own cutbacks if they do not adopt those asssumed in the instructions.

The discretion of legislative committees to deviate from the expected cutbacks is partly a function of their jurisdictional scope. Committees responsible for a small number of programs are likely to have less room for maneuver than committees with broader jurisdiction. The fact that Medicare and Medicaid are so costly and contain numerous subprograms has enabled the House Ways and Means and the Energy and Commerce Committees and the Senate Finance Committee to put together cutback packages that diverge significantly from White House recommendations.

The first time reconciliation was applied, it was limited to a single fiscal year. Committees were able to meet the instructions with temporary savings and bookkeeping gimmicks, such as shifting program costs to the outyears. In response to this problem, Congress stretched reconciliation (as well as the targets and ceilings in budget resolutions) to three fiscal years. Affected committees receive, and have to satisfy, separate savings instructions for each of these years. While budgetary legerdemain is still possible, the multiyear framework does stimulate more durable savings than might be realized in a single year. It also provides modest encouragement to examine the future program implications of current financial cutbacks.

The reconciliation bill. The savings recommended by various legislative committees are channeled to the House and Senate through the budget committees. The role of the budget committees is quite limited, however. They package the various recommendations into a reconciliation bill (or bills) but are barred by the budget act from substantively altering the recommendations of legislative committees. If the committees of jurisdiction fail to meet the cutback targets, the budget committees can take the issue to the floor. The capacity to do so in the House depends on the rule under which the reconciliation bill is considered. There is no comparable constraint in the Senate, but

the Budget Committee may nonetheless be reluctant to confront other committees on the floor.

Despite the weak position of the budget committees, there have been remarkably few instances in which legislative committees have failed to meet or come close to the dollar targets. Sometimes, committees come up a bit short, as if to show that they retain some independence. According to computations by the House Budget Committee, with the exception of fiscal 1984 (for which no reconciliation bill was enacted), Congress has passed more outlay reductions than have been called for in the instructions.[20] This pattern has been pronounced in Medicare legislation. In three of the four years that reconciliation bills have been enacted, Congress has exceeded the Medicare reduction targets.[21] This behavior reflects fidelity to the reconciliation process as well as congressional concern over cost escalation in health care and willingness to make deeper cuts in Medicare that allow it to make smaller ones (while still meeting the cutback instructions) in Medicaid.

While the budget committees have overstated the savings achieved through reconciliation, it appears that legislative committees have generally been responsive to the instructions. There are a number of reasons for this behavior. First, committees do not cavalierly disregard the instructions of their parent body. Second, the deficit-reduction mood in Congress has spurred committees to cooperate with budget cutters. Third, the reconciliation process enables committees to blame others—namely the budget committees—for forcing them to make unwanted cutbacks. The role of the budget committees in absorbing blame is essential to the success of reconciliation.

Most reconciliation instructions give committees a deadline for reporting legislation. While the deadlines are sometimes ignored or delayed, legislative committees do not ordinarily have much time to undertake a wide search of possible cutbacks or to assess the program effects of their actions. Time compression places a high value on actions that promise immediate cuts and are simple to put into effect. Quite probably, therefore, reconciliation impedes far-reaching structural changes and favors financing changes that save money.

The budget act does not require Congress to pass reconciliation measures, only to consider them. It is possible for members of Congress to "grandstand" by voting for cutbacks in the budget resolution but against actual cutbacks in the reconciliation bill. This has happened less frequently than might be expected. When a reconciliation bill comes to the floor, it is portrayed as a deficit-reduction measure. The amount by which the deficit is to be narrowed—not the specific

cutbacks—are emphasized. By packaging many reductions into a single bill, reconciliation enables members to come out against big deficits while avoiding separate votes on the programs that are to be cut.

The arithmetic of cutbacks. Because reconciliation is oriented to dollar cutbacks, it is necessary that committees and other participants know how the figures have been derived, what they mean, and the manner in which the savings are computed. The key concept is that of the "baseline"—an extrapolation of future spending trends under current policy. The savings are not calculated in terms of the president's budget or of the previous year's spending level. It is possible for spending to be labeled as a cutback even if it is above either of these measures. The baseline adjusts for assumed changes in prices and participation rates. For example, the Medicare baseline estimates the number of persons who will receive health care, the rate at which these services will be used, and the price levels. Since reconciliation is structured to secure savings for three fiscal years, a baseline is computed for each of these years. For instance, the baseline used for the 1984 Deficit Reduction Act projected that Medicare outlays would be $68.8 billion in fiscal 1985, $77 billion in fiscal 1986, and $86 billion in fiscal 1987. Actions taken by Congress to hold Medicare below these projected levels were classified as cutbacks.

The baseline is used by the budget committees in devising reconciliation instructions and by legislative committees in responding to them. (The appropriations committees generally avoid baseline computations, preferring instead to compare their actions with the previous year's appropriations and with the president's budget.) The baseline is usually computed early in the annual congressional budget cycle and then frozen for the remainder of the legislative session. Although a static baseline avoids a babble of conflicting and changing numbers, it means that the savings estimates might be out of date by the time Congress acts on the reconciliation bill.

Because they are pegged to baselines, cutbacks represent assumed, not actual, savings. The savings are realized only to the extent that the assumptions turn out to be valid. If hospital reimbursements were frozen, actual savings might be above the assumed levels when inflation is underestimated, but below these levels when inflation is less than expected. It is an almost impossible task to estimate the actual savings that have been realized in Medicare and Medicaid. To measure actual savings, one would have to relate legislative actions to the complex changes taking place in the health care industry. Nevertheless, it is probable that savings have been substantially overstated in recent years, both for the budget as a whole and for the health

sector. The Urban Institute has estimated that Medicare and Medicaid outlays were $6 billion lower in fiscal 1985 because of changes enacted in the first three years of the Reagan administration. These estimates are significantly below the reconciliation savings estimated by the budget committees.[22]

The baselines provide an important political advantage. They depict rising expenditures as budget cutbacks. Between fiscal 1981 (when reconciliation was first applied) and fiscal 1986, Medicare climbed from $39 billion to an estimated $66 billion. Yet Congress has taken credit for many billions of dollars in Medicare cutbacks during these years. By using baselines, Congress can foster the appearance of satisfying two conflicting demands: to save programs and to cut spending.[23]

Making the Cuts: Tricks and Treats

The political dilemma of cutting money while saving programs is evident in public opinion polls, which show strong support for maintaining benefit levels. According to recent polls, a majority of Americans oppose cuts in Medicare benefits. One survey sponsored by the American Association of Retired Persons found that only 5 percent favor benefit reductions while 66 percent think that the government should cut other programs and use the savings for Medicare.[24] A 1982 ABC News–*Washington Post* poll asked respondents to choose between the following statements: "Under no circumstances should Medicare aid to the elderly be cut back"; or "Because of the financial crunch, Medicare, like other government programs should be cut back." More than 80 percent selected the first statement.[25] A 1985 Harris poll found 56 percent opposed to cuts to make Medicare financially sound and to reduce federal spending.[26]

If this were the full picture, Congress would face an almost impossible political chore. Financial stress in the budget and the Medicare funds would impel it to curtail health care, but public opinion would make it exceedingly difficult to garner majority support in Congress for cutbacks. What has made Medicare reductions politically feasible is that most Americans—85 percent in one poll—believe that the cost of medical care is too high. Almost three quarters favor a requirement that doctors accept Medicare as full payment for services. Sizable majorities also endorse various cost-savings controls and incentives.[27] In sum, Americans favor actions that reduce costs without cutting services. They think that doctors and hospitals are charging too much and are willing to support changes that promise to contain rising costs.

The health care financing actions of Congress dovetail nicely with public opinion. The constant theme of Medicare and Medicaid cutbacks has been to control costs without directly taking away benefits. This balancing of objectives has been pursued by freezing payments, providing incentives for greater efficiency, giving states and providers greater flexibility in buying or delivering services, and allowing some updrift in the costs borne by beneficiaries. If service levels or quality has been degraded, it is not because Congress has explicitly withdrawn benefits but because cost pressures have altered the behavior of financers, providers, and recipients of health care.

The public opinion data cited above referred to Medicare. Yet despite strong support for it in the polls, Congress has enacted deeper cutbacks in Medicare than in Medicaid. The Urban Institute's calculations show a 6.8 percent cutback in Medicare, compared with only 2.8 percent in Medicaid. The Gramm-Rudman-Hollings deficit reduction law exempts Medicaid from automatic cutbacks but provides for reductions in Medicare payments. Why has a program that serves the elderly, who have been so successful in protecting social security, been more vulnerable than a program that serves the poor? A number of explanations can be offered for this anomaly. First, a dollar cutback in Medicare reduces federal costs by $1; the same cutback in Medicaid saves the federal government only about fifty cents. Second, Medicaid is seen by many members of Congress as a vital part of the safety net for low-income Americans. Moreover, as pressure has grown to curtail entitlements, there has been greater willingness to differentiate between means-tested programs and other benefits. Third, Medicare cutbacks have been spurred by financial crises in the Hospital Insurance and Supplementary Medical Insurance funds. Since it is financed out of general revenues, Medicaid is affected only by the overall deficit. Fourth, states have been effective lobbyists against federal cutbacks in Medicaid. Their efforts have been motivated by concern that reduced federal assistance would compel them to pick up a larger share of Medicaid costs.

In both Medicare and Medicaid, Congress has resorted to a variety of budgetary tactics that ease the political problem facing it. The remainder of this section briefly identifies some of these tactics.

Leave the cutting to others. During the growth years of Medicare and Medicaid, the federal government was seen to be in a weak position because it was the "third party" paying the bills run up by the other parties. As the third party, Uncle Sam had a weak voice in determining how health care was to be delivered. In the cutback era, however, Congress has turned this weakness to political advantage. Because it only pays the bills, the federal government need not dictate

make-up costs later. The first reconciliation bill (for fiscal 1981) suspended the Julian calendar by providing that Medicare would have eleven months in fiscal 1981 and thirteen months in fiscal 1982. The 1982 Tax Equity and Fiscal Responsibility Act took six weeks from several fiscal years and added them to future years.

These tactics—and numerous variations—complicate the task of computing the real cutbacks in health care programs and partly explain why Congress and the administration often disagree on the amount of cutback that has been enacted.

Buy time, pay later. The pattern of Medicare cutbacks shows that Congress has been unwilling to confront directly the prognostications that demographic and other trends will compel drastic structural changes in the program. Instead, Congress has skillfully postponed the day of reckoning, in the hope that it might never arrive. The evidence is that Congress has been successful thus far. While 1983 forecasts gave Medicare only four years until bankruptcy, 1985 projections suggest that the trust funds might make it until the mid-1990s. Success begets repetition; the fact that the bad news has been postponed reinforces the tendency of Congress to behave in this manner.

The Future of Health Care Financing: More of the Same or Less for Less?

Can Congress continue to cut costs in the second half of this decade and beyond in the same ways that it did in the first half? Yes, but only up to a point. Jack Meyer has suggested that in the short run, the good news about Medicare is that the bad news is wrong. Medicare can continue to make ends meet and contribute to modest deficit reduction in the overall budget by further resort to the cost and financing cutbacks that have proven so attractive to Congress. But Meyer has also argued that in the long run, "the bad news is the good news is wrong."[28] Technological developments and demographic trends will exert such great upward pressure on Medicare costs that decremental financing tactics will not suffice.

Even before these pressures become compelling, however, Congress might be forced to alter its cutback tactics. The overriding strategy of Congress has been to lower costs while avoiding direct program cutbacks. Sooner or later, however, the hidden effects of these cutbacks on the quality and availability of health care will become evident. Stories have already appeared in the media about the adverse effects of cutbacks on medical care, and these are likely to multiply in the years ahead.[29] It will not be long before in-depth

policy analyses strip aside the veil of ignorance that has enabled Congress to cut costs without seeming to cut programs.

This writer cannot foretell the substantive changes that will be made in federal health care programs. One should not be surprised if a future Medicare rescue package were to combine payroll tax increases, financing and program cutbacks, and means of tapping some general revenues. But one should not expect such a package to be put together in the short-term frenzy of reconciliation. Just as social security was handled outside the congressional budget process, so too might structural reform in Medicare. The federal government might not resort to a Greenspan-type of commission, but it will have to find an approach that brings both parties and both political branches to the packaging table. The financial, medical, and political stakes are too high to permit business-as-usual repair of the health care system.

Notes

1. For a perceptive case study of this legislation, see Richard A. Rettig, "The Policy Debate on End-Stage Renal Disease," *Law and Contemporary Problems*, vol. 40 (Autumn 1976), pp. 196–230.

2. Quoted in ibid., p. 157.

3. These expenditures are classified in the president's budget as "relatively uncontrollable under present law." This clumsy term suggests that there are different degrees of controllability and that uncontrollables can be controlled by changing the laws mandating the expenditure.

4. See Linda E. Demkovich, "Who Says Congress Can't Move Fast? Just Ask Hospitals about Medicare," *National Journal*, April 2, 1983, pp. 704–707.

5. Linda E. Demkovich, "Making Sense of Medicaid," *National Journal*, February 11, 1984, p. 280.

6. Michael D. Bromberg, executive director of the Federation of American Hospitals, testifying before the Senate Finance Subcommittee on Health, quoted in Demkovich, April 2, 1983, p. 705.

7. P.L. 92–599. The main purpose of this measure was to raise the debt limit, but as so often happens, it became a vehicle for efforts to strengthen budget control.

8. Congress now adopts only one (spring) resolution each year. For a discussion of the development and early years of the budget process, see Allen Schick, *Congress and Money: Budgeting, Spending, and Taxing* (Washington, D.C.: The Urban Institute, 1980).

9. Increases and decreases in major domestic programs are estimated in John L. Palmer and Isabel V. Sawhill, eds., *The Reagan Record* (Washington, D.C.: The Urban Institute, 1984), especially table 6.1.

10. See John L. Palmer and Barbara Boyle Torrey, "Health Care Financing and Pension Programs," in Gregory B. Mills and John L. Palmer, eds., *Federal Budget Policy in the 1980s* (Washington, D.C.: The Urban Institute, 1984), table A.3, p. 156.

11. See *National Journal*, April 16, 1983.

12. The main substantive control was a bar on considering legislation that would cause total spending to rise above, or total revenue to fall below, the level set in the second budget resolution. No point of order could be raised, however, against spending in excess of either the level set for a particular budget function or the level allocated to a House or Senate committee.

13. S. Rept. 95–90 (1977), p. 5.

14. Senate Budget Committee, transcript of the markup of the first budget resolution for fiscal 1976, p. 342.

15. Senate Budget Committee, transcript of markup of the first budget resolution for fiscal 1978, p. 472.

16. The factors contributing to legislative fragmentation included weakening of the seniority system, proliferation of subcommittees and staff, public markups of most legislation, and increased numbers of roll calls in the House and Senate.

17. For a discussion of reconciliation procedures, see Allen Schick, *Reconciliation and the Congressional Budget Process* (Washington, D.C.: American Enterprise Institute, 1981).

18. House Committee on the Budget, *Views and Estimates of Committees of the House, Fiscal Year 1981*, p. 1086.

19. S. Rept. 97–28 (1981), p. 99.

20. See House Committee on the Budget, *A Review of the Reconciliation Process*, October 1984, pp. 16–48.

21. Ibid., p. 64–67.

22. Palmer and Sawhill, *The Reagan Record*, p. 185.

23. For a further discussion of the political uses of baselines, see Allen Schick, "The Evolution of Congressional Budgeting," in Allen Schick, *Crisis in the Budget Process* (Washington, D.C.: American Enterprise Institute, 1985).

24. These and other public opinion data on Medicare are presented in William Schneider, "Public Ready for Real Change in Health Care," *National Journal*, March 23, 1985, pp. 664–65.

25. Cited in William C. McMorran, "Confronting the Medicare System: A Beneficiary Viewpoint," *National Journal*, May 15, 1982, p. 889.

26. Cited in *National Journal*, March 16, 1985, p. 604.

27. Schneider, "Public Ready for Real Change in Health Care," pp. 664–65.

28. Jack A. Meyer, "Major Issues in Medicare," in John C. Weicher, *Entitlement Issues in the Domestic Budget* (Washington, D.C.: American Enterprise Institute, 1985), pp. 16–17. The "good news, bad news" theme is adapted from the title of a recent book by Ben Wattenberg.

29. See, for example, Janet Hook, "Medicare Budget Facing Triple Jeopardy," *Congressional Quarterly Weekly Report*, January 18, 1986, pp. 115–20, which quotes a September 1985 report of the Senate Committee on Aging that found evidence that "seriously ill Medicare patients are inappropriately and prematurely discharged from hospitals."

Newsweek

The Revolution

America spends $425 billion on health care, but few of us understand why it costs so much and why it is changing so fast. In this Special Report, Newsweek offers a comprehensive guide to a subject that is, after all, a matter of life and death.

BY GREGG EASTERBROOK

Nowhere are the dilemmas of modern medicine more striking than in the intensive-care units of American hospitals, where terminal patients may be tagged DNR—"do not resuscitate." Ed Stainback, a hospital administrator in Nashville, Tenn., relates one such case.

An 80-year-old patient who had suffered a stroke in early 1984 was brought to the emergency room on Christmas Eve of that year. After observation he was released in a "moderately coherent" condition, so that he could spend Christmas Day with his family. On Dec. 27 he was returned to the hospital and placed in intensive care.

Stainback met for two hours with the man's doctor, his wife and one of his sons. They discussed the chances the patient would ever be himself again—extremely slim. They talked about his life, a full life in which he had never depended on anybody for anything, and whether in his final moments he would want to be webbed up in thoughtless machines.

And they talked about money. Medicare would provide for the patient if he died within a moderate time—generally, full coverage lasts two months, and though statistically very few people stay in the hospital longer, when this happens it is quite properly called catastrophic. If he clung to life, family members would have to watch helplessly as his hard-earned legacy to his children was wiped out. "When we provide a service it's got to be paid for by somebody," Stainback told the family. "If not by the patient himself, then by the taxpayer or by the next patient down the line. You can't shirk this reality no matter how much you want to, even in tragic circumstances." The decision was made—DNR.

No heart attack came. The patient stabilized and on Jan. 29, 1985, was discharged to a nursing home, where he died peacefully a month later. Donelson Hospital billed $29,052 for the patient's intensive care, or about a thousand dollars a day. His estate paid $356, the Medicare first-day deductible in effect at the time. The federal government paid $3,912.20—a standard reimbursement for treatment of stroke, plus $121.71 in miscellaneous costs. The hospital ate the remaining $24,783.80.

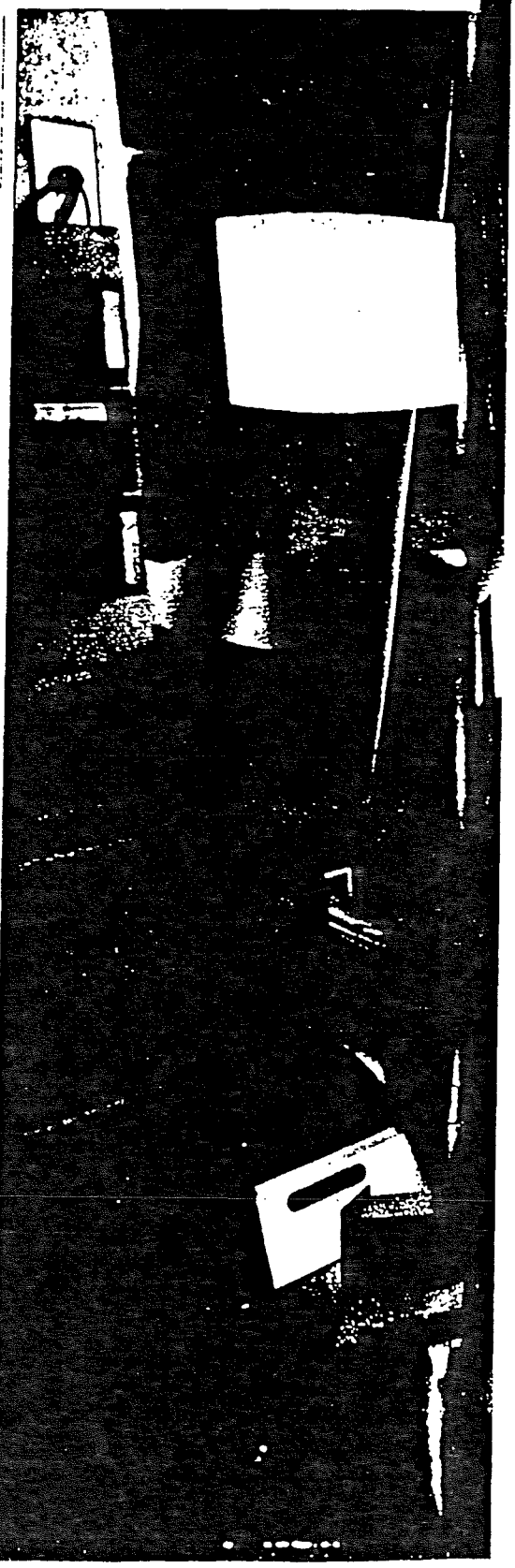
"The question of putting a terminal elderly patient into intensive care comes up here five or six times a month," Stainback said. "Every one of those cases is a money loser for us. That means I must recover the money from average cases of people who have 30 or 40 years of life ahead of them. That just doesn't seem fair to the younger generation, and I bet every older patient, who was lucid, would agree."

Stainback knew the figures and dates in this case from memory. In fact, he knew them by heart. The patient was his father.

The United States spends more each year on health care than it does on national defense. Individual Americans spend more annually on health care than on automobiles and gasoline combined.

Yet while military affairs, gas prices and the latest automotive-styling gimmicks are analyzed in stupefying detail, few people understand modern medicine.

Health care, the most personal of subjects, is in our public discourse shunted aside as a vast, unapproachable enigma. A Dallas cancer patient named John Stan-

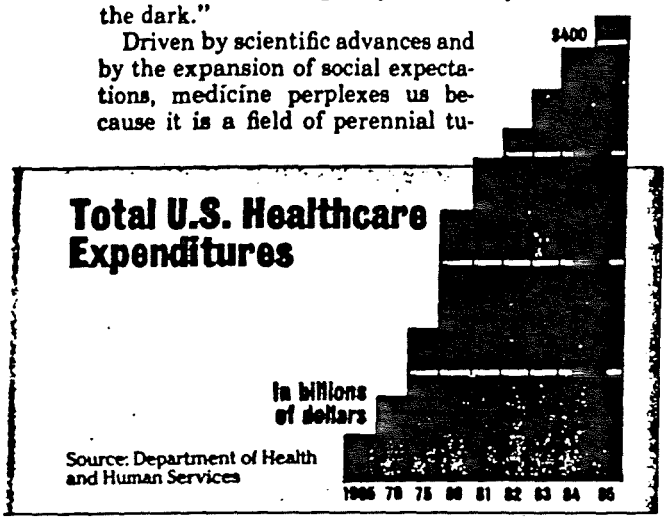


High-tech diagnosis: *A patient at Penn undergoes cardiac catheterization*

LEIF SKOOGFORS—WOODFIN CAMP

cill, who recently suffered through operations that may have been avoidable, put it this way: "You can get elaborate star ratings on restaurants, movies, any kind of product. But on one of the central issues affecting your life—which doctor is good, what treatment is right—you're totally in the dark."

Driven by scientific advances and by the expansion of social expectations, medicine perplexes us because it is a field of perennial tumult. Only in nostalgic reveries were there ever "good old days" when the norms of medical practice stood still.



Consider the shifts of the last five years alone. Hospitals have changed from overcrowded to underused; hospital financing has shifted from cost-plus to fiercely competitive; delivery of services has been effectively deregulated, leading to surgical clinics, physician advertising, "docs in a box" and the return of the house call; the medical-cost spiral has slowed for the first time in two decades; a new category of medicine, "managed care," has come into wide use; a new category of antitechnology technology, "noninvasive" surgery, has been developed; nearly everybody who works in the health professions has started grumbling; federal and corporate officials who foot health-care bills have started applauding; patients have grown hopelessly confused.

At the center of these changes are American physicians, the best in the world. Today many doctors describe themselves as disturbed by the direction of modern medicine, but it is difficult to be sure whether their anxiety stems from concern over the quality of care or threats to their incomes and social status. It is equally problematic whether health "consumers" sympathize with the physicians or hold them to blame.

The story that follows is complex and asks much of readers. But the subject—the economics of life and death—merits a depth of attention. Before beginning, it may be useful to cast aside a few popular misconceptions:

■ The "disappearance" of the Marcus Welby-style solo practitioner, a topic of much recent commentary, has been predicted on a regular basis for at least half a century. In 1916, for example, an author named Michael Davis declared that the private physician was defunct. Today more than 60 percent of U.S. doctors remain traditional office-based practitioners.

■ Hospitals now suffer greater overcapacity than heavy industry. In 1970 the occupancy rate for U.S. hospitals was 80 percent; in 1985 the figure was 69 percent.

■ Though the medical lobby claims that multitudes of unhappy doctors are fleeing their profession, there is little evidence of this. In fact, the number of doctors continues to increase faster than the population; this trend is projected to hold at least through the year 2000.

■ While many physicians are crying sudden financial hardship, there is no evidence of this, either. Doctors average $113,000 in annual net income, with income for most specialties increasing.

■ Though an ominous wave of for-profit hospitals has become a media refrain, the percentage of for-profit hospitals in the United States today is far smaller than it once was. In 1910 slightly more than half of American hospitals were operated for profit. By the end of World War II the figure was down to 18 percent. Today it stands at about 13 percent.

■ Nonprofit hospitals can be more profitable than for-profit hospitals. Baptist Memorial Hospital of Memphis, the nation's largest nonprofit, had a 16.2 percent profit ratio in 1984, according to documents obtained under the Freedom of Information Act by the Memphis Commercial Appeal. The similar figure that year for HCA, the largest for-profit hospital chain, was 8.5 percent; for Humana Inc., 9.9 percent; for AT&T, 4.1 percent.

■ Opponents of a new Medicare payment system adopted in 1983 maintain that it leads to "quicker and sicker" discharges from hospitals. Yet the average length of stay in hospitals has been declining steadily for decades. In 1968 stays for patients over 65 averaged 13.4 days. In 1981 the figure was 10.4 days. By 1985 it was down to 8.8 days. Lengths of stay for those under 65 have shown a similar pattern of steady decline, regardless of payment system.

■ Though doctors lament that malpractice premiums have risen dramatically in the last three years—four times faster than inflation—they don't add that from 1976 to 1983 their insurance costs declined relative to inflation. Premiums have shown the sharpest escalation in obstetrics—this is one medical field doctors really do seem to be leaving. It is also a field that had an oversupply of specialists; some would have left anyway.

■ There is virtually no difference between the amount of care given the poor by for-profit hospital chains and by nonprofit hospitals—even nonprofits run by Catholic orders. According to the American Hospital Association, for-profit hospitals devoted 4.3 percent of their total costs to "unsponsored care" in 1984. The figure for nonprofits was 4.6 percent.

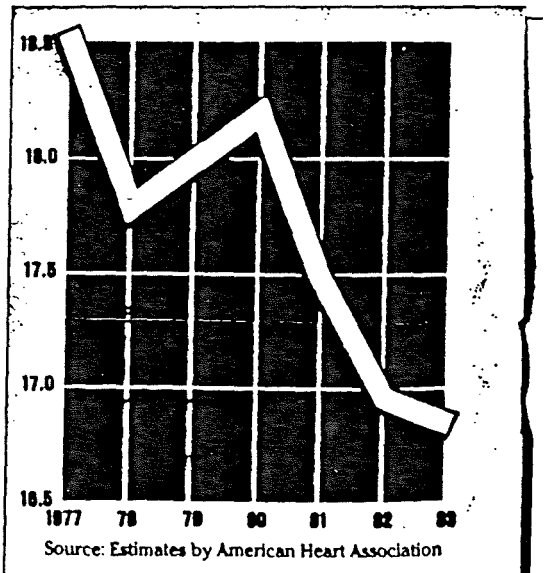
The Doctor's Century

Until this century doctoring was a lowly profession. Hospitals were notorious places, more likely to spread diseases than cure them. Anesthesia was first employed in 1846; before that, patients were cut open while conscious. Antiseptic surgery was not tried until 1867; before that, surgeons didn't scrub.

A review of this century's major medical developments helps put today's situation in perspective:

The years leading up to World War I were distinguished by the publication of the Flexner report, a stinging condemnation of medical education. In its wake bogus medical schools were closed, standards became more stringent and an overall goal of "scientific medicine" was formulated. For good or ill, American doctors would become mainly like scientists, right down to their white lab coats.

The decade of the 1920s was marked by campaigns for physician licensing and restricting hospital-admitting privileges to members of medical societies.



These reforms drove out the quacks.

The 1930s saw the development of sulfa drugs and penicillin, though the latter would not be widely available until the 1940s. These enchanted substances gave physicians their first true power to cure. Nearly every disease based on infection, which had killed many millions through the centuries, would soon be bested.

The World War II years saw a sharp increase in the number of physicians and nurses with scientific training. Tending the wounds of combat, they received a solemn opportunity to hone their skills and develop new techniques.

During the 1950s and '60s came vaccines against polio and measles and the beginnings of high medical technology—respirators, dialyzers and "nuclear" medicine. Vaccines and medical machines, combined with antibiotics, would transform our image of doctors. No longer were they artisans with limited knowledge who did what they could to mitigate suffering. Now, people expected to leave the doctor healed. And in turn, as Americans began to anticipate visiting doctors and hospitals many times during the course of a lifetime, they grew concerned over how they would pay for all that: private health insurance grew rapidly in response.

The next great change was the creation, in 1965, of Medicare (for the elderly) and Medicaid (for the poor). Violently opposed by many doctors as "socialized medicine," these two programs rectified deep inequities in access to care. They also made government the leading purchaser of health services. In 1985 federal, state and local funds underwrote more than 40 percent of medical costs. Private insurance pays slightly more than 30 percent; individuals pay slightly less than 30 percent out of their own pockets. (As recently as 1950, individuals paid 65 percent of health costs; government paid 22 percent; private insurance, at 9 percent, was barely a factor.)

Physicians who prophesied ruin under Medicare soon learned to stop worrying and love the system, since it meant they were no longer constrained by the older patient's ability to pay. Their earnings would begin to rise handsomely; by 1985 Medicare would be the American physician's leading source of income.

And wherever government guarantees tread, corporations are sure to follow. In the wake of Medicare the for-profit chains would form: Hospital Corp. of America in 1968, National Medical Enterprises in 1969.

When conceived, Medicare contained a huge flaw: payment was pass-along. Hospitals forwarded their invoices to Washington, physicians claimed their "customary" fee, a phrase that came to mean almost anything a doctor wanted it to mean. The more the health-care system ran up the bill, the more it could profit.

"The incentives were to keep people in the hospital, to perform more tests and procedures, to increase costs," says Michael Azzara, president of Valley Hospital in Ridgewood, N.J. "People respond to incentives, and higher cost is what the system was rewarding." Or as Lois Corcoran, treasurer of QRScan, a Boston cardiovascular-laboratory firm, put it, "It was nirvana. Everybody charged whatever they wanted."

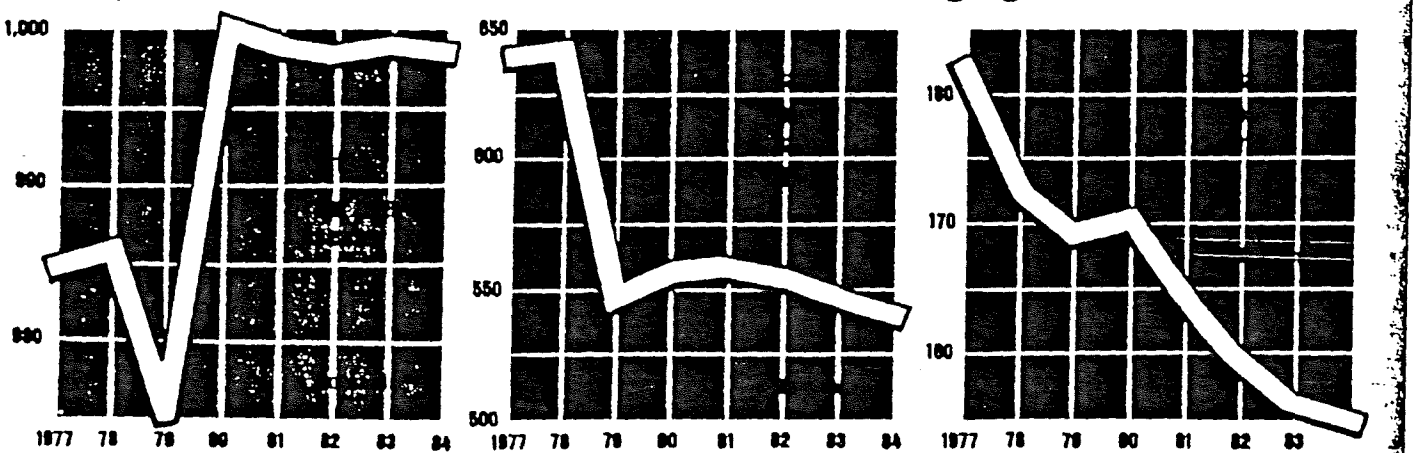
Thus, predictably, the 1970s saw an explosion of growth. New hospitals and clinics were constructed, often backed by federal and local capital subsidies; medical-school admissions escalated rapidly; foreign-educated doctors poured into the country; open-heart surgery, organ transplants and helicopter ambulances came into general use. Hospital admissions increased; so did surgery, with total operations in the United States rising from 15.8 million in 1971 to 26.2 million in 1983.

Some of the new facilities were necessary to serve areas short of beds or patients the system used to turn away. But many were expensive white elephants. And while some of the increase in surgery was justified, it was an ominous sign that the procedures most beneficial for the surgeons themselves seemed to grow at the fastest rate. Through the 1970s, for example, the frequency of heart operations for men tripled; the coronary bypass came into widespread use. Researchers now question whether the bypass is really worth it for many recipients—life is prolonged for just one in 10. But bypass operations are unquestionably worth it for surgeons, whose fees average $5,000 for a few hours' work.

During the 1970s prodigious growth also occurred in the "intensity" of medicine. Intensive-care units became the rule rather than the exception in hospitals, expanding in complexity as machines grew better at keeping even very sick people breathing. Establishment of trauma centers—advanced emergency rooms staffed with surgeons round the clock—is thought to be a primary reason deaths from automobile collisions have declined steadily through the last decade, as victims of accidents and violence stand a far greater chance of survival if operated on within 60 minutes.

Trauma centers, which can make a direct claim to increasing the number of people "saved," seem like the exemplar of a medical advance that is expensive and worth every penny. But soon intensive care, designed for temporary use following shock or surgery, was extended to the terminally ill and the declining old—the kind of patients who, doctors say, "will never

Taking America's Pulse: The Numbers Are Encouraging



Charts by Christoph Blumrich—Newsweek

leave the hospital." A painful dynamic was created in which the number of people who survived other stages of affliction, in order to reach the terminal stage and be hooked up to machines, increased with each new advancement in technology.

The developments of the last decade possessed a common denominator: all were expensive. In the late 1970s U.S. health-care expenditures increased at an average rate of 13 percent annually. Medicare expenditures rose even faster, growing more than 20 percent per year when the 1980s arrived. Private insurance, operating on pass-along principles similar to Medicare, soared in cost, too. In a celebrated epiphany, Lee Iacocca, on becoming chairman of Chrysler, discovered that Blue Cross/Blue Shield of Michigan, not U.S. Steel or Goodyear Tire & Rubber, was the company's leading supplier. Unnecessary procedures appeared rampant; Chrysler auditors found that two-thirds of hospital admissions for low back pain were unjustified.

In 1982 total U.S. health-care spending exceeded 10 percent of the gross national product for the first time. Something had to be done, but nobody knew what.

A Revolution in New Jersey

Back in 1967 a Yale management professor named Robert Fetter was asked by Yale-New Haven Hospital whether industrial quality-control theory could determine if the hospital was spending its budget wisely. Fetter and some grad students compared the diagnosis of patients entering Yale-New Haven with the expected recovery rates for similar patients reported under ICD, an obscure international system for collecting mortality statistics. Fetter then proposed that Yale-New Haven classify its admissions by diagnosis—an idea later named "diagnosis-related groups."

It was the beginning of the end for pass-along medicine. By 1983, diagnosis-related groups—DRG's—would be written into federal law as the funding mechanism of Medicare.

Doctors and hospitals dearly loved the pass-along system. Although it encouraged unnecessary procedures, it also insured that conscientious doctors could order whatever care they deemed necessary to help patients. Fearing, however, that care would grow so expensive that not even government could afford it, the medical establishment made early attempts to restrain pass-along attitudes. In 1972, not long after Medicare was created, committees of physicians were delegated to watch for colleagues taking advantage of the system. "They'd get a group of doctors together and ask something like, 'How long are you guys keeping patients in the hospital for gallbladders?' " explained Dr. Richard Egdahl, a Boston surgeon who was active in the peer-review movement of the 1970s. "If one doctor said 6 days, and another said 8, and a third said 12, they'd put down 12 as the standard. There was no attempt to be parsimonious, only catch that very small percentage who were pulling truly outrageous things."

There was also a push to control costs through local planning, especially "certificates of need" (CON's) for hospital construction. If the problem was that hospitals could overexpand and then pass along superfluous costs, perhaps the solution would be regulation of building permits. But planners usually could not resist the political lobbying power of hospital interests: the primary effect of CON's was to add paperwork and administrative delay, increasing costs further. Dr. William Roper, head of the Health Care Financing Administration (HCFA), which oversees Medicare and Medicaid, once served on an Alabama health-planning agency. "Whenever we got our gumption up to say no to a hospital, their lawyers were always better than our lawyers. We always lost," Roper said.

A third attempt to slow health spending came when President Jimmy Carter staked considerable political capital on a program called "cost containment." Under it, a Medicare reimbursement ceiling would be triggered if a hospital exceeded a mandated spending guideline.

Just the mention of spending caps caused the medical establishment to blow a gasket. In the ensuing political struggle, cost containment failed to pass Congress. The fact that it was a top-down approach based on regulation, rather than a bottom-up approach based on incentives, reflected the prevailing attitude of the time—that there was something fundamentally unclean about economic motivation in medicine.

Meanwhile a former New Haven city official named Joanne Finley was being hired as health commissioner of New Jersey. New Jersey hospitals were in a pickle. Facilities in the state's affluent suburbs were flush, while urban hospitals in populous but increasingly run-down Newark were strapped for funds.

Traditionally, health-care providers had dealt with poor patients by practicing "cost shifting," charging more to those paying with private resources than to those covered by Medicaid, a bare-bones program. One study found that in 1982, typical hospital bills to commercial insurers were "marked up" 27 percent; the markup to Blue Cross was 17 percent; Medicare broke even; Medicaid bills were

Operating on the English Language

Though Latin names for common body parts may seem bad enough, the special form of English employed within the medical community can be almost as perplexing.

Doctors, for example, don't call each other doctors. They say "physician," to distinguish themselves from that lesser species of doctor, the Ph.D.

For-profit hospitals don't call themselves for profit. They say "proprietary" or "investor owned," two terms with soothing neutral timbres.

Neither hospitals nor physicians call their charges a "price." Instead they speak genteelly of "reimbursement."

In the new world of medical marketing, hospitals refer to departments, like orthopedics or radiology, as "product lines." Package concepts clearly tied to one hospital are "branded products"; services arranged through the hospital but delivered elsewhere are "product-line extensions." "High-touch products" are those requiring physical contact with patients.

The process of getting more business is "patient accrual." People who pay with private insurance are "retail customers." Patients in general are now referred to as "consumers."

Anything a doctor does that requires cutting, jabbing or injecting is a "procedure." Anything a doctor does that requires thinking, talking or counseling of patients is "cognitive services." Procedures pay much better than cognitive services.

Colleges have begun conferring doctorates of pharmacology. As a result there are now Ph.D. pharmacists roaming hospital corridors sporting little name tags prefaced with the magic abbreviation Dr. This is driving M.D.'s, "medical doctors," crazy.

When spoken by an official of the Health Care Financing Administration, "realistic fees" means low fees. When spoken by a doctor, "realistic fees" means high fees.

The American Medical Association does not use the word "malpractice." It speaks of "physician liability."

"General medicine" is now considered a specialty.

marked down by 10 percent, and, of course, charity cases or "uncompensated care" paid nothing.

State laws were passed giving Finley unusual powers to intervene in New Jersey hospital management. What would she do with this authority?

Most payments for health care were then, and remain today, retrospective—that is, the bill is calculated after services are rendered. Retrospective billing and pass-along compensation are a dangerous mix. Though only a cynic would contend that the typical physician thinks, "Guess I'll run a few needless tests to pad my bill," every doctor knows at some subconscious level that additional procedures are financially beneficial—and human nature dictates that what is in the back of the mind can be as influential as what is in the front.

A padded plumber's bill results in a dissatisfied customer's taking his future business elsewhere. But a padded medical bill passed along to a distant third party is not subject to the same free-market checks. Moreover, while most consumers have a reasonable awareness of whether a plumber is taking them for a ride, they have no way on earth of knowing whether what the doctor recommends is truly necessary. "It's not realistic to expect the patient to say to a doctor, 'No thanks, I don't need that procedure'," says Dr. Alfred Gellhorn, director of medical affairs for the New York State Department of Health.

The alternative was an idea that had been kicking around for years: prospective payment. Price would be negotiated in advance, the way most goods and services are purchased. Prospective payment could eliminate incentives to run up the bill. But applying it to the hospital had frustrated everyone who tried. The stumbling block always was: what mechanism would set the prospective fee? In New Haven, Finley had heard about diagnosis-related groups.

The Fixed-Fee Breakthrough

Adopted as a payment scheme, DRG's work this way: after the patient has been diagnosed, the hospital receives a fixed fee reflecting an average cost of curing that condition. If the patient is worse than average and requires extra care, the hospital must pay any cost beyond the DRG allowance. But if the patient is better than average, the hospital keeps any money left over. When expenses for a severely ill patient become catastrophic, an extra payment called an "outlier" kicks in—this in recognition of the fact that one patient who is very ill can generate losses far exceeding the bonuses available from several patients who recover faster than average. A catastrophic case can cost a hospital $100,000 more than DRG's allow; the patient who recovers under the DRG line typically creates a bonus of $1,000 to $2,000.

The key to the system is averaging. Rarely would the hospital receive exactly what a patient's treatment cost. But as long as there is equal distribution on either side of the sicker/healthier averaging line, specifics for patients are irrelevant. What mattered was finding out what it cost to cure a *disease;* then you could create a standard, and that would expose anybody trying to run up the bill.

New Jersey had a breakthrough. Prospective payment was snuck into the state's law; the enabling legislation was cryptic, to avoid setting off stonewalling by the hospital lobby. In return for allowing New Jersey to be used as a DRG test vehicle, Finley won federal assistance designed to ease the money problems of Newark hospitals. Prospective payment went into effect in New Jersey in 1980. Medical expenditures began to stabilize at a time they were increasing sharply nationwide.

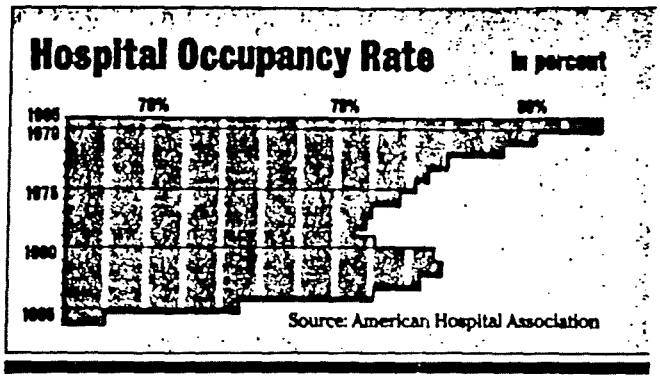
Now the scene shifts to Washington. In 1981, flush from victory, Ronald Reagan pushed through Congress his supply-side tax cut, which reduced projected federal revenues by an incomprehensible $750 billion. In 1982 megadeficits began.

Congress, frightened by what it had done, quickly passed the Tax Equity and Fiscal Responsibility Act (TEFRA), which rescinded part of the revenue reduction. TEFRA was a tax increase in all but name. And since no congressman wants to be associated with a tax increase, it was passed quietly. Riders aimed at reducing federal spending were added. One set an annual limit on expenditures per hospital for Medicare, among the fastest-growing items in the budget.

The medical establishment, according to a congressional health-committee aide, "went amok." TEFRA, supported by Reagan, had casually imposed exactly what Jimmy Carter wanted—federal restrictions on local hospital spending. Hospital and doctor lobbies, frantic for any alternative to spending caps, dropped their guard against what happened next.

Buried in TEFRA was an arcane provision asking for proposals on how to halt the escalation in government spending for health care, which in 1982 hit 42 percent of total U.S. health spending. (A note to anyone who fears the United States will someday have "socialized medicine"—we're just shy of halfway there already.) HCFA, with White House approval, decided to endorse the New Jersey solution.

In truth, DRG's had not existed long enough for anyone to know whether they really worked. But a historic opportunity was approaching. During 1982 word leaked that social security was veering toward bankruptcy. A presidential commission was appointed; a three-ring media circus commenced; soon a bailout package was in the works. In a House subcommittee a Reagan-approved measure converting Medicare to DRG's was tacked onto the social-security bailout bill.



The sponsor was Rep. Andrew Jacobs, a liberal Democrat from Indianapolis. "I had been desperately searching for an issue I could agree with President Reagan on, and this was it," Jacobs said. "Health care was being financed like defense procurement, cost-plus and no sense that it mattered what the final bill came to. Something had to be done to encourage free-market thinking."

With all eyes focused on the politically provocative issue of social-security rescue, the DRG measure flew out of committee. The American Medical Association tried to block it. But this normally powerful lobby had just finished losing a highly publicized battle for legislation against doctor advertising. "The AMA had worn out its welcome around here," the congressional aide said. "The fact they opposed DRG's turned out to be a point in favor of the idea."

A mere two months after being introduced in committee, Medicare DRG's passed Congress as a rider to the social-security bailout. There was practically no debate on the House or Senate floors. A year later Reagan administration officials won congressional approval for a freeze on Medicare physician fees. Between DRG's and the freeze, it's fair to say the medical-industrial complex is the only moneyed interest group that the Reagan administration has actually stared down.

Doctors were madder about the freeze than about DRG's, since DRG's apply only to hospitals—physicians continue to bill Medicare on a pass-along basis. A measure of the doctoring world's wealth is that the AMA spent an estimated $4.5 million dur-

ing the 1986 election trying to defeat congressmen who had backed these changes. It contributed about $300,000 to Representative Jacobs's opponent, believed to be the largest sum ever spent by an interest group against a congressman. (The money blitz backfired: Jacobs won handily.)

DRG's broke the dam. Though so far they govern only about three-quarters of hospital financing—being phased in year by year, DRG's won't take full control of Medicare reimbursements till next year, and they have no direct bearing on anyone under 65—their passage in 1983 signaled that the end of the pass-along nirvana was in sight.

Three great social trends were about to conjoin: an oversupply of hospital beds and physicians, a new philosophy of treatment based on keeping patients out of the hospital and an emphasis on "market driven" medicine in which medical consumers bargain for lower costs.

Federal health spending began to moderate almost immediately after application of DRG's. From 1983 to 1984 Medicare expenditures grew only 8.6 percent, the smallest increase in the history of the program. From 1984 to 1985 the rate of increase fell to 5.5 percent.

Total national spending began to cool as well. During the 1970s overall health costs grew at an average rate of 12.7 percent annually; since 1983 the rate has fallen to 9 percent, the lowest figure since 1963. (The 1985 grand total for U.S. health spending was $425 billion. By way of comparison, last year's defense budget was $289 billion.) "Nobody ever would have guessed how much effect DRG's would have, all across the spectrum," Jacobs says.

Adjusted for inflation, rates of increase during the 1970s had not always been as bad as they seemed. In 1979, for instance, real growth in health spending was only 2 percent. But as inflation chilled in the early 1980s, an ominous thing had happened—medical costs, unlike most other prices, kept right on rising, shooting up 6 percent in real terms in 1982. The increase was widely viewed as unstoppable.

Two other economic phenomena of recent years were described as unstoppable—the energy crisis and inflation. Both were stopped in remarkably little time by historic standards. If it turns out health costs are now truly being brought to heel, the mid-1980s will be seen as the turning point, another testament to the American economy's ability to adapt and innovate.

No one pretends DRG's are a perfect medium of deliverance. Flat-out absurdities have resulted. In one case a hospital was denied payment for operating on a patient with a severe brain tumor, while another got $6,000 just for setting a broken finger.

But whatever its faults, the new system provided the shock necessary to shatter the pass-along mentality. There was no going back. Joseph Califano, secretary of health, education and welfare under Carter and once the country's leading advocate of increased federal health regulation, became a vocal convert to the market-based approach. With singular speed, hospitals, doctors, insurers and others began a series of complex reactions to the new realities of modern medicine—reactions, only now beginning to be understood, that will be the subject of the balance of this report.

Hard Times at a Megahospital

In the corridor doctors use to enter the monumental Presbyterian Healthcare System in Dallas, there is a chart that changes daily. The chart, positioned so that doctors can't help seeing it, lists admissions from the previous day, plus the hospital "census," or occupancy rate. Recently it read: TODAY'S CENSUS—60%

"When I started here seven years ago that number hovered between 98 percent and 103 percent," said June Hunter, a hospital official. "Sometimes we kept people overnight in the emergency room, because there was nowhere else for them to sleep. That's all changed now."

Presbyterian, a nonprofit, is the characteristic American megahospital. Nearly every form of surgery and treatment is offered on its 110-acre "campus." And like many other megahospitals, Presbyterian is nearly half empty. During the 1970s the number of hospital beds in the United States grew about 50 percent faster than the population. Then came the 1980s; between DRG's and the advent of less debilitating forms of surgery, the call for beds declined. Presbyterian found itself bigger than it needs to be.

In addition to 838 beds, Presbyterian has a psychiatric center, cancer and physical-rehabilitation facilities, a gynecology building, a day-care center, apartments for medical residents, 901 doctors certified to admit patients, 125 doctors physically present in two office buildings, hotel rooms for families and a public health club. "You can imagine what it does for our referral base to have club members meeting our doctors when they work out there," says a hospital spokesman.

In 1985 Presbyterian had revenues of $152 million. The hospital admitted 32,585 people, receiving an average of $740 per day for their care. Of the 32,585 admitted, 616 never left. Almost two people a day died at Presbyterian—few of them under dramatic circumstances, most simply at the end of a long life. Until our era the vast majority of Americans died at home. Today 80 percent die in hospitals.

Institutions like Presbyterian are referred to as tertiary centers: "primary" care being what a family practitioner dispenses; "secondary," the type available at clinics and community hospitals; "tertiary," the serious kind. Tertiary hospitals are by far the most expensive element of American medicine. As Sister Irene Kraus, head of the 42-hospital Daughters of Charity National Health System consortium, notes, "Acute care is where the big bucks are."

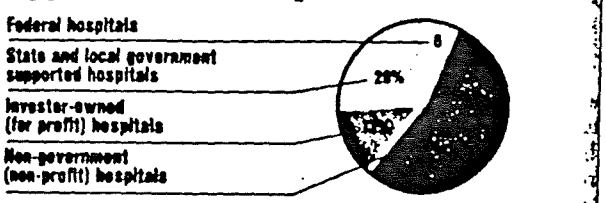
The cost of acute care is commonly ascribed to the tertiary hospitals' insatiable desire to one-up each other on technology. "Need is often secondary in decisions about CT scanners, transplant centers and similar forms of expensive technology," says Douglas Hawthorne, president of Presbyterian. " 'We gotta have one because they have one' can be the bigger factor."

Technological expense in medicine is unquestionably a quandary, but labor is the greatest hospital cost. More than 55 percent of the typical hospital bill is for staff—and that's not counting doctors. Most hospitals have the equivalent of three nurses (one per shift) for each bed; tertiary hospitals may have six. Plus orderlies, accountants, lab technicians, pharmacists, cooks, maintenance crew—all 24 hours per day. The typical registered nurse now makes $12 an hour. That translates into nearly $300 per day per patient for nurses alone.

Hospital labor costs are driven by the peak staffing paradox: the need to have sufficient people available at all times for emergencies that occur only occasionally.

Anyone who has spent time in a hospital knows that even conscientious nurses may pass hours idly regarding the electronic screens that make modern nurses' stations resemble the master control rooms in science-fiction movies. On the other hand, anyone who pushes a call button from a hospital bed and does not receive a prompt reply is furious. And if a "code call" to resuscitate a dying patient rang and half a dozen people didn't pour into the room within a few seconds, the victim's family would not only be deeply

Types of U.S. Hospitals



Does not include psychiatric and some short-term specialty hospitals.
Source: American Hospital Association, 1985 data.

outraged but sue for huge sums of money.

When a patient convalesces at home or in a limited-care setting, there doesn't have to be an entire costly entourage standing by around the clock. This equation is emptying out American hospitals.

'Quicker and Sicker'

Hospitals have always been expensive. But until DRG's managers had little incentive to do anything about it. Now when a patient is discharged sooner than the DRG predicts, the hospital profits.

Negative incentives have been added, too. A new system of peer-review organizations (PRO's) has the authority to "ding" a hospital by denying payment for a questionable admission. PRO's operate on contract to the Health Care Financing Administration; they score bureaucratic points by finding dubious claims.

In response, most hospitals have created tough internal "utilization review" committees that audit doctors' decisions on when to admit patients and how long to keep them. At Presbyterian, the average length of stay fell from 6.5 to 6.3 days in 1985: cutting just two-tenths of a day per patient worked out to $4.7 million in charges avoided. Such important savings may, however, be taking place at the expense of care: faster discharges are the most controversial aspect of the diagnostic-related-groups approach.

"The medical staff feels under a great deal of pressure to accelerate discharges," says Dr. Maynard Ewton, Presbyterian's chief of staff. Sen. John Heinz of Pennsylvania, chairman of the Senate Special Committee on Aging, has charged in a much-publicized series of hearings that Medicare beneficiaries are being sent home "quicker and sicker" as a result.

Both charges are true, HCFA administrator Roper told me. "As for 'quicker,' that's simply a matter of statistics," Roper said. "Patients are also being released 'sicker,' meaning they are spending part of their recovery time outside of the hospital instead of being fully recovered and ready to resume normal activities on the day they leave. The question is not whether people are being discharged quicker and sicker, since they obviously are. The question is, are they being harmed by that?"

The evidence so far at least suggests that patients are not being harmed. "There are 11 million Medicare discharges annually," says Dr. Robert Mullin, a surgeon at the Hospital of St. Raphael in New Haven, Conn., who participated in DRG development. "If any significant percentage of them were improper, statistically hundreds of thousands of people would have been harmed by now. Yet the Senate Aging Committee spent a year scouring the country for examples and the best they could come up with were a few anonymous anecdotes."

That's not quite true: the committee found several individual abuses, but no solid evidence of damage on a wide scale. Medicine is an elaborately studied subject. If there were a worsening in incidence or severity of ailments, it would show up in statistical tables, particularly those kept for actuarial purposes. No such increase has been detected. In fact, statistics say the American population is growing healthier. Incidence of stroke and heart disease is falling, even considering the aging of the population; life expectancies are increasing; hypertension and infant mortality are declining. Life-insurance premiums have fallen slightly in recent years reflecting these improvements, which in the media have been overshadowed by the continuing lack of progress against cancer and AIDS.

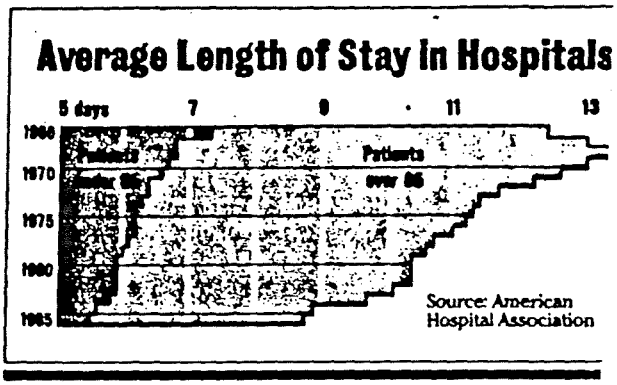
The New England Journal of Medicine, the profession's most prestigious publication and an intense editorial foe of DRG's, recently ate humble pie by publishing a study indicating that even premature babies—one of the costliest and most delicate categories of hospital patients—were not harmed by accelerated discharge. The babies studied, weighing an average of just 2.5 pounds at birth, were sent home after an average of 47 days, instead of the typical 58 days. These accelerated-discharge "preemies" did as well as a control group who stayed longer; the average cost for their care was $54,029, as opposed to $72,589.

Ten years ago a common critique of American hospitals was that they admitted too many people, violated them with unnecessary tests and procedures and hung on to them long after they wanted to go home. To the extent that characterization was accurate—and many physicians privately concede it contains truth—the reverse now obtains.

Today you have to be really ill to get into Presbyterian. The average patient's bill is $3,345, as opposed to $1,749 just five years ago, mainly reflecting more severe illnesses rather than increased prices. And today, if admitted to Presbyterian, you'll be shipped out the moment you're able.

On the other hand, while you are there doctors and nurses will dote on you, because they are no longer madly pressed for time. You stand a good chance of a private room. The place is quiet and restful; for a little extra patients can arrange a suite with sitting area, a fruit basket, decent meals and a kitchenette refrigerator. In the main, you have to stand on your head to view this humanizing of the hospital as a bad development.

A high percentage of doctors are opposed to DRG's and accelerated discharge. That opposition must be placed in perspective—doctors have an intense self-interest, from the standpoints of both pocketbook and ego, in preserving the status quo. One would not trust a panel of journalists to decide whether special protection ought to be granted to freedom of the press, even though journalists are "experts" in this subject; when it comes to public-health policy, the medical community's views must be approached with equal skepticism.



One reason physicians dislike the new system is that many of them labor under a common misconception—that DRG's impose a time limit on hospital stays. "Any doctor or hospital administrator who asserts that a patient must be discharged because he has 'used up' his DRG ought to be put in jail," Robert Fetter says.

Unfortunately, some health-care providers are asserting exactly that, relying on the pervasive confusion about DRG's to bluff Medicare patients into thinking that a clock is ticking.

There are now Medicare "ombudsmen" to help patients file appeals against improper discharges: this is cold consolation, since a patient let go too soon may die or suffer needlessly before his hearing rolls around. More important is that Medicare beneficiaries understand their prerogatives. Hospitals must give whatever duration of care is required to redress a diagnosed condition, even if this costs 100 times what DRG's allow. There may be genuine disagreement regarding when it is safe for a particular patient to go home, but there is nothing like a federal time limit. Anyone who tells a patient otherwise is lying.

One consideration accelerated discharge overlooks is the social admission—the patient who needs hospitalization for reasons not directly related to pulse or temperature. Presbyterian's Ewton explained, "Recently we had an elderly lady come in with two broken arms. Otherwise she was in good health, and medically, broken arms

do not justify admission. Her internist came to me and said, 'This woman just has to be in the hospital. There's no way she can care for herself at home alone.' We admitted her and will probably have to swallow the charge. The Medicare peer-review criteria don't take into account social complications, which tend to be worst in urban areas where people lack family support."

Another doctor told me, "You'd be surprised how many older patients love the hospital. It's the only place they are surrounded with concern. They become very upset when I tell them they are no longer allowed in unless they really need it."

A hard concept to communicate to the aging is that sickness is not necessarily a criterion for hospital admission. A hospital administrator explains, "People tell me, 'You've got to take my mother in. She's sick.' I say, 'You're right, she is. And she's going to stay sick until the day she dies.' If a person has a specific disease like pneumonia that we can cure, then we admit. But there's nothing we can do about deterioration from aging. In the past, we admitted a person in this situation for a few days of observation, to make the families feel better. Now the PRO rejects such admissions. There's no DRG for general decline."

One response has been a growing use of nursing homes and hospices for elderly patients who are strong enough to be discharged but unable to care for themselves. Medicare will cover such costs in the short term; it's long-term nursing-home care for which the federal system resists paying (an issue beyond the scope of this article). An almost goofy market adaptation has been hospitals affiliating themselves with hotels. A Medicare patient with a social-admission complication may find himself discharged to a hotel for a few days, with a nurse visiting periodically. Memorial Medical Center in Savannah, Ga., has bought a motel adjacent to its grounds. Rooms not booked for hospital business are available to travelers.

Poverty, loneliness and lack of family support are, of course, social problems that the Health Care Financing Administration cannot be expected to solve. But to the extent that moving people out of hospitals lessens one social problem (health-care spending), we must be prepared for the possibility it will make others worse.

These concerns aside, there are reasons to believe that lengths of stay would have declined regardless of whether DRG's had come into existence. One is simply the historical trend toward faster healing, driven by improved drugs, refined technology, better doctors, more sophisticated treatment and a health-conscious population. A century ago the average stay at Boston City Hospital was 27 days. Sixty years ago the average stay at hospitals was down to 12.5 days, and by 1975 it was seven days.

Another factor is that private insurers have begun cracking down on admissions. Many private and group plans now require second opinions before surgery; most have increased the "copayment," or portion of the bill individuals must cover. Five years ago a good group health plan paid nearly all of a patient's costs. Now a typical plan expects individuals to pay a $200 to $500 deductible, followed by 20 percent of

A Doctor's Desire to Do Good—And Do Well

In the medical mind, service is often at odds with monetary gain

It's Christmas dinner. The founder of the feast prepares to slice turkey. A beeper sounds. There are groans. "I've got to go to the hospital," he says. "It'll just take a minute."

Late that night, after the kids have been put to bed and the grandparents have left for the drive home, the doctor drags himself back through the door, exhausted. There's mangled turkey in the icebox. His wife, seated by the ashes of a fire, won't even say hello. This man has just performed a service to humanity—and everybody he loves is mad at him. He begins to feel an emotion, a powerful and seductive emotion with which physicians must wrestle throughout their lives. He's resisted it before, but this time is different. The doctor begins to feel sorry for himself.

The medical mind is a complex arena. Within it an ethic of service is at war with a craving for gain. Most occupations make no pretense of an obligation to human kindness. But physicians must vow to place others above themselves, and it is a vow most doctors struggle to honor. Those who lose the conflict between their better and lesser natures may descend into self-pity.

How else can we explain that physicians, earning on average $113,000 per year and occupying positions of immense respect, spend so much time complaining? Many physicians I interviewed described their personal situations in terms impossible to square with their status and creature comforts. One said he was "sure glad my son didn't go into this dreadful business." Another lectured me on how "the physician has been placed in involuntary servitude by the federal government."

Some involuntary servitude: today the federal government is the doctor's chief source of income. "Doctors want to blame the government for everything," says Dr. James F. Daniell, a Tennessee surgeon. "Government is always the villain—the government this, the government that. They never want to talk about how many of them got rich off Medicare."

Like farmers and civil servants, doctors are dependent on the political system for their livelihoods and thereby stand to benefit from public complaining. Also like them, doctors lately have been claiming that times are so hard that everybody's quitting. Dr. James Todd of the American Medical Association has been quoted as saying, "Physicians are leaving the system in unheard-of droves." I asked Todd what evidence backs this assertion. He said he had no specific examples, nor any statistics showing physicians leaving—in droves, taxis or anything else—though he had seen a survey indicating that 27 percent might retire early.

People naturally want money, but among doctors it has an added significance: as a repayment for the sacrifices they have had to make.

The doctor starts his career with four intense, stressful years of medical school. Next he moves on to three grueling years of residency (five, on average, for surgeons) at token pay—possibly less per year than he had to shell out for his degree. Nearly every middle-aged doctor was subject to the old "doctor draft" and also had to serve in the military. That adds up to nine to 11 years of unstinting work with little financial reward.

By the time many doctors arrive in practice, they have started feeling the world owes them a fancy living. Patients become "customers"; the reception room, a cash-register line. "When you walk into a doctor's office and see 20 people waiting, that's just egregious," said Dr. John D. Berryman, a Washington, D.C., obstetrician. "Most medical-judgment errors are caused by overbooking. The doctor is so anxious to move on to his next patient and start the next billing he doesn't

costs up to a total of $1,000 to $5,000.

Of course, insurance carriers like copayments because they take a slice off direct costs. But a more significant saving for the companies is attained by discouraging admissions. Studies by the Rand Corporation have found that imposing even moderate out-of-pocket expenses on individuals discourages the use of unnecessary health services. (Use of clearly needed services is not affected by copayments, Rand has found; there is a question about what happens in the gray area in between.)

"It's human nature that any system which is free to the individual will be overused," says James Smeeding, director of pharmacy at Brackenridge Hospital, a city-administered institution in Austin, Texas. Smeeding knows because until recently, Brackenridge extended first-day, first-dollar coverage to its own employees. As a result, in 1985, 18 of the pharmacy department's 50 staff members had radial keratotomies, the controversial operation designed to correct vision without lenses. "There were so many eye patches going past my door I thought I was on a pirate ship," Smeeding reports. A radial keratotomy costs $2,200 in Austin. Brackenridge now charges a 20 percent copayment.

Medicare has also increased copayments. The basic hospital expense for a senior citizen is the "first-day deductible," a flat fee per admission. This fee has soared in the wake of DRG's, from $304 to $520.

Older Consumers

As with private plans, the Medicare deductible serves partly to cut expenses for the insurance carrier, in this case the federal taxpayer. But the amount this deductible will raise in fiscal 1987 —a projected $3.8 billion— represents just 5 percent of the $78 billion HCFA expects to spend on Medicare during that period. The primary purpose of the deductible is to encourage senior citizens to go into the hospital only when they need to.

Here arises one of the great misunderstandings surrounding Medicare, a misunderstanding that will likely have to be addressed politically in years to come. When Medicare was created in 1965, senior citizens as a group were poor and shockingly neglected, one-third of them classified as impoverished. The very notion of denying medical care to our aging parents if they couldn't pay was a national outrage.

Today, thanks to social security, Medicare and other federal programs, and to general national prosperity, the tables are turned. As a group senior citizens have become the best-off segment of the American population. They have the lowest poverty rate; a recent study conducted by The Conference Board, a research institution, found that after taxes and expenses senior citizens have more discretionary dollars to spend than any other age group, including Yuppies. "The older consumer, so cavalierly ignored by many marketers, is in fact the prime customer of the upscale market," the study noted. "It is a striking fact that households age 65-75 have more in-

spend enough time on the patient he is with."

At some point even the most conscientious doctor may come to see a generous income—and an annual raise—as a "right." Indeed, doctors have been acting close to hysterical about their incomes in the last two years, not because they've lost ground, merely because their rate of increase has stalled. Recently the accounting firm Arthur Andersen & Co. studied the attitudes and opinions of more than 1,000 health-care professionals—doctors, nurses, hospital administrators, others. On the key question of how to manage increasing costs, all groups studied except one said shifting care from an inpatient to an outpatient setting was the best single idea. The exception was physicians. They said patients should be charged more.

A journal called Medical Economics is the tribune of doctors losing the struggle against their materialistic urges. A recent cover asked: HOW WOULD YOU INVEST A SPARE $100,000? The story began, "You have plenty of insurance, you've contributed as much as you want to your pension plans, your personal portfolio is bulging. And you don't really want another Mercedes ..." The same issue contained a guide to private retirement spots on Maui. A third of America's physicians receive Medical Economics. It is not a magazine they leave lying around the waiting room.

The structure of private practice ordains much of the tension in the medical mind. Doctors who work solo give up the privilege of calling their lives their own; whenever a patient calls, they must respond. But they are also free to practice as they please. Anyone who has ever been his own boss knows how satisfying this freedom can be—how it can make up for other impositions, like phones ringing in the middle of the night.

Most new managed-care plans, by contrast, place restrictions on what treatment a doctor can order and when; that is the essence of "managed" care. Doctors who treat patients belonging to an HMO, for example, must first call the HMO and get an authorization number before admitting the patient to a hospital. Old-school practitioners are infuriated by the thought of having to get anyone's consent before they act. Further, they fear that such minor stipulations are laying the groundwork for a much-dreaded major change, the introduction of "prescribed protocols," regulations defining exactly what therapies may be used in specific situations.

There is an alternative to the stresses of the solo lifestyle: group practice. Group practice—in which several physicians band together—eliminates the need for doctors to be on call 24 hours a day, because they can cover for each other. The ability to have a great year financially declines somewhat, as profits must be shared; but so does the anxiety about malpractice premiums, also shared. In HMO's and at teaching hospitals where doctors are salaried staff, they don't have to worry about malpractice insurance at all, being covered by institutional policies. As doctors increasingly become group practitioners or employers—the number of group practitioners doubled between 1969 and 1980—their autonomy and incomes may decline, but their lives should grow less harried and draining.

Doctors who came of age in the postwar generation lived as members of an exclusive fraternity during a period of material affluence and scientific progress. They enjoyed steadily increasing prestige, the freedom to practice without supervision and the satisfaction of doing tangible good in the world. And virtually everything that helped the patient just happened to be highly lucrative for the doctor. It was an era when, as one older practitioner put it, doctors "wore the golden ring."

Now, with the dawn of managed care, physicians will sometimes have to take orders. A doctor faithful to the credo of "patient's advocate" will sometimes be obligated to make decisions that subtract dollars from his income.

Is this really such a horrendous fate? It does not mean being a doctor will cease to be admirable, or desirable, or rewarding. It just means removing the golden ring. Many doctors may find themselves happier without it.

come per person than those under age 45."

Yet Medicare does not consider need—it works the same for rich and poor alike. This means that poor senior citizens, for whom $520 constitutes a hardship, must shoulder deductibles in order that well-to-do seniors can retain their discretionary dollars for the "upscale market." It further means that younger taxpayers who have trouble covering their own insurance bills must pay higher taxes so that the best-off group in society gets care at deep discount.

In 1986 Congress passed a law (currently blocked by a court order) that comes close to imposing on doctors "mandatory assignment" for Medicare; Massachusetts already requires this, and other states are considering similar legislation. Mandatory assignment means doctors must treat senior citizens strictly for the 80 percent of standard fees that Medicare typically pays; they may not "balance bill" the remainder to patients. The trouble with mandatory assignment is that it grants as much largess to those who don't need it—now wealthy retirees on Cape Cod pay nothing at all for doctor visits—as it does to those who do need help, while shifting more of the burden onto taxpayers who finance Medicare in the first place.

"Every doctor ought to have a moral if not legal obligation to take assignment for those who can't afford to pay," says Dr. William Marsh, a family practitioner in Washington state. "But to force doctors to take assignment for those who do have money is crazy."

A fairer approach would be to link benefits to need, an idea recently endorsed by the American Medical Association and by the Blue Cross and Blue Shield Association. A Medicare "means test"—based, probably, on the annual means test to which all Americans must submit each April 15—would both reduce federal health spending and render it more equitable.

As further cuts are required, legislators should bear in mind that Medicare has been as kind to business as to senior citizens. Nearly everybody in the medical industry discusses Medicare with the same kind of double-talk defense contractors use—griping endlessly that they can't make money on government business while eagerly maneuvering for more. Thomas Frist Jr., chief executive officer of HCA, which draws 44 percent of its revenues from Medicare, complained to me, "Since Medicare was formed the government has cut back on us every year. Every time we reduce costs they just use the new lower costs to squeeze us down further."

My heart did not cry for this conglomerate that somehow squeezed out $283 million in net profit during 1985 despite being squeezed down. Throughout the rest of our discussion Frist held forth on how free enterprise was better for medicine than federal regulation, a view I tend to share. But when I noted to him that free enterprise works by having customers like Medicare constantly pressure suppliers like HCA for cost reduction, he changed the subject.

What bothers doctors and hospitals is not that they can't make money on Medicare—they can—but that in the wake of DRG's, it has stopped being a pot of gold.

The Competition for Outpatients

A basic consideration to bear in mind about modern American medicine is that most doctors don't work for hospitals. Though teaching hospitals and a few prestige institutions have staff physicians on salary, most of the white-coated people wandering the halls have little formal connection with the place. They are self-employed or affiliated with a private clinic or HMO. They have won permission to admit patients to particular institutions—a hotly contested privilege in areas where there are more doctors than work for doctors to do—and may be found in several hospitals during the course of a day, doing a procedure here, a test there, scribbling orders and dashing off.

Another basic consideration is that there is nothing like a "standard" treatment for many ailments. Patients assume some government agency or medical society formally sanctions the way doctors go about their business. In fact, there's almost none of this. Dr. Floyd McIntyre of Dennis, Mass., notes that doctors still argue among themselves about circumcision—some say that it should always be done, others that it should never be done, still others that it makes no difference. "If we can't make up our minds about circumcision, a simple procedure which has been in use for thousands of years, it's no wonder patients are baffled about whether they need extremely complex new treatments," McIntyre says.

Some doctors, for example, say stay off a sprained ankle; other say get back on it as soon as possible. Some suggest heart surgery for almost anyone with severe chest pains. Others say drugs, diet and exercise accomplish as much. Some endorse a new operation called a carotid endarterectomy, in which the main artery leading to the brain is scraped clean of the platelets which break loose and cause strokes. Others say the platelets just build up again. When a physician advises a patient to take drugs or have an operation, there is no final authority the patient can turn to for answers; he's on his own.

The Food and Drug Administration certifies whether pharmaceuticals and certain in-body devices such as artificial knees are safe to use; it allows considerable leeway in how to use them. There are fewer restrictions on devices used outside the body or in conjunction with medical procedures—the surgical-supply business, for one, produces new products so rapidly that salesmen are sometimes present in the operating room itself, giving surgeons pointers on how the latest gadget works. In turn, no official organization mandates how operations should be carried out (how to make the incisions, what to remove and so on).

Where the free-agent doctor and arguments over the correct way to treat patients intersect is in searching for new ways to cut costs.

At the height of the pass-along era, hospitals felt it was their role to let the physicians roaming their corridors order whatever protocols they pleased. Now a consensus is emerging that while it may not be possible to determine what treatment is ideal, it is possible to determine what's cost-effective—and that hospitals should exert some authority over how physicians go about their business. This, to doctors, is blasphemy.

For example, the typical American big hospital stocks an inventory of about 3,000 drugs. In Sweden the number is about 900. Many drugs are different brands of the same thing; the overlap is especially prominent in antibiotics. Traditionally hospitals would never dare question a physician's choice of drug brand. Now they are pressing doctors to be more selective. Brackenridge, in Austin, keeps a computer inventory of which drugs physicians order. Those who favor expensive drugs when a cheaper one could be substituted get a talking-to.

Outpatient surgery is the area where assumptions about the right way to treat patients have changed most in a short time. Presbyterian was in 1971 among the first hospitals in the country to offer outpatient surgery. There were few takers. At that time the reigning belief was that only a handful of operations, such as biopsies, could be performed without formal admission. Patients usually wanted to check into a hospital if only because they associated surgery with misery and incapacitation. Some insurance plans wouldn't cover a procedure unless it occurred in-patient, which was supposed to prove the condition was serious; naturally, under pass-along, few hospitals objected to that.

Now almost 40 percent of Presbyterian's surgery—gynecology, urology, arthroscopies, cataract removal—is performed on an outpatient basis. Patients report in the morning; a great deal of money is saved by the simple expedient of not having them sleep over the night before. Margaret Schwall, head nurse in Presbyterian's outpatient division, estimates that of Presby-

terian's 670 surgical outpatients per month, perhaps 20 are transferred to the main hospital when the doctor finds something more serious than expected. The rest go directly home, often by noon.

Public resistance to outpatient surgery has been overcome partly by a growing awareness that it is safe and partly through the spread of copayments, which gives patients, too, a stake in holding down costs. Meanwhile, outpatient treatment is encouraged by the logic of DRG's.

Azzara, the president of Valley Hospital, explains that his institution began to offer outpatient surgery in 1973 because a bed shortage made it impossible to meet demand any other way. "At the time it was the only option for handling our patient load," Azzara said. "We were penalizing ourselves because those extra days of charges were gravy. Now, outpatient techniques are very much working to our financial benefit." At Valley, fully 45 percent of surgery is outpatient; the average length of stay is down to 4.5 days, a level at which DRG's allowances are more than sufficient. "Almost all of our patients now say they prefer it this way. This is the classic example of an idea which both cuts costs and improves quality," Azzara said.

The next step beyond outpatient surgery is ambulatory surgery—operations performed outside the hospital altogether. "Once the hospitals showed it was safe to get surgical patients in and out on the same day, physicians began to say, 'Wait a minute, this means I could do the whole procedure right here in my office'," said J. Alexander McMahon, a former president of the American Hospital Association.

Ambulatory centers, nicknamed "surgicenters" by proponents and "doc-boxes" by critics, have sprouted up across the country. Usually they are owned by doctors; sometimes by investors with doctors as employees. Because they have generally not been subject to certificate-of-need regulations, such centers have more flexibility than hospitals in responding to market trends. There are now ambulatory outposts for cataract removals, cosmetic surgery, foot operations, hernia repair, gynecological procedures and "sports medicine" (Yuppie orthopedics); there are also wonderfully named "minor emergency" centers for breaks and bruises. Some even offer 800 numbers with catchy numerations, like 1-800-THE-NEW-U (for fat removal, an operation most physicians consider ill-advised). In appearance, the facilities vary from boutique to sprawling. The 35-physician Brown-McHardy Clinic in New Orleans seems like a hospital in every respect except that patients don't sleep there.

For doctors, the financial incentives of ambulatory care are powerful. Since the physician claims approximately the same fee regardless of where he performs a procedure, doctors doing minor operations in their offices are spared the inconvenience (and unbillable hours) of driving around to hospitals. Offering a full line of service in the office allows doctors to perform (that is, sell) more examinations like X-rays and blood panels, high markup products that are hospital cash cows.

The Pros and Cons of 'Doc-Boxes'

Though the movement to out-of-hospital surgery was driven by expediency, it has turned out to have positive health consequences. Most patients prefer to be spared the hospital experience. Recovery appears to progress more rapidly in the familiar surroundings of home, too. "Outpatients show lower blood pressure, less oozing around incisions and other measures of enhanced recovery," says Dr. Stephen Sohn, founder of the Boston Center for Ambulatory Surgery. "Just being in a hospital is an unnerving experience. There's constant noise and commotion. You may be in a room with someone else who's not very well, whose pain complicates the psychology of your own recovery."

Sohn's center is a partnership owned by the five physicians who practice there. Defenders of doctor ownership maintain that no one can do a better job of controlling costs than doctors themselves. "We have direct knowledge of what's really needed and what isn't," Sohn says. He notes that hospital supply catalogs list "medical carts" for $1,000. "What they call a 'medical cart' turns out to be indistinguishable from a $150 Sears rollaway tool cart, which is what I buy."

Opponents point to the obvious drawback: doctor ownership creates another incentive to recommend operations that aren't necessary. Most medical observers believe that the incidence of totally unnecessary surgery is low, but there is great disagreement regarding the gray area—the cases where nobody really knows for sure. Fee-for-service surgeons, for example, are twice as likely to perform a coronary bypass as HMO surgeons.

A related worry is that the level of accountability for ambulatory centers and similar deregulated facilities may be lower than at hospitals. If people living in a city with five hospitals have trouble figuring out which one is good—and usually they do—how will they ever make heads or tails of dozens of surgicenters?

When doctors open surgery centers, they are stealing customers from hospitals. From the industry's standpoint, there are not enough patients to go around. Or at least not enough for doctors to continue living in the style to which they have become accustomed.

The United States today has 553,000 licensed physicians, a third more than just a decade ago. There are 22 doctors per 10,000 people, compared with 17 in 1976 and 14 after World War II. If trends hold there will be 26 doctors per 10,000 people by the end of the century. Most of the surplus is concentrated in big cities and the specialties.

Physicians have of late been feeling very sorry for themselves over this glut. The American Medical Association has gone so far as to call on medical schools to produce fewer graduates. There continues to be agitation within physician ranks against "FMG's," or foreign medical graduates, particularly the large numbers trained in India. The arrival of FMG's has slowed through the last decade because of tightened regulation. The peak year was 1973, when 45 percent of new doctor licenses were granted to holders of foreign degrees; by 1981 the figure was down to 17 percent. But the fact that any foreign-born physicians have been able to hitch on to the U.S. gravy train makes many American-born doctors steam. It's import competition.

From a market standpoint, a doctor glut is a rational response to the appeal of medicine as a career. When pay in a profession rises, it shouldn't come as a surprise that more people clamor to enter. Economists refer to a phenomenon known as monopoly suicide: any enterprise that succeeds in raising prices to a windfall level inevitably entices others to jump into the field, thus ruining the monopoly.

Indeed, economists often advise corporations to charge somewhat less than what the market will bear, so as not to invite competition. Physicians in the last two decades did not heed this advice and now must face the consequences.

An additional factor is that in 1965, responding to widespread claims of an impending doctor shortage, the federal government began subsidizing medical schools. Predictably, the number and size of med schools jumped; by 1984 there were twice as many first-year medical-school students as when the federal money started flowing. And there were *five times* as many medical-school faculty members. When grumbling about competition from these "doctor factories," middle-aged physicians don't like to add that they, too, have benefited from the expansion in medical academe. Affiliation with a medical school is avidly sought because it confers stature on a practice. Faculty slots are coveted: they combine prestige and high pay with lower stress than treating patients. Assistant med-school professors average nearly $100,000 per year; full professors net more on average than private practitioners.

Economists are also fond of saying that

there is no such thing as oversupply, just overprice. Hospitals may be able to fill empty beds by converting them to less costly uses, such as psychiatric care or treatment of alcoholism; physicians, possessing a valuable skill, will always be able to find work at less spectacular incomes. House calls are staging a moderate comeback because physician oversupply has forced doctors to it. In Florida, American Medical International is contracting with underworked doctors to make house calls; AMI charges $75 and pays the doctor an hourly wage, plus bonuses for productivity. Even more striking, recent figures show that 200 of the nation's 75,000 medical residents (doctors in training) have agreed to work for free—so desperate are they for entree into an overbooked profession.

There is a school of thought that says doctors can defy market forces, because patients do not comparison-shop for medical services the way they do for other goods. Anytime a doctor lacks enough business, this theory goes, he simply raises his prices, which is the reverse of how supply and demand is supposed to function. The trade journal Medical Economics has found that when physician net incomes rose only 1 percent in 1985, doctors responded by upping their office fees 10 to 15 percent in the first half of 1986.

But the day of casual price hikes is drawing to a close. Individual patients still generally do not shop for deals. But large buyers of medical services, like Medicare and corporations, have most definitely started comparing prices; and they shop on a big-money, nationwide basis.

Meanwhile, in categories like gynecology or eye care—where buyers can be choosy because they don't have an acute condition that must be treated immediately—indications are that shopping by individuals is on the rise. Paul Keckley, a medical consultant, notes that in the late 1970s hospitals began developing birthing centers with the poor in mind. "They discovered that many customers were middle-class mothers in their 30s, trying to save money. This was one of the first big clues that the medical market was becoming consumer driven."

Competition has yet to damage doctors as a group financially. But it has wreaked havoc with the physicians' world view. In the old order, when patients flowed into the waiting room without having to be lured, their tabs picked up by distant third parties, it was possible for physicians to acquire wealth without considering themselves tainted by business—or wrestling with the disquieting idea of profiting from someone else's suffering. Now that has changed. While a physician may still earn an excellent income, he must look on doctoring as a business as well as a calling.

Doctors who have known another, more genteel way find that unpleasant. Patients who yearn for the good old days when profit was alien to medicine must remember there never was such a time. But there was a time when doctors and hospitals could *pretend* this was so.

Doctors Examine Their Peers

One beneficial side effect of the physician oversupply may be that doctors will lose their inhibitions about criticizing colleagues. Doctors rarely report peers to state license boards, and not because they don't know who to report. "Everybody in the hospital, and I mean everybody, knows who the bad doctors are years before their names show up in the paper," says Dr. Jacob Kornberg, a Puyallup, Wash., surgeon. Admission privileges, controlled at most hospitals by boards of physicians, traditionally are determined half by economics and half by personal connections. The latter creates great pressure for doctors not to act against one who has been admitted to their club.

There is also a legal consideration. Owing to the novel arrangement under which self-employed physicians float in and out of different institutions to practice, courts have often held that restricting a doctor's access to a hospital constitutes restraint of trade—an antitrust violation of his ability to compete with other doctors. This works out to something like a "right" to practice.

The right to practice medicine is a curious notion—as if a free-lance journalist sued claiming he had a right to work out of the newsroom of The New York Times. No one questions a corporation's freedom to hire and fire, because legally speaking the employees of a corporation are in competition with employees of other corporations, not each other. But if a hospital attempts to say it doesn't want to "hire" a physician—even because of incompetence—it may be sued and assessed huge damages.

Like many legalistic protections, the right to practice may end up helping those who deserve help least. A capable doctor need not panic if turned down for privileges at a particular hospital—other things being equal, he will be able to obtain privileges elsewhere. It's the inept who sue, knowing lawsuits are their best hope.

Overcapacity likewise has changed the psychology of the hospital industry. In the pass-along era, colossal blundering was required to drive a hospital out of business. Now hospital administrators can take nothing for granted. "Common sense says something's got to happen to all these empty beds," says Sister Irene of the Daughters of Charity consortium. "Hospitals are going to fold. That's rarely been a threat before in this business."

Most Americans seeking health care check into hospitals that are neat, proper, regimental. There is also a kind of healing institution where disorder reigns—the teaching hospital. About 15 percent of U.S. hospitals are affiliated with medical schools. It is in such places that the physician's mind and world view are forged.

One of the nation's oldest teaching hospitals belongs to the University of Pennsylvania and is known by the acronym HUP.

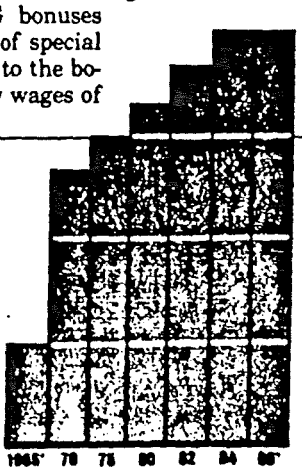
HUP is a study in chaos. Scores of people, poor mainly, mill about a cavernous lobby which evokes a train station more than the portal to a temple of science. Inside, carts and supply crates are stacked randomly in corridors, the old structure having long ago run out of storage space to accommodate the unceasing arrival of modern equipment. In the wards sit strange machines with the handmade, science-project look of limited-production-run items—technology in testing, with scribbled notices attached like PLEASE DO NOT ANSWER ALARM IF YOU ARE NOT FAMILIAR WITH THIS SYSTEM.

Most of all, HUP is alive with sleepy young doctors dashing about in various states of agitation. Med-school graduates spend at least three years in a teaching hospital. Teaching is hands on in the literal sense—second-year residents often instructing their first-year counterparts. "The saying is, 'Watch one, do one, teach one'," says Dr. Susan Eysmann, a HUP resident. "By the third year you are already consulting."

Supervising the residents are "attendings," or salaried medical staff employed primarily to treat patients. Though tied to medical schools, teaching hospitals are also places of business. The federal government gives them DRG bonuses and other forms of special assistance; owing to the bonuses and the low wages of

Expenditures on Medicaid and Medicare

As a percent of the Federal Budget

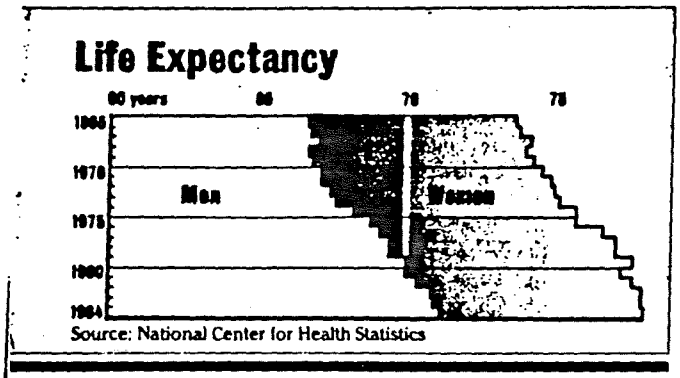


*Estimates: Office of Management and Budget; Sanford C. Bernstein and Co., Inc.
Sources: Department of Treasury, Office of Management and Budget

Fiscal years 1965* 70 75 80 82 84 85*

residents, teaching hospitals can be gainful enterprises—recording an average gross profit of 15 percent in 1984, as opposed to 12 percent for all hospitals, according to one Reagan administration study.

At prestige institutions like HUP, residents compete to win fellowships, extended studies supported by grants and leading toward subspecialties—specialization in a single disease or organ. Fellows are expected to stay in academic medicine. It's an open secret, however, that many plan to jump to private practice. Thus the most prized fellowships involve cardiology, one of the most prestigious in the private fields. Roughly speaking, the fellowship system subsidizes private medicine the same way fighter-pilot training subsidizes the airline industry.



Because the patient census of teaching hospitals often reflects a high proportion of the old and poor, many assume teaching hospitals are places to be avoided. In fact, the prevalence of poor patients is mainly a demographic coincidence—teaching hospitals tend to be located in old urban areas, adjacent to old urban universities. Physicians generally consider these institutions the summits of modern medicine.

At teaching hospitals the science is most current and the physicians most objective: being salaried, their income is unaffected by how much or little care they order. Once doctors reach private practice many feel compelled to project an omniscient demeanor, pretending they know what is wrong with a patient even when they don't. In the teaching environment, by contrast, patients are prodded and poked by scores of curious young residents—which is irritating but greatly increases the odds of astute diagnosis. If only all the poor were treated as well as those in teaching hospitals.

Residency obviously works; American physicians know their subjects. But the system contains unsettling flaws with which the medical community has been struggling quietly for years.

The central objection to residency is that it dehumanizes young doctors through a tyranny of long hours and physical exhaustion. Typical workdays are uninterrupted 12 hours—not sitting behind a desk, but hard labor tending people in pain—interspersed each third night by the dreaded "call," or 36-hour shift. The atmosphere evokes military-academy-style hazing. Egos are smashed, insults are shoveled down the pecking order to the lowest-ranking, effort is thanked with a shrug. "I have incredible responsibility, up to the power over life and death, yet I am treated like a child," Eysmann noted.

The blur of overwork can instill in young doctors a subtle form of antipathy to patients. Callousness, necessary to survive the hours and emotional strain, is fostered; after a few months on call, residents subconsciously begin to blame patients, rather than the system, for their weariness.

Since the poor are usually admitted to hospitals "without doctors"—they show up unannounced, knowing no one—residents take on patients using a rotation system. At HUP each assignment is known as a "hit"; a seriously ill admission is called a "hurt me," because any resident drawing such a patient can kiss the next several days of his personal life goodbye. Psychologists may have a field day analyzing a slang metaphor that has the physician being "hurt" by his patient, but there's no denying residency burns this mode of thought into the brain. The warm bedside manner of first-year interns becomes, in third-year residents, clipped businesslike deportment.

Deep-frying the young doctor's brain is not, however, without compensations. A physician must learn to view patients unemotionally, especially when it comes to imposing procedures that cause increased pain over the short term. The physician must further learn to perform acts unpleasant to him personally—sticking your hands inside diseased strangers is not many people's idea of a good time—without flinching or losing his nerve. The residency regimen, mind-bending as it is, breaks down natural resistance against taking a dispassionate approach to the highly intimate reality of suffering.

The dilemma concerns where to draw the line between the inculcation of professional judgment and the loss of human empathy, which is of objective value to healing. Undergraduate premed courses, the first level of doctor screening, concern the hard sciences almost exclusively; the most notorious is organic chemistry, the mere thought of which causes premeds to quiver. Courses like "orgo" gauge the ability to assimilate and recall huge amounts of technical data—no small consideration in the making of a good physician—but tell nothing about the potential doctor's ability to handle the human questions of day-to-day practice. The next phase of screening, the MCAT (a medical variation of the SAT), occurs before admission to medical school; it is likewise a measure of hard-science aptitude. By the time young physicians become residents they have been sifted twice in ways that favor detached intellectualism over compassion; the teaching hospital then amplifies the effect.

While in residency, doctors work cheap. The national average is around $22,000. Fellows make about $30,000. Many moonlight in suburban community hospitals as night-shift doctors, further adding to their sleeplessness.

In a way it is refreshing to think that people on a journey to positions of great privilege should spend an apprenticeship in backbreaking service to the poor. The problem is that residency as now conducted produces few who remain humble. If anything it grinds that inclination out.

The Dehumanizing Grind of Residency

Talking to residents, I heard them repeatedly describe their situation with phrases like "mistreatment," "systematic abuse," "slave wages," "deprivation." A surgical fellow lamented, "Most of us don't even own sports cars." Though the thought of a young doctor at a leading university hospital viewing himself as "abused" may seem ludicrous, there is a certain internal logic to it. The cheap labor of residents subsidizes older doctors, who show little gratitude; physicians spend many more years in education and indenture, earning only small sums or paying money out, than people in almost any other job category. With the cost of private medical school approaching $15,000 per year, graduates carry an average of $33,000 of personal debt into residency, more than enough to mince the take-home portion of a $22,000 wage.

A subtle source of discontent among residents is that they must forgo their young adulthoods. Typically doctors do not leave the learning sequence until 30, and though they embark on a path that can lead to affluence, they have had to sacrifice years in the process. Resentment builds, followed by a determination to make up for lost youth by earning heaps of money.

Medical education encourages money hunger by reflecting perhaps the worst fault of the current practice system, the huge disparity between what doctors are paid for "procedures"—surgery and tests—and what they get for "cognitive ser-

vices," the doctoring world's fancy name for anything that isn't a procedure.

Surgeons average about $1,000 per hour. An internist who spends an hour counseling a patient to alter his lifestyle in order to avoid future surgery will be lucky if he can bill $50. Medicare pays around $1,400 for a 45-minute cataract extraction and about $22 for 45 minutes of physical examination and diagnosis. "Scopes," pushed inside joints or organs, pay more than "scans," viewing the inner body without breaching it. Anytime a doctor sticks something into someone, he receives a bonus.

Dr. Curtis Margo, a Tampa ophthalmologist, notes that many fees for procedures are relatively high because they date to a period when the intrusion was more dangerous physically and when there was less division of labor. "Twenty years ago a cardiac surgeon might have been involved in administering anesthesia, in the post-op care, and would have done more with his hands," Margo says. "Now we have anesthesiologists and surgical nurses and highly specialized equipment, reducing the surgeon's workload and generating billings of their own. But the surgeon still commands the same 'customary' fee."

It should come as no surprise that the payment hierarchy creates an oversupply of students wanting to enter "procedure tracks." What is surprising is that educators encourage this skew. HUP fellows researching invasive procedures make more than those in cognitive fields such as the study of infectious disease. Nationwide, med-school professors of cardiovascular surgery, the king of procedures, earn a mean of $171,000; professors of pediatrics, a mean of $82,000.

The way young doctors come to view their calling is a matter of an increasing concern within the medical establishment. The every-third-night-call system, demanding though it is, is much improved over the previous standard of every other night. Johns Hopkins University, whose medical school has often been in the vanguard of innovations, dropped the MCAT as an admission requirement. But what may ultimately trigger the most lasting change in doctor attitudes can be anticipated simply by glancing at the residents scurrying about the hectic halls of HUP.

Almost half of them are women.

Roughly a century ago, doctoring in the Western world was not a male preserve. Concurrent with the advent of scientific medicine in the early 20th century, women began to be shaken out of the physician ranks. One need not be a conspiracy theorist to deduce that there was a relationship between rising income and the profession's appetite for making itself an all-male club. As late as 1969 just 9 percent of students entering medical school were female.

Today a third are female. HUP has numerous female residents in every field save one, surgery. "The culture of surgery is oriented toward attacking the body, which is the machismo approach to problem solving," says Dr. Jeane Ann Grisso, a HUP staff physician. "There is discrimination in the surgeon's network, but it's also true that most women don't want to be surgeons. Women are more inclined to an interest in primary care. Even in basically invasive areas like heart disease, women tend toward the noninvasive side, such as echocardiography" [the study of the heart using ultrasound waves].

What women themselves will ultimately derive from the practice of medicine remains to be seen; from the standpoint of the system, the hope is that they will bring more sympathy to the delivery of care, and that they will break down the cultural barriers between doctors and nurses.

Keckley, the medical consultant, noted: "Middle-aged male physicians are unbelievably resistant to the idea that issues such as affinity and tone of voice are relevant to treatment. We've put patients behind one-way mirrors and let doctors watch as we interview them. Female patients say things like, 'Quality is a doctor who talks to me before he tells me to take off my clothes.' Male physicians often react vehemently, saying, 'No way am I going to believe that makes a difference.' For people who spend their lives giving care to the distressed, it's amazing how little doctors understand of the basics of tenderness."

The patients themselves are partly to blame. "Some patients come in saying, 'I want answers, and I want answers now'," explained Dr. Frank Marchlinski, a cardiologist. "We constantly emphasize the limitations of treatment and the importance of basic lifestyle choices like diet, smoking and exercise. But patients resist this message. They may be insistent that you do something like a cath [a moderate form of heart surgery] even though you feel observation would be just as effective."

"If you refuse to do a procedure, the patient goes away thinking that the insensitive medical establishment has refused to provide him adequate care," Marchlinski added. "You'll lose future referrals from the doctor who sent the patient in, because he doesn't want you upsetting his customers. And the kicker is that you've cost yourself money. In medicine, doing the right thing often doesn't pay very well."

Surely women, thought to possess more empathy and introspection than men, will work against the notion that doctors must act imperious and all-knowing. Female physicians may for personal reasons also be willing to accept somewhat less pay in return for reasonable hours, a saner lifestyle and more time with their families. It's hard to see how anything but good could come from such an example—since most male doctors ought to follow it, too.

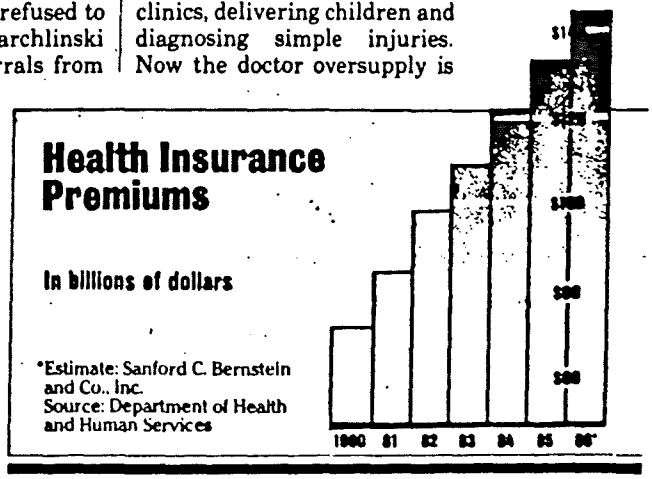
Doctor Vs. Nurse

As the doctoring business sees the light on gender, nursing remains almost exclusively female—95 percent of nursing students being women.

Anyone who has found himself in a hospital bed knows that nurses can be as valuable to recovery as doctors. They spend the most time with patients, and often end up explaining procedures the doctor considers himself too important to explain. Yet doctors rarely acknowledge the significance of nurses, and hardly ever approach them as colleagues. There's reason to hope that the influx of female doctors will bring nurses and physicians closer together.

"The old pattern of dominance based on doctors being men and nurses being women is changing," says Maryann F. Fralic, a vice president of Robert Wood Johnson University Hospital in New Brunswick, N.J. "Female doctors are less likely to treat nurses in a demeaning way, though it happens. Of equal importance, many nurses now have university educations. They can speak the physicians' language."

Where tension between doctor and nurse was once sexual, it is now as likely to be territorial. With their better educations and increased competence, nurses have become another threat to the doctor's franchise. During the 1970s there was a push on the part of midwives (most of whom are licensed nurses, not hocus-pocus types) and nurse practitioners (registered nurses whose advanced-course work puts them somewhere between nurses and doctors) to take over many lower-order physician functions such as running clinics, delivering children and diagnosing simple injuries. Now the doctor oversupply is



crowding out the midwife and nurse.

Money is a constant if unspoken point of contention: M.D.'s make on average nearly five times as much as R.N.'s. From a career standpoint, nurses achieve peak earnings (around $30,000) and responsibility in their late 20s, leaving them with "teacher's dilemma"—they can advance only by going into administration, which takes them out of the very thing they are good at. Praise, which can mean as much as money, is hard to come by. "Economics is an issue between doctors and nurses," said Jean Walsh, a vice president of Allegheny General Hospital in Pittsburgh, "but lack of recognition is just as great a factor."

Younger doctors, less likely than the postwar generation to insist on traditional role-playing, are considered more willing to share responsibility with nurses. At Memorial Medical Center in Long Beach, Calif., for example, committees of doctors and nurses meet regularly to talk and iron out areas for independent nursing "interventions."

The future of nursing may be on display in a small Albuquerque, N.M., hospital called Northside Presbyterian.

At Northside nurses are paid salaries, not hourly wages, bridging a cultural gap similar to the one that exists between labor and management in factories. There are no complicated inhibitions governing what doctors and nurses are allowed to say to each other.

"Who has a greater need to know what's on the physician's mind than the nurse? Yet traditionally doctors and nurses do not talk things out face to face. Everything has to be filtered through 14 layers of administration and memo writing," says Donna Davidson, a former nurse and Northside official, who devised the system. "People told me, 'Donna, this is never going to work. Nurses don't want responsibility.' Recently we had a month when the patient census jumped without warning. My nurses worked 33 extra 12-hour shifts without overtime. Nobody had to tell them to do it, they just did it."

If HUP has the ambience of a train station, West Side Hospital in Nashville, Tenn., feels like a law office. The halls are decorated in tasteful earth tones; the administrator's office, wood-paneled like a law partner's. The staff is businesslike, befitting the fact that West Side is owned by HCA, the largest for-profit hospital chain. HCA headquarters is, in fact, just a few hundred yards away from West Side; from there the company administers the 483 hospitals it owns or manages, producing revenues of $5 billion in 1985.

West Side is a secondary-care facility of medium size designed for a suburban clientele—just the kind of hospital the for-profits like to build. It's in the sun belt, where the chains like to be. West Side is set up mainly to handle routine procedures, not complex intensive-care cases. It does a lively trade in senior citizens, but only 3 percent of its patients come in under Medicaid.

Founded in 1968 by a cardiologist, HCA expanded rapidly in the early 1970s under Jack Massey, the venture capitalist who discovered Harlan Sanders. This earned HCA the nickname "Kentucky Fried Hospitals." Wandering through West Side, one notes the franchiser touch. Nearly all windows, for example, are the same size. HCA estimates it can build a hospital for 15 to 20 percent less than others spend by using standardized design elements. The chain also saves substantial amounts by placing bulk orders for supplies and equipment.

Some health-care intellectuals think it ominous that for-profit chains favor the warm white suburbs, which is the same as saying they avoid the inner city. That is true, but there are sound business reasons for doing so—the suburbs of the sun belt are where the population growth is. With hospitals in general over capacity, few East Coast or Midwest cities present opportunities for new hospital construction; few cities anywhere in the United States have a valid need for a new tertiary center. Which is fine with the for-profits—intensive-care cases, gold mines during the pass-along era, are becoming liabilities in the era of DRG's.

Until the concept of nonprofit-hospital associations began to catch on roughly half a century ago, most hospitals were either pure charity (doctors charged only for services performed in their offices) or for-profit. Now that for-profit hospital management is staging a comeback, Americans have grown apprehensive about the idea.

Today some 1,900 of the nation's 5,800 hospitals, along with 70 percent of its hospital beds, remain nonprofit, and nonprofits are forming associations of their own to compete with the for-profit chains. Many of these associations operate with the same hard-edged business determination as the for-profits, and in at least one case a nonprofit association (Fairview Hospital, based in Minneapolis) has swallowed up a for-profit chain (Brim of Portland, Ore.).

The big indictment among health-care intellectuals is that chains "put profits before health." Yet doctors have never neglected to maximize their incomes (the pure-charity hospitals sure didn't last); nurses strike for higher wages; pharmaceutical and hospital-supply corporations have always been for-profit; medical patents can bring lavish returns; the big institutions which sponsor much of America's medical research, like Hughes and Robert Wood Johnson, were made possible by corporate profits. Why should the administration of hospitals be any different?

Animosity against for-profit chains reflects discomfort over seeing out in the open what has, before, always been kept in the background. Hospitals are the part of the system with which patients come into personal contact. There was something reassuring about their calling themselves nonprofit, even if all other actors in the drama were making money like mad.

The chief functional difference between for-profit and nonprofit care is that nonprofits don't pay taxes. Nonprofit hospitals are perfectly free to earn more than they spend; many do, and some even transfer their excess income to for-profit holding companies. Because publicly held corporations like HCA and Humana are required to disclose information that tax-exempt nonprofits may conceal, the nonprofits can be more "private" than private industry. Nonprofits are free to be luxurious—Presbyterian of Dallas is a good example—and free to pay their staffs handsomely, which is in effect not all that different from profit-sharing. Administrators of big nonprofits now typically earn $100,000 to $150,000 per year, hardly charity wages, and grant themselves the glorified title "CEO."

Economic organization is, in short, a side issue. The real questions regarding for-profit hospitals are: Is the care good? Do they neglect the poor?

The Big Concern: Quality Care

On the care question, evidence so far supports the for-profits. The Institute of Medicine, a branch of the National Academy of Sciences, recently released an exhaustive report finding that quality of care at for-profit hospitals was just as good as at nonprofits. The Institute of Medicine also found that for-profits charge on average 10 percent more than nonprofits and take something of a free ride on the system by rarely conducting clinical trials or sponsoring residencies for the young doctors.

Conversely, for-profits don't get public subsidies. All things considered, it's no surprise that their care costs 10 percent more, as taxes and profits are included. This conclusion is supported by a recent study published in Harvard Business Review. It determined that the net social subsidy to nonprofit hospitals was 17 percent of their capital base, while the net subsidy to for-profits was 2 percent. "Nonprofit hospitals are frequently depicted as instruments of social policy, but we found them not to be so," the study's authors wrote. "The high levels of social subsidy they require do not produce commensurate social benefits."

I asked the 50 or so doctors I interviewed whether for-profit medicine was a threat to quality. A handful said yes, but only a

handful. Most said the tax status of a hospital was of little relevance; what mattered, they said, was the sincerity of the people running the place. "I practice in two hospitals, West Side and Baptist, the city's biggest nonprofit," said Dr. William Anderson, a Nashville internist. "I can't tell any difference between them. Once a year Baptist sends me a computer printout telling me whether I'm making money for them on my Medicare admissions. If the nonprofit does that, what's the difference?"

Medical overcapacity—a scourge under pass-along—becomes a tool of check and balance in a market-driven system. "The surest way to lose your market share in a competitive environment would be to cut back on quality," said Samuel Feazell, administrator of West Side. Feazell conceded that individuals have little practical way of knowing if a hospital is cutting corners. "But the physicians know instantly, and we view physicians as our primary customers. They are the patient's purchasing agents. With so much excess hospital capacity to choose from today, a competent physician would have to be crazy to associate himself with a low-quality hospital."

Whenever there is a surplus of beds, hospitals need the physicians' patients much more than physicians need the hospitals. Here, market forces and independent physicians constitute a faster-acting quality-control mechanism than anything government could devise—since regulatory agencies, even when effective, move much more slowly than businessmen. Private action is far from a perfect constraint. Health-care services are not consumer products: while we can let the marketplace exact revenge on a manufacturer that tries to pass off a crummy toaster or VCR, when a hospital goes downhill people may die as a result. So government involvement will always be required. But in the main, a little deregulated medical overcapacity may be a better quality safeguard than a lot of policy statements and commission reports.

On the question of snubbing the poor, the for-profits are guilty. Unfortunately, so is everybody else. More on this later.

Malpractice Suits: Doctors Under Siege

The next patient through the door could be the one to go to court

Malpractice is an area where everyone seems hungry for the latest astonishing numbers. Here they are:

The average medical-malpractice jury award is up from $166,165 in 1974 to $1,179,095 in 1985. A decade ago there were about three claims per year per 100 physicians; by 1983 the number was up to 20, the equivalent of one physician in five sued per year. It's thought there were four jury awards of $1 million or more nationwide in the year 1974; in 1985 there were 79. Premiums now range from about $2,000 a year for family physicians in rural areas to $100,000 for some specialists in major cities. According to Jury Verdict Research, the biggest malpractice award so far is $29 million.

A majority of malpractice suits are settled out of court; of those that do go to trial, juries rule in favor of the doctor nearly 75 percent of the time. Win or lose, doctors say the mere fact of being sued is the guts of the problem: they feel under siege.

Even if your conscience is clear and you have the resources to defend yourself, being sued is nerve-racking. There is the emotional shock of receiving legal documents formally accusing you of incompetence and carelessness; the distastefulness of settling out of court for a token sum, which may be cost-effective but implies guilt; the building anxiety that each patient who walks through the door might be the next one to turn nasty and vindictive about what you thought was legitimate treatment. If journalists were sued every time they chose the wrong word, they'd feel under siege, too, even if they ultimately won the suits.

"Many physicians now assume that if a testing technology is available, the doctor is legally obligated to use it, even if the clinical indications that the test is called for are minuscule," says Dr. Eric Ravitz, who runs a clinic in Des Moines, Iowa. Ravitz suggests that if a physician has a patient complaining of a headache, he may feel compelled to order a CT scan to compile a record useful in fighting a future malpractice claim. The AMA estimates that doctors spend $15 billion a year practicing such "defensive medicine."

Defensive medicine is not necessarily bad. Perhaps a CT scan for a headache will turn up something important; to the extent that the threat of litigation causes doctors to go about their business more attentively, malpractice law has exactly the "deterrent" effect it's supposed to have.

But can it really be that American doctors are such nincompoops that one in five does something dangerously negligent each year? Can it really be that doctors in major cities, where malpractice suits are most frequent, are nowhere near as proficient as doctors in small towns, where claims are infrequent? Logically, the increase in malpractice claims must be related to the escalating number of lawyers in society—it's in the big cities, after all, where the lawyers roost.

But lawyer overload can't be the sole explanation. Lawyers represent clients, and it is the clients—society—whose changing expectations about risk and money are driving the malpractice expansion.

"'Malpractice' used to mean negligence or error," said Dr. John D. Berryman, a Washington, D.C., obstetrician. "Now it simply means a bad result. If a child is born with a withered arm, all the lawyer must do is get that child before a jury and he'll win an award. The jury may even understand that the doctor is not to blame and see the whole case as simply a withdrawal from a vast fund designed to compensate victims."

What's wrong with viewing it that way—since the family of a handicapped or retarded child may need financial help?

Berryman has three objections. "First, the system makes no attempt to distinguish who is truly in need," he said. "Further, patients don't realize that one way or another—through their health-insurance premiums, their medical bills or their taxes—they are the ones who pay malpractice costs. But by far the worst flaw of the system is that it subsidizes the incompetents. Bad doctors get to fob their mistakes off onto a pool of funds underwritten by the majority, and they keep right on practicing."

In Pennsylvania, for instance, more than 25 percent of malpractice payments were accounted for by 1 percent of practicing physicians. A good bet is that this 1 percent comprises a guided tour of the state's bad doctors. Nationwide, just 406 medical licenses were revoked in 1985, or one per 1,300 of the country's doctors. Another 1,702 doctors received formal rebukes.

Though physicians by and large are trustworthy, it's difficult to believe only one in 1,300 is pulling a fast one. And the 1985 disciplinary figures are up from recent years, as state licensing boards are being granted more meaningful enforcement powers. Yet most

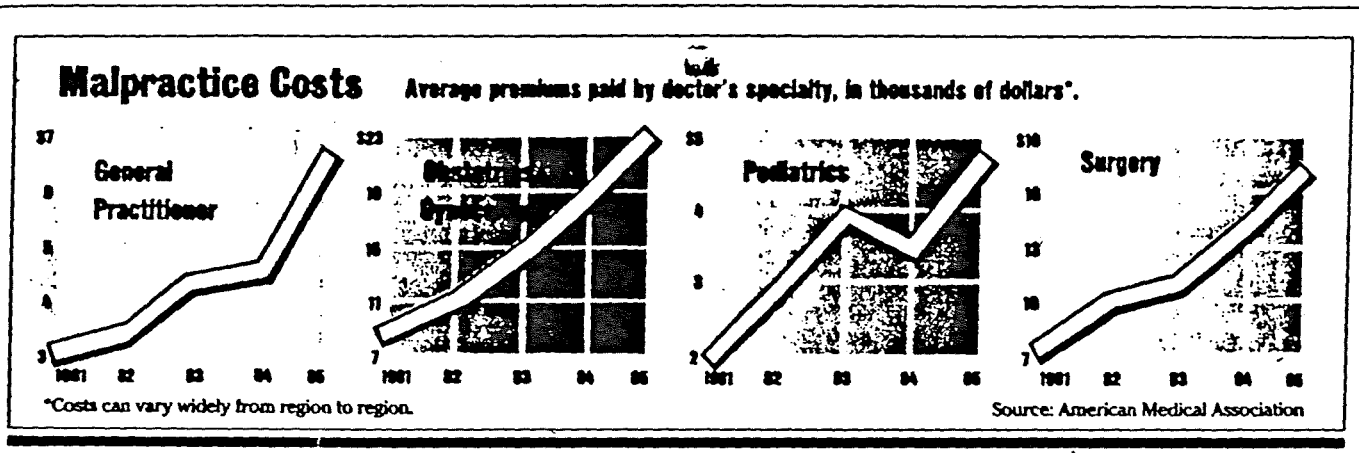
Fighting Over Ailing Bodies

Patients usually take their doctor's advice about what hospital to use. Doctors also control "procedure capture"—sending patients up the chain to specialists—thus referring business to each other. When doctors were in short supply, or when hospital beds were overtaxed, the medical community was content to let referrals proceed on an ad-hoc, old-boy basis. No more. Doctors and hospitals now fight over your ailing body.

"Many hospitals are now in active competition with their own medical staffs," said Dr. Richard Vazquez, a Chicago surgeon. Vazquez tried to organize physicians at Northwestern Memorial Hospital into a health network that would contract directly with corporations. The hospital in turn created a nearly identical plan, mandating that all business be routed through it.

"In the real world what counts is who controls the patient flow," Vazquez said. "If we [doctors] win that struggle then hospitals will become less important. If they [hospitals] win then physicians are going to lose status. Nobody will admit this is what's going on inside the profession, but it is."

Federal regulations forbid formal agreements on admission of Medicare or Medicaid patients. This makes hospitals extremely nervous about any suggestion they consciously seek referrals, although nearly all do. One vice president of a West Coast hospital described to me his search for a physician who would set up practice in an area of town from which the hospital wasn't getting referrals. This administrator traveled to career-counseling sessions at teaching hospitals, telling residents how his hospital would "help the right person get started." By this he meant low-interest loans and similar favors. "Everything has to be done in code," he explained. "I would



competent doctors apparently find higher malpractice premiums more palatable than stronger action to eliminate the source of the problem. "Physicians seem willing to pay an absurdly high price for the notion of professional loyalty," Roy Petty, a Chicago lawyer, wrote in the journal Health&Medicine.

There's a factor here that doctors will only talk about off the record: Nice Guy Burnout. Many is the physician who worked hard in youth, built a name for himself in the community and, as he began to graduate into country-club society, started to lose his touch. Usually he's a nice guy, not a crook; was a good doctor once, and still does OK; probably won't kill anybody, and now has college tuitions to pay. In most fields he would be shifted to a harmless administrative position. The doctor, however, is on his own, and if he in any way admits he's not quite as sharp as he used to be, his practice is doomed.

All human beings err. Few, however, work in occupations where errors can have catastrophic consequences. Society asks the impossible when it expects doctors *never* to make a mistake.

Where is the medical malpractice issue headed? A number of states have passed legislation capping pain-and-suffering awards; some have set up malpractice arbitrators; others, panels to screen cases before they come to trial; some have limited potential windfalls for attorneys.

Each of these approaches has been challenged by various courts, although they may eventually be upheld as the statutes that govern them are refined. It seems likely these legislative responses will put to rest the immediate perception of a malpractice "crisis." None, however, resolves the long-term question of what malpractice law is supposed to accomplish for society.

Is it supposed to identify and punish bad doctors? If so then the courtroom focus should be on the doctors, not the money. The culpability of the doctor would be decided by jury, while the award is determined separately by arbitration. That way the physician would be assured of due process and the jury could concentrate on the question of competence, without being sidetracked by sparring over million-dollar awards.

Or is the purpose of malpractice to compensate victims of suffering? If so, then it's a funny system we have, indeed. "In medicine you see so much sadness," said Dr. Richard E. Bettigole, an internist at Erie County Medical Center in Buffalo. "Sometimes young people get terrible diseases and don't survive. Sometimes people come in with injuries from car accidents and there is nothing you can do to save them. If sadness happens in a way that can be blamed on a doctor or a company, we shower the victim with money. If not, we say, 'Tough luck'."

It may be that someone whose child is born profoundly retarded or who loses his legs in a car crash deserves help from society. But if that's the case we ought to decide it outright and establish some rational balance between medical-problem assistance and assistance for other personal calamities. This argues for getting malpractice out of the courtroom altogether. Doctors could be policed by stricter peer-review and licensing authorities; victims could get help from agencies roughly like a workmen's compensation board.

get into trouble if I just said, 'We give you a practice, you give us referrals'."

Restrictions on referral deals apply only to government programs, however. For private transactions, there is a way to make official what was once done informally. The trick is called "managed care." Several organizing schemes within the category go by an array of acronyms like HMO's, IPA's and PPO's. What they have in common is that, instead of letting the patient wander through the health-care system finding doctors and hospitals where he may, they control who sees whom.

The HMO Alternative

Health Maintenance Organizations (HMO's) date at least to the 1930s, when the Group Health Association of Washington, D.C., was formed by federal workers and quickly became locked in a bitter lawsuit with the American Medical Association, which tried to put it out of business before the idea could catch on.

In the 1940s, the industrialist Henry Kaiser became convinced that the basic American approach to medicine—curing the sick, as opposed to preventing illness—was mistaken. Kaiser opened HMO's for his workers, then founded Kaiser-Permanente, which now has branches around the country. Medical societies fought Kaiser, too; in the California cities where he set up shop, they tried to deny his physicians hospital-admission privileges. Kaiser, however, had the great equalizer, money, on his side. He simply built his own hospitals.

Whether HMO's can achieve Kaiser's theoretical goal of helping people avoid illness is a matter of debate. What is certain is that, in the deregulated medical environment, they represent a major health-financing alternative.

In the HMO form of managed care, consumers buy memberships instead of insurance. When ill, they go to HMO-run clinics to see physicians who are salaried employees. If an HMO member needs hospitalization, he is checked into a private hospital with the HMO's clearance (except in a few places where big HMO's own entire hospitals); bills are sent to the HMO, not the patient. As long as the member stays within the HMO sphere, he spends little or nothing beyond his annual fee. If, however, he visits a doctor or hospital that isn't HMO affiliated, too bad—he pays 100 percent.

HMO's thus represent "prospective payment" on an annual basis. Payment is in advance, not after treatment, and reflects an average cost, not the actual cost per individual. Another way to look at this phenomenon is that the HMO is socialized medicine promoted by private enterprise.

Currently about 11 percent of the population belong to HMO's, most corporate-backed chains. The big names are Kaiser, Cigna, MaxiCare and U.S. Health Care Systems; Kaiser is nonprofit, the others for-profit. In some states, Medicare beneficiaries can sign up for HMO's under a pilot program started by the Health Care Financing Administration. So far the experiment has produced migraine headaches: the biggest Medicare HMO, Florida's International Medical Centers, has been in and out of several kinds of trouble.

Several major corporations have indicated interest in opening HMO's for their retired workers. GM and Chrysler, for instance, are contemplating taking on patients for 95 percent of the annual Medicare cost per beneficiary and believe they can earn profits at that discounted rate. If nothing else, this provides counterpoint to the medical industry's self-serving claims that it can't make money on Medicare.

HMO's have been plagued with the perception—sometimes, the reality—that their staffs consist of doctors who couldn't cut it elsewhere. "When I arrived at medical school at University of California at San Francisco eight years ago, only the dregs of the class went to work for Kaiser," said Dr. Michael Lesh, a Philadelphia surgeon. But then the doctor glut came along, and attitudes changed. "By the time I graduated, all the private-practice opportunities in the city were taken. Some of the best people were signing up with Kaiser," Lesh said.

To patients the attraction of an HMO is no unexpected costs. How can HMO's promise care at fixed cost? Since there are no insurance forms to fill out, paperwork expenses are lower—an important consideration, as a recent study published in the New England Journal of Medicine put the administrative cost of U.S. medicine at an amazing $78 billion, or 22 percent of total health expenditures. And with no incentive to run up bills, HMO's are less likely to order tests and procedures. Studies have found that fee-for-service physicians perform significantly more Caesarean sections than salaried staff physicians and order 50 percent more chest X-rays and electrocardiograms than their HMO counterparts. This corresponds with the experience of National Health, which Britain runs as a socialized HMO: its doctors order far fewer X-rays than American doctors.

In pass-along medicine, not only does the doctor make more by spending more, he has no reason to delay. Rather, the financial incentive is to act immediately and get the invoices started. HMO's reverse the temptation. Delay is rewarded; even if a procedure is ultimately authorized, pushing it from one year to the next improves that year's bottom line. Dr. Joan Mass, a St. Louis internist, once worked for and enrolled her family in an HMO called Health Care Network. "We had terrible hassles trying to get my daughter, who had a congenital problem, referred to the right specialists," Mass said. "Eventually I quit, because I couldn't in good conscience work for a group I wouldn't send my own family to."

Americans are spoiled by the idea of immediate access to almost any kind of medical treatment. And they ought to be spoiled by this idea, because it's a good one. In Britain waiting lists for elective procedures such as hip replacements can stretch to two years. Economically this may be more "rational," but it also means patients suffer in the meantime. British National Health rarely underwrites kidney dialysis, which can cost $20,000 annually for life. In the United States, dialysis is available to anyone; Medicare pays, regardless of age.

At the core, the dilemma of the HMO is a familiar one—nobody can really say what level of health care is right. Most X-rays, for example, are wasteful in the sense that they reveal nothing of interest. But what about the one X-ray in 100 that finds an unsuspected tumor? What is the value of peace of mind? When a doctor says, "I think you're OK, but let's take a few X-rays just to be sure," chances are he will waste some money, but you will feel much better for it.

Many HMO's evaluate physicians using statistical measures such as how long the doctor spends on the average patient. Doctors object vehemently to such yardsticks—partly because it is a challenge to their autonomy. There's nothing inherently wrong with this idea, so long as it's used conscientiously. "Doctor productivity" becomes an eerie concept, however, when money rewards are thrown in. Physicians staged a 25-day strike against Washington, D.C.'s Group Health Association last winter when administrators announced a plan to initiate productivity bonuses. It was hard to work up much sympathy for the strikers, earning an average of $91,000 per year. But they had a point. Seeking efficiency in health care is one thing. Creating a personal financial incentive for physicians to rush through their tasks is quite another.

Eerier still is the development of "gatekeepers," doctors paid specifically to send patients away. Seen from a distance the concept makes sense: managed-care patients first visit a primary physician—the gatekeeper—who screens them for other doctors, pointing the really sick ones to specialists or hospitals, keeping the rest in a clinic where costs are lower.

But because the choice between clinic and referral usually represents the difference between profit and loss, some HMO and IPA plans let gatekeepers keep a percentage of the money they save by not sending patients to specialists and hospitals—

essentially, a commission. Can anyone trust such a system to produce unbiased judgments?

HMO's command considerable support among government planners and health-care intellectuals. But when it comes to the ultimate test, Washington Report on Medicine and Health, a health newsletter, has found something revealing: "Not one of the top Reagan administration officials or key members of Congress promoting prepaid health insurance belongs to a prepaid health maintenance organization." Not even Sen. Edward Kennedy, paladin of national health insurance.

The Rand Corporation has for several years studied a Seattle HMO called Group Health Cooperative of Puget Sound. Rand determined that Group Health has cut health-care expenditures by 25 percent without adverse effects for the middle class but was less sure about the effects on the health of the sick and the poor, who can't stand up for themselves as well as verbal Yuppies can. This constitutes a mild vote of confidence in HMO's but not the clear-cut justification some backers predicted.

The Alphabet Soup of Managed Care

Rapidly supplanting HMO's as the leading alternative to traditional medicine is the preferred-provider organization (PPO). PPO's have a huge advantage—they can be imposed on the present network of hospitals and doctors without having to build clinics or convert doctors into employees.

In a PPO a group-insurance buyer agrees to steer employees to particular hospitals or doctors in return for volume discounts. This addresses the payer's desire for lower prices and the provider's need for a vested flow of referrals. A related approach called an independent-practice association (IPA) resembles an HMO run from scattered private offices rather than a central clinic; doctors who join remain self-employed and get a DRG-like "capitation," or standard fee per member patient per year. Most of the major players in health care are forming PPO's to appeal to group buyers: a huge market considering that corporations are the largest purchasers of private health insurance, covering 130 million Americans and their dependents.

The biggest managed-care operation is Partners National Health Plans, a joint venture between Aetna Insurance and VHA Enterprises, a for-profit "controlled subsidiary" of the nonprofit Voluntary Hospitals of America. (VHA, whose hospitals have combined revenues of $23 billion, is larger than Humana and HCA combined but rarely draws negative press as it is not officially interested in money.) Those joining Partners PPO's are steered to VHA hospitals and affiliated local physicians. "Limitation of choice in exchange for reduction in price is what the alternative delivery system is all about," says Donald Simmons, Partners president.

Individual doctors may join more than one PPO, HMO or IPA while continuing to see patients with traditional indemnity insurance. "Keeping the paperwork straight is becoming a nightmare," one doctor noted. Most doctors hold a low opinion of managed-care concepts. But those needing referrals to maintain their lifestyles have little choice but to sign when a plan comes along offering business. "Eventually hospitals and physicians will totally lose control over the patient flow," Simmons predicts.

A noteworthy development here is that private insurers are finally reacting to medical prices. One mystery of the 1970s was that insurers rarely fought the pass-along mentality—since, after all, it was to them that many inflated bills were passed along. But insurers had an alibi, too. During the 1970s buyers had little alternative to indemnity plans. When expansion of HMO's began to create an alternative, the normally chummy old-line carriers suddenly discovered the word "competition."

At the same time that private insurers have joined the fight against costs, however, they have begun backing away from the sale of individual health plans—a troubling trend in a country where people often change jobs and self-employed entrepreneurs are said to animate the economy.

The reason individual policies are such a bugbear to carriers is that the people who buy them are more likely to need them. Group plans factor out an individual's knowledge of his own health weaknesses, offering statistically predictable risk pools. As more people belong to huge group plans, the chances increase that an individual buyer will be high risk and unattractive to insurers. Thus a vicious circle develops: the easier it is to join a group, the harder it is for a person or family to buy insurance.

Insidiously, many insurers have added "pre-existing condition" clauses to policies: provisos that typically say patients will not be covered for ailments treated within the previous two years. Attempts to write such clauses regarding AIDS have drawn wide publicity, but the public seems unaware that such restrictions may apply to nearly every kind of routine problem—backache, chest pains, migraines—experienced by someone who has changed insurance policies since roughly 1980.

An intriguing managed-care experiment is called Primary Care Network (PCN), designed by Blue Cross of Arkansas. It may represent a compromise solution combining the best elements of fixed-fee and pass-along payment. Here's how it works:

First, local physicians are asked to sign on. In the cities where PCN is operating, a high proportion have. Then employees are asked to switch from their traditional group plans to PCN. Patients get HMO-style full coverage without copayments or deductibles—the individual's incentive—in return for designating a PCN physician as a "case manager" who must clear them to see specialists or enter a hospital. (Savvy medical marketers are already fleeing from the term "gatekeeper.") Since most local doctors have joined, patients can usually pick the physician they already use.

PCN doctors are paid on a pass-along basis but get only 80 percent of their fee up front. The balance goes into a reserve for specialists and hospital admissions. At year-end any money remaining is split between the physicians. After 1985, according to Blue Cross, there was a $188,500 balance in the specialists fund; half that, $94,275, was distributed among 70 doctors as their bonus.

"What this boils down to is reducing your fees 20 percent in return for keeping your patients," says Dr. Thomas Wortham, a Jacksonville, Ark., physician who enrolled in PCN. Wortham says he and his colleagues "were not thrilled about the changes we saw coming a few years ago but decided it would be better to change with the times."

So far PCN patients are using one-fifth fewer hospital days than is typical in Arkansas, while visiting the family doctor four times as often. This turns out to be fine with employers, since hospital days are the killer expense, and fine with patients, since now they can drop by to see their doctors without having to worry about getting stung with a bill for what turns out to be nothing. Owing to reduced hospital usage, PCN coverage costs employers approximately 17 percent less than traditional indemnity plans, which is the corporation's incentive. Blue Cross's incentive is its 50 percent share of the reserve, plus developing a "product" that keeps insurance buyers from shifting to a competitor.

The beauty of the PCN approach is that it preserves the fee-for-service arrangement in which doctors and patients are on the same side—a doctor can judge the need for tests and procedures independently, with assurance that most of his charge will be covered. At the same time there is a moderate incentive to keep overall spending within reason.

One of the largest PCN participants is Baxter Travenol Laboratories, a hospital-supply conglomerate. "We tried several managed-care theories with Travenol, and the problem was they all created an adversarial relationship where either the provider or the insurer would 'win' depending

on how much care went to the patient," explained Orlo Dietrich, a health-care consultant who helped set up PCN. "You can't have financial bickering where people's lives are at stake. And you can't have runaway spending. We kept racking our brains trying to come up with a system where everybody would give a little and get a little in return, and this was it."

A reform like this where everybody gives a little and gets a little in return sounds like an ideal model for a health-care system that is basically on track but needs improvement: ours, let's say.

During the 1970s there was a hue and cry over the emergence of a diagnostic machine called the computed-axial tomograph, or CT. A CT scanner cost $750,000 to acquire, plus several hundred dollars a shot to use. Every hospital seemed to want one, for prestige as much as diagnosis. It was said that soon everybody who entered a hospital would be scanned, and hang the expense. Here was proof at last of the medical-industrial complex run wild! Health-planning agencies tried to block acquisitions of scanners; editorialists expressed consternation; legislation was introduced to restrain CT mania.

Somehow missed in the hubbub was that CT scanners represented a fantastic step forward for medicine. Conditions could be diagnosed far more reliably. The horror of "exploratory surgery," in which a patient is cut open merely to figure out what's going on inside, could be reduced, and dangerous tests eliminated. Which would you rather be: probed with a scope, or scanned?

And though no one could deny that scans were costly, painting the proliferation of CT's as an excess overlooked another relevant consideration—that mass manufacturing, made possible by a multitude of orders, would cause the price to fall. Today, when inflation is taken into account, CT's cost about half what they did a decade ago. More than three-quarters of America's secondary and tertiary hospitals now have the machines, and no one is complaining.

The CT is instructive because it exemplifies most of the arguments about technology in medicine. New developments usually (not always) add to society's medical costs. They also usually (not always) lessen suffering. How can a wealthy society such as ours turn away from creating the best possible medical care, the kind of care that not only saves individual lives but relieves the anxiety of loved ones as well?

The best—as in the sentence, "Doctor, I want the . . ."—is the phrase nearly every American, given a choice, utters about care. "We can only talk about medical technology rationally when we don't need it ourselves," notes Alan Steinert Jr., a Massachusetts businessman who has served on several hospital boards. "In the abstract most people agree that too much is spent on medicine. But when they personally need a liver operation and someone says, 'Fine, we are going to send you directly to the low bidder,' they go berserk."

The search for the best is most pointed in the area of technology. Consider the successor to the CT, the magnetic-resonance imager (MRI), which uses a magnetic field rather than X-rays. The image produced is "richer" than a CT picture; no contrast fluids need be injected, as is often the case with CT's. On the flip side, MRI's make CT's look like bargains—$2 million to $3 million each plus $500 to $1,000 per use.

As they did with CT's, manufacturers are pushing to put MRI's into nearly every hospital. Because the machines must be used 10 times per day for a hospital to break even on its investment, MRI acquisition will inevitably beget some extraneous testing. So how can the sums wasted be reconciled with the tangible good a machine like this may do? Answer—it can't.

Both philosophically and from the standpoint of science, the "correct" level of social investment in health facilities is unknowable. Since Americans like clear answers, the fact that it's impossible to say whether hospitals are buying the right equipment, or apportioning it properly, creates a permanent haze of unease around the medical system: a feeling that nags at people even when things seem to be getting better.

Even useful technology carries with it perils. Possessing equipment creates a psychological disposition to run tests; and a legal imperative as well, since failing to run a test may be ground for a lawsuit. Among physicians the saying is, "If a doctor has a machine in his office, he's going to use it." Unnecessary high-tech tests usually only generate needless bills. Sometimes they cause outright harm. Dr. Anthony Scialli, a Washington, D.C., obstetrician, described a cascade of technology-triggered errors:

A fellow obstetrician gave a new examination called an alpha fetoprotein (AFP) test to one of his patients. It came back positive. The AFP is reasonably, though not completely, effective at predicting whether a baby will be born with a defect such as spina bifida, which often, though not always, causes profound retardation. The drawback is the test sometimes appears to find defects that aren't really there.

The obstetrician administered a second AFP, also positive. Next he performed a sonogram. This sound-wave viewing of the womb can determine the exact stage of pregnancy, which has bearing on interpreting AFP results. But the sonogram was inconclusive. The doctor moved on to an amniocentesis. This procedure accurately predicts birth defects but also may lead to spontaneous stillbirth. This is an effect doctors do not know how to control, and it happened to the woman in question. Her baby, now lost, was revealed to have been perfectly normal all along.

"We are conditioned to think that technology produces clear yes-or-no answers," said Scialli, who opposes routine use of the AFP test. "When a doctor suggests a test, patients almost always agree. If he argues against a test they become suspicious. Patients want to believe the tests are smarter than the people who devise them."

Affording the Best

Medical technology does not always add to cost. Many drugs are extremely cost-effective. Antibiotics, which foil potentially fatal diseases for a few dollars, are masterpieces of value, as are vaccines and analgesics. An evolving form of technology serving both health and cost control is "noninvasive" surgery—operations which entail a minimum of cutting or none at all.

Sports fans know about arthroscopic surgery, which in the last five years has transformed many types of orthopedic injury from a calamity to a brief inconvenience. To repair a knee, rather than open a wide slit by the patella and fold back layers of tissue—an "invasion," in surgical terms—doctors make a hole the size of a dime and insert a flexible viewing pipe called an arthroscope. Alongside the arthroscope they insert other pipes tipped by tiny grabbers or grinders. These pipes wiggle around tissue that isn't being operated on, leaving it undisturbed. Recovery time for arthroscopic surgery can be weeks or days, instead of months; pain is greatly diminished.

Forms of noninvasive surgery for women are being perfected using instruments similar to arthroscopes. Excision of a tubal pregnancy until recently required cutting and a week of hospital convalescence; now it can be performed with a dime-size entry through the hip, followed by a day of observation. Menorrhagia, or excessive menstrual bleeding, has traditionally been cured by a hysterectomy, an operation both unpleasant and psychologically onerous for women. Now a noninvasive approach using laser light cauterizes the uterus without removal; the operation can be done on an outpatient basis and costs about half what a hysterectomy costs.

Another noninvasive technology coming into use is the lithotripter, a machine which destroys kidney stones from outside the body, using sound waves. Lithotripters are expensive, costing slightly over $1 million apiece, and still imperfect but represent a step forward in patient comfort.

Just how technology will mesh with

DRG's is a subject of intense debate. Executives of medical-supply companies contend that willingness to invest in development of expensive new approaches like lithotripsy will disappear, along with hospitals' willingness to buy them. So far this sounds like a self-serving alarm. Patents for new medical technology are at record levels; sales of magnetic-resonance imagers, lithotripters and other devices are solid.

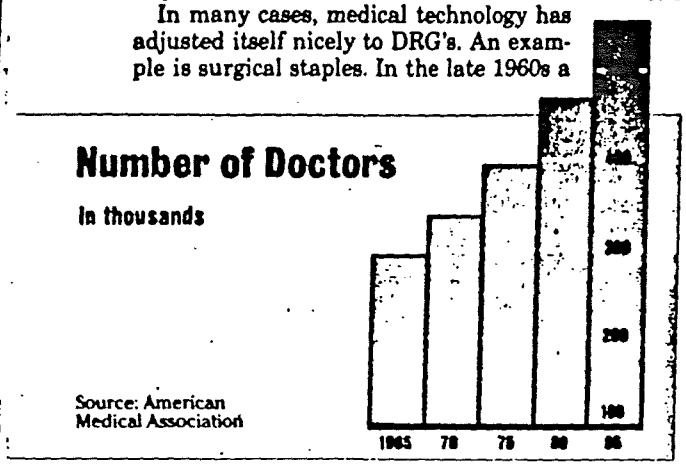
In many cases, medical technology has adjusted itself nicely to DRG's. An example is surgical staples. In the late 1960s a company called U.S. Surgical Corp. began selling surgical staple guns, which are pretty much what they sound—they close incisions using staples rather than sutures. Stapling is much faster than suturing; speeding up the operation is beneficial, because the less time under the knife the fewer the potential side effects from anesthesia, blood loss and shock. The drawback is that staples are about four times more expensive than a needle and thread.

Around 1980 staples appeared on their way to replacing sutures as the technique of choice. Then DRG's hit, and sales slowed noticeably. U.S. Surgical commissioned two studies which concluded that while staples cost more at the O.R. level, faster recovery allowed the typical patient to leave the hospital 3.5 days sooner than a comparable sutured patient—on balance, saving money. This discovery fit perfectly into the logic of DRG's. "Instead of selling to doctors on a technical basis," said Renee Handler, a spokeswoman for U.S. Surgical, "we started a completely different approach of selling to administrators, nurses and purchasing agents." Surgical staplers are now moving briskly again.

Another emerging technology that market forces encourage involves miniature wearable and implantable pumps and testing devices, made possible by microelectronics. The leading "wearable" is the infusion pump—about the size of a cigarette pack, worn around the waist, used to dispense minute quantities of drugs via an inserted needle.

Infusion pumps permit "patient-controlled analgesia," or self-administration of painkillers for cancer victims. The pumps are also being modified for diabetics. Research suggests that receiving very small amounts of insulin throughout the day enables diabetics to lead lives with fewer impositions—eating when they please, for example—and less long-term deterioration.

Several categories of cost-conscious technology point in the direction of home care, a growth industry. Home care entails sending nurses and technicians to check up on patients, refill pumps and so on. Roger Klotz, an official of Caremark, a California company, estimates that a patient who has lost his digestive tract to disease or accident can be fed by tube for $50,000 per year at home while leading a reasonably normal life, compared with $130,000 per year in the hospital. "Some private insurers are now paying 100 percent for home care, as opposed to 80 percent for hospital care," Klotz noted. "This is like offering to split the savings with the patient."



Implantables, pumps about the diameter of a hockey puck, are surgically placed below the skin. Their first use is in chemotherapy. By dispensing chemicals directly into a cancer site (where the pump is implanted), they reduce side effects; by eliminating in-hospital chemo cycles, they make the lives of patients more normal.

Often it is assumed that breakthroughs in medical technology emanate solely from towers full of scientists furrowing their brows over petri dishes and white mice. In truth a surprising number come from inventors, entrepreneurs and private practitioners.

The leading miniature insulin pump, for instance, was created by an engineer named Alfred Mann, who got his start designing solar-power arrays for spacecraft and then founded a company to make helicopter searchlights. He has no formal medical training.

The idea for Mann's current project came to him as he was visiting his mother, laid up in the hospital and attached to a 16-pound feeding machine. "To take her for walks through the hospital I had to wheel around this gigantic apparatus that was always about to tip over," Mann said. "She could have gone home a month sooner if she hadn't been tethered to it." Soon Mann hopes to be selling a miniature feeding pump which will enable some patients once bedridden to be ambulatory. These are the kinds of advances the research community does not anticipate but ends up studying.

An important pure-science leap involves a group of proteins called "growth factors," discovered years ago but only recently synthesized in quantity. Growth factors enable rapid revitalization of body parts. Epidermal growth factor, which instructs the skin to grow, has in tests caused unusually fast healing of some conditions. If growth factors turn out to be affordable and safe, the trend of getting patients out of hospitals will accelerate anew.

When technology promises miracles, however, it can blind health-care professionals and generate costs that are hard to justify no matter how much value one puts on human life.

Seeking prestige, publicity and $150,000 fees, more than 90 U.S. hospitals have opened heart-transplant centers in recent years. But just 730 transplants were performed in 1985, owing to what transplant advocates politely call an "organ shortage." In other words, not enough physically fit young people are suffering brain death in auto accidents, this being a primary source of hearts to transplant.

Unless someone plans to start a crusade *in favor* of drunken driving, it's difficult to imagine what social trend would increase the availability of young human hearts for transplant. It's equally difficult to imagine how 90 transplant centers could become proficient—much less cost-efficient—in this most extraordinary of procedures, doing only a few per year. But the fad goes on: in early 1986 Fairfax Hospital of Falls Church, Va., a facility built at public expense, opened a heart-transplant center. There were already two heart-transplant centers within 100 miles. Lacking hearts to transplant, Fairfax did not perform its first transplant until January 1987. Local press coverage was lavish and adulatory. Now five other hospitals within shouting distance of Fairfax have announced they will establish heart-transplant centers, too.

High-tech artificial organs so far fall into the same questionable category. "It's only a matter of time until a more practical version of the Jarvik is introduced, and then the pressure will be on to implant an artificial heart in everybody who wants one," says Marchlinski, the HUP cardiologist. Jarvik's creators are talking about their new model not as a replacement for failing hearts but as a "bridge" to keep transplant candidates alive until a living heart is found. There's also an invention similar to an artificial heart that has gotten no press coverage because it goes by the boring designation "left ventricular assist device"; it serves the bridge function, too. Given the paucity of living hearts, widespread "bridging" could result in very sick patients competing at stunning expense for the comparatively small number of real organs that come along, while lesser heart therapy for others must be rationed.

The federal government has been resisting transplants and artificial organs, on the ground that this technology is focused

on the stages of life where huge investments often lead to only small gains. Right now the FDA is refusing to certify the smaller Jarvik, while HCFA has only reluctantly agreed to pay for a limited number of heart transplants and won't pay for liver transplants except among the young who are otherwise healthy.

Since it's impossible to know what life or even a few extra weeks of life is "worth," the measure to use for deciding issues like this is reasonableness. Trauma centers, MRI's, infusion pumps and many similar technologies are costly but offer society a reasonable return. So far most transplants and artificial organs do not.

Controlling the Best

The ultimate test of reasonableness is played out not in the operating room, but the intensive-care unit. There the costliest activity in modern medicine takes place, the artificial maintenance of life. Mysterious machines are required—respirators, dialyzers, isolation chambers. Blood plasma, immune suppressors and antibiotics flow in great quantities. Nurses are everywhere: usually two per patient round the clock, plus orderlies and aides—easily $50 per patient per hour in labor costs alone. Good ICU's are set up so that surgeons can yank back a curtain and start operating right there, in the middle of the ward, in case something goes wrong and the patient is too close to the line to be wheeled down to the O.R.

There's an easy way for hospital visitors to tell when they are near an ICU. People are moaning aloud in pain. Patients don't cry out much in American hospitals; modern healing practices and pain killers have seen to that. But at the ICU level their conditions may be wretched, and not even the strongest drugs soothe that.

Sometimes a trip to intensive care is temporary, as when the treatment given there allows a patient to recover and walk away from the machines. Everybody agrees that is reasonable. Sometimes the trip is speculation; nobody can tell if the patient is going to recover. The reasonable view is that even when the prospects are dim, it would be a crime against nature not to try.

But increasingly, the trip to the ICU is the last step in a long life. More money may be spent on these patients than on dozens of others who have their lives ahead of them. Medicare won't pay for senior citizens to buy eyeglasses so they can read while they have their health. But it will pay for a respirator. Is this reasonable?

Today one-third of Medicare spending on the typical American occurs in the final year of life. An estimated 10,000 Americans are being sustained in what doctors call "persistent vegetative state." Maintaining life in an ICU costs a minimum of $100,000 annually. That's roughly $1 billion per year to keep heartbeats present in the forever comatose.

Perhaps, since society cannot answer the question of where the soul of a brain-dead patient stands in relation to the wishes of God, some of this expense is unavoidable. But much more commonly, those on a final trip to the ICU will die soon no matter what is done by the hand of man. The spiritual question becomes much different when death is near. Does a brief postponement of this finality, coupled with added physical agony for the patient and emotional anguish for the family, accomplish anything?

The question itself is new. Machines capable of preventing the very sick from passing on did not become widely available until the 1970s; there are no families in which the previous generation had to face the heartbreaking question of whether to put grandparents on life-suppport systems.

The modern respirator grew out of machines developed as aids to surgery. Use was to be temporary; the idea that someone would be hooked up and left there was not in the plan. Then, through the 1960s and 1970s, hospitals began to acquire more respirators than needed for surgical recovery. Once the machines were in place, it simply became the next standard step, as the terminally ill deteriorated, to pass them up the line to the ICU.

Everyone in the medical community knew at some level that hooking a terminal patient up to machines was fiscal foolishness when eyeglasses were being denied to the living. But the system is programmed to react after conditions become grave. We can endlessly debate abstract issues of technology and allocation, but when someone is lying on a bed gasping for breath, every normal human being's instinct is to help him breathe. After the machines click in, we feel reprieved from dealing with the larger questions and sit back waiting for nature to solve the remaining dilemma.

Now that intensive care is in common use doctors increasingly view the answer to whether it is reasonable for terminal patients as no. Not all feel this way. Some hold religious or philosophical convictions that life should be sustained no matter what; others believe that courts or legislatures, not physicians, must decide the issue; still others, trained through a lifetime to keep patients breathing, simply can't bring themselves to do differently.

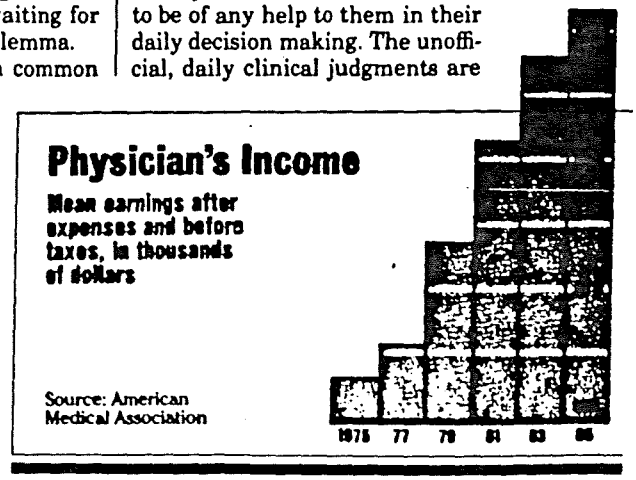
Many physicians deal with hopeless sickness using a concept called "stop in place." That means continuing to do whatever they were already doing but starting no additional sustenance. Stop in place is often ordered for brain-dead patients in comas, whose essentially normal bodies may function many years. For the elderly and for terminal-cancer victims, patients whose bodies are deteriorating irrevocably, the doctor's quandary centers on how to respond to a heart attack, an event which in the intense scientific spotlight of the ICU may be thwarted many times, but only temporarily and to no happy end. On the charts of such patients an increasing number of physicians write the fateful letters DNR—do not resuscitate.

"The publicity goes to cases like Karen Quinlan, but the conventional DNR situation is a thousand times more frequent," says Dr. John Hansen-Flaschen, an attending physician at University of Pennsylvania Hospital. "Day in and day out, DNR is the toughest issue we face."

Do not resuscitate has nothing to do with pulling the plug—what the Quinlan case was about. It means that if a terminal patient begins to die on his own, don't interfere. A few years ago doctors only whispered about DNR, often pasting the initials on medical charts with stickers that could be removed later, leaving no written record. Now the concept is common.

Because the order may not be recorded, nobody knows how often DNR's are written. One recent study found that physicians in a medium-size San Francisco hospital wrote nearly two DNR's per day. The median DNR patient was 74, almost precisely the present life expectation for an American.

Some states allow families to make such decisions; in others, courts must rule; sometimes the patient's informed consent, pre-ICU, is required; sometimes disconnections and DNR's are forbidden. Laws and precedents have been changing so frequently for the past decade that many doctors consider the flow of mutually contradictory court cases far too muddled to be of any help to them in their daily decision making. The unofficial, daily clinical judgments are



often more important than court cases anyway, since these determine whether patients get into connect/disconnect situations in the first place.

"When you sit down with older patients, you find a surprising number have already thought this through, and almost all say they do not want to be hooked up to the machines," Hansen-Flaschen said. "They don't want to suffer at the last, and they don't want their savings wiped out so there is nothing to leave for descendants. But the key is you must do this before lucidity is lost. If you wait, it not only becomes impossible to know what the patient wants, but the legal picture transforms. Things get much more complicated."

Like so many delicate questions in medicine, there is no set procedure regarding whether a physician talks to patients about DNR issues, or when. "Talking through death with a patient can be very draining and also time-consuming," Hansen-Flaschen noted. "Physicians are no more eager to confront the subject than anybody else."

Courts tend to approach life-prolongation questions as though they were civil-rights cases, with the individual at the center. But in the hospital, decisions often turn on families, who are looked to when the patient is not lucid, and whose emotional suffering, while having no legal standing, is nonetheless real.

"When it comes to consulting with families," Hansen-Flaschen continued, "everything is the reverse of talking to the patient himself. The family hasn't thought about ultimate questions. They have been dealing with the declining health of a beloved relative by pretending it isn't happening. Even when the day comes and grandmother is rushed to the emergency room, they cling to the family's internal fantasy that nothing is going to change."

Now comes a fork in the road. "It all depends on how the physician phrases the situation," Hansen-Flaschen explained. "If he says, 'What do you want me to do?' the family will respond, 'Do everything you can. We want the best for her'."

This may not be what grandmother herself would want, and viewed from a social perspective the response can be seen as selfish, but as the question is phrased it is virtually the only reply a loving relative can make. "On the other hand," Hansen-Flaschen said, "if you say, 'Having reviewed the situation and discussed it with other doctors, I feel the kindest thing we could do would be to let nature take its course,' families will almost always agree to that. The distinction is whether you make the family feel you are putting them on the spot or that you are trying to help them resolve an impossible choice."

In 1986 Hansen-Flaschen presided over four cases of withdrawal from the machines. He described one:

"It involved a woman whose elderly husband was in an irreversible coma. His brain waves were flat. I talked with her and the rest of the family, with several other physicians and with the nurses who had attended him. We waited a few days in case anyone decided to change their minds. Then we went to the bedside.

"The woman was standing by her husband. There were two other physicians present, plus several nurses. We joined hands and said a prayer. Then the wife left. I administered morphine, in case her husband still had any inner sensation of discomfort. We removed the respirator. We all stood by, watching for any sign. He was peaceful. About an hour later he left us. His wife came back in to kiss him goodbye, and later she thanked us for helping him go in the way he would have wanted."

The issue of depriving living beings of mechanical sustenance is fraught with pitfalls, religious and legal. How much better would the whole picture be if doctors adopted a standard of talking the question through before the stage of artificial prolongation is reached—to keep people out of this moral quagmire in the first place?

Dr. H. Tristram Engelhardt Jr. of Baylor College of Medicine is fond of saying, "Doctors want to play God, but they don't have the resources." Society doesn't, either. Did Hansen-Flaschen do the right thing by letting out of the world someone who could have been kept there longer? Yet keeping him would have been "playing God," too.

Man plays God by setting broken bones, extracting tumors, transplanting livers; man plays God by hooking the old up to machines; man plays God by unhooking them. Nobody knows what God himself thinks of all this play. We do know that society has limited resources and that human beings have limited reserves of emotion; both are better spent on the living than on the nearly departed.

The Catch: Serving the Poor

Unlike the nation's many half-empty hospitals, Cabrini Medical Center, a teaching institution in lower Manhattan, is bustling. Occupancy runs at almost 90 percent.

Cabrini serves a demanding clientele, the poor. A quarter of its patients occupy "public beds"—admitted under Medicaid or with no resources at all, their care to be paid for by the order of nuns that sponsors Cabrini.

The length of stay at Cabrini averages 11 days, much longer than the national average, because poor patients are usually sicker than middle-class ones. The poor don't eat properly, their living circumstances are unhealthy, they don't have access to preventive care and, yes, some are pretty irresponsible about looking after themselves. Many of Cabrini's patients are street people who qualify for admission when they have a specific medical problem Cabrini can address, such as pneumonia or strep throat. Once cured they are discharged to the streets to get sick again.

"The idea that we can extend optimal care to the poor is a mirage," says Dr. Angelo Taranta, chief of medicine at Cabrini. "Incidence of rheumatic fever, for example, corresponds with square footage of floor space in a person's living quarters. I can give shots which cure the fever, but I cannot give a less crowded place to live. Even if you treat everyone equally in the hospital setting, the poor are still going to end up behind, since they start from a worse position."

Because Cabrini sits in one of the rare areas in America where rich and poor are compressed together—it is a short walk to Gramercy Park, a vestige of *fin de siècle* Manhattan elegance, and also to the Bowery—it is one of the rare hospital settings where everyone *is* treated equally. Public beds at Cabrini are a financial concept; in the halls, bag ladies mumble side by side with society matrons.

Mingling of the classes in American health care occurs infrequently not by design but through the same dynamic that makes suburban public schools so much better than inner-city schools, even though both operate on the same principles and teach the same subjects.

Those among the poor who live near teaching institutions like Cabrini are well served. But most poverty care is delivered by city or county hospitals in the crumbly parts of town or by "Medicaid mills," the truly dismal clinics found in inner cities and depressed rural areas. Medicaid mills are run by dropouts from the respectable part of the health-care system: doctors whose credentials are questionable, seedy businessmen who could scarcely care less about their clientele.

Here we find the catch in the changes at play in modern medicine. Basically, things are good. People are getting healthier; medical technology is improving; costs are stabilizing; there are plenty of hospitals and physicians. To the extent that the system is increasingly driven by market forces it can be trusted to serve the typical patient well, because the typical American is middle class and the American middle class commands a vast quantity of money that the market seeks. But by the same token, a market-driven medicine will flee from the poor. That's basic business logic. No seller of expensive goods would locate in the ghetto or the backwoods.

Not only do the poor lack money, they

don't have much in the way of insurance, either. Medicaid, the federal program for the disenfranchised, covers only 21.6 million of the 33.1 million Americans under the poverty line. Much of the working poor and the lower middle class who don't qualify for Medicaid are "medically indigent"—meaning that they can pay for their basic needs but that adding a medical expense wipes them out.

During the Reagan administration, spending for Medicaid has not increased as rapidly as that for Medicare; nothing at all has been done for the medically indigent. In 1985, for example, the federal government spent $70.5 billion on Medicare, $21.9 billion on Medicaid (about a third of which went to the elderly, since Medicaid pays long-term nursing care for the impoverished old) and granted to corporations tax breaks worth about $30 billion for private group-health insurance. State and local governments contributed an estimated $25 billion to Medicaid and to support of city and county hospitals. There are more senior citizens than poor people, but most senior citizens are middle class; so after you juggle those figures around you find that government devotes approximately twice as much to health-care assistance for people of means as it does for those without means. That doesn't make health-care assistance to the middle class bad. It just puts our priorities in perspective.

The Key Question: Are We a Stingy Society?

Because Medicaid, unlike Medicare, is state administered, the quality of programs varies. Defenders of this arrangement say it fosters "local control," "federalism" and so on. What they really mean is, "Let somebody else worry about this." It's no coincidence that Medicare, a program with uniform federal standards and full federal funding, serves a segment of the population whose living circumstances have steadily improved since its creation, while Medicaid, a partly funded program with sporadic enforcement, serves people whose lot grows worse.

In some states Medicaid pays enough for hospitals to break even on poor patients, but everywhere its payments to doctors are far less than can be made from Medicare or private insurance. Therefore the Medicaid mills, which dispense physician services such as examinations and prescriptions, practice "bulk billing"—making the patient come back repeatedly for little things in order to generate multiple invoices.

Since only a sainted few first-rate physicians locate their practices in depressed areas, emergency rooms are the doctor's offices of the poor. The poor also have their babies via emergency rooms, rather than under a private obstetrician's care. Forty-five percent of self-pay or no-pay hospital discharges involve some aspect of maternity, Vanderbilt University sociologist Frank Sloan has found. Because poor pregnant teenagers often have premature babies—babies that can be saved by technology, but at a staggering postnatal expense—this aspect of emergency-room politics is a sensitive issue in medicine.

A logical and discrete free-market response is simply to have no emergency room for the poor to enter. Many hospitals built in recent years, particularly for-profits, lack them. Another logical free-market response is to dump poor patients, shunting them off to public hospitals. The first question asked in many emergency rooms is, "Does he have numbers?"—meaning, does the patient have insurance?

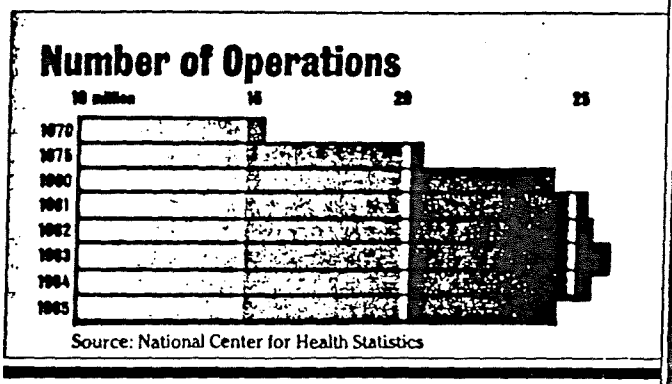
Today a dumped patient is as likely to come from a nonprofit hospital as anywhere else. The Modesto (California) Bee recounted the chilling story of William Jenness, a 27-year-old man severely injured in a 1984 auto crash. Jenness was taken to Memorial Hospital Medical Center of Modesto, a nonprofit. When officials discovered he had no insurance and could not post a $1,000 down payment, they transferred him to Scenic General Hospital, a public facility, despite the fact that he was badly wounded. As a result, surgery on Jenness did not commence until four hours after the crash. Jenness died on the operating table; the autopsy report noted almost a quart of blood in his chest cavity.

Disgraces like this are rare; that's why they make the papers. But dumping under less dire circumstances is, by all estimates, up. Dr. Robert Schiff, a physician at Cook County Hospital, Chicago's public facility, has found that 24 percent of patients transferred to Cook County from private (for-profit or nonprofit) hospitals are in unstable condition.

Private hospital executives often maintain that since the purpose of the tax-supported public hospital is to care for people who don't have resources, there is nothing wrong with transferring indigents to the institutions created with them in mind.

On one level, this line of reasoning is hard to dispute. Unless America as a society is willing to determine that everyone should receive equal medical care—a determination the people's representatives in Congress have strenuously avoided—there exists no reason beyond pure voluntary choice why private hospitals should be expected to provide for patients when public alternatives are available. In fact, moving such patients to public facilities has advantages. Society can acquire a clear fix on how much indigent care costs, instead of hiding the figure in subsidies and write-offs.

But this reasoning works only as far as it goes, which is not far enough. The quality of care in most public hospitals is not as good as that in most private hospitals, and care delivered to the poor by most Medicaid doctors is abysmal compared with care delivered by most private physicians. If America were a society struggling to get by, this might be a necessary evil. But America is the richest and strongest society in history. If with all our wealth we begrudge the healing of the poor, we are the stingiest society as well.



Source: National Center for Health Statistics

In his book "Just Health Care," Tufts University philosophy Prof. Norman Daniels has argued that while access to unlimited medical technology regardless of cost cannot be justified as a right—this would add little to liberty, while contravening society's need to organize itself rationally—an increased level of care for the poor can be justified because it bears on equality of opportunity. Someone who has health problems cannot compete equally in the job market or in education. If opportunity is laid before a person and he fails to reach for it, that's his problem. But if he cannot grasp it owing to a curable ailment, that's society's problem.

At the time the Constitution was written, oxygen had not been discovered: whether there should be a right to medical care could not have been debated, for the concept of rational medical science was unknown. But the founding fathers expected their work to be a living document, changing as the times changed, fixed only in respect to certain underlying principles. Rights could be added to the social inventory, if that was the citizenry's wish: a prohibition against *subtracting* rights was what the fuss was about in 1789.

Today it is difficult to take seriously

anyone who maintains that health care should not be accorded the status of a right. Though we've never made it official, Americans have been viewing access to medicine as a right for years—certainly any American over 65, including any conservative, would howl if denied Medicare assistance. The only important argument concerns what fosters this right most efficiently.

Most industrial nations—Britain, Canada, France, Sweden, Australia, Italy, others—say a nationalized system is best. Based on the experience of such countries, the core choice seems clear—access will improve, cost will flatten, quality will decline. Britain, for example, spends only 6 percent of its GNP on health care, compared with nearly 11 percent in the United States, and anyone who walks into a doctor's office there is not challenged to show an insurance card. On the other hand, how many people would voluntarily choose to have an operation done in a British or Italian hospital rather than an American one?

The U.S. approach costs more than other systems, but it also produces the most sophisticated care: an outcome which should not be dismissed as coincidental. Of the socialized nations only Canada is thought to have medicine equal to ours, and its conversion from an enterprise system is most recent. European socialized approaches are possible in part because the money-hungry American system produces breakthroughs others can buy or duplicate.

How to Keep the System on Track

The U.S. choice of private care has been tempered by quasi-socialized medicine for senior citizens and a dose of government bullying so private providers don't completely shirk their duty to the poor. This is the classic response to the challenge of making America prosperous yet not inhumane: for capitalism is a powerful tool but must be hammered smooth by compromise to prevent it from harming the holder.

Whatever national health care may promise in theory, it is unimaginable that in the present political climate the American public would support it. But political climates change. If we are to continue introducing market forces into the delivery of medical services, we must assume that free enterprise will with clockwork efficiency create intolerable disparities in the quality of care and that some counterbalance will be required. So—unless you'd rather switch to socialized medicine—get ready to pay more for Medicaid.

What reforms are required to keep modern medicine flowing in its present, generally positive direction? Here are some:

- Medicaid should be replaced with a federal system similar to Medicare. This will cost more. So be it.
- In a day when senior citizens live better statistically than average citizens, giving public insurance to them but not others stands justice on its head. Either everyone should be eligible for Medicare (that is, there should be socialized medicine), or Medicare should gradually adopt a means test. The 1983 social-security reform made up to one-half of an affluent senior citizen's benefits subject to tax; asking this same group to pay half the true cost of its insurance would be an equitable compromise.
- Catastrophic coverage should be included in Medicare and become a mandatory component of private insurance, as Dr. Otis Bowen, HHS secretary, proposes. A million-dollar medical bill is the sort of expense no one can reasonably be expected to plan for. Since statistically only a tiny percentage of people are hit with huge bills, insurance against this calamity can be created for a socially reasonable cost. The knee-jerk response that this should not be done because it includes a role for government is the epitome of doctrine blocking out common sense.
- One of the few important medical statistics currently moving in a dangerous direction is the number of Americans under 65 who have no insurance at all. At 14.7 percent in 1982, it's 17.5 percent today. That translates into 37 million people.

Some of those 37 million could afford health insurance but are acting irresponsibly. Most, however, are the working poor—overwhelmingly white—whose employers don't provide adequate coverage. Denying them care is morally wrong, and also a failure of pragmatism as the working poor, poised between dependency and productive contribution, are a group it is in society's interest to nurture.

The three basic choices here are to require all employers to provide adequate insurance, while making everybody else eligible for Medicaid; or to create a new insurance system specifically for the medically indigent, or to switch to socialized medicine. The first choice would seem the most palatable.

- "Pre-existing condition" clauses in insurance plans should be done away with. Getting a disease, or incurring an injury, isn't like committing a crime. Why should someone be punished for it? Refusing to cover an existing medical problem is the kind of thinking that makes sense for an individual company and is nonsensical for society as a whole. With the exception of AIDS, where an argument can be made that a national emergency justifies government assumption of costs, insurers should be compelled to sell equal policies to all. Otherwise we'll soon have another great argument for socialized medicine—millions of hardworking middle-class citizens who can't buy adequate health insurance even if they try.
- A motto of American medicine could be: millions for cures, not one cent for prevention. Federal and private insurance should extend coverage for certain precautionary tests (mainly physicals and cancer screening): premiums will rise somewhat in response, but it will be worth it.

At present, for example, few insurers pay the cost of screening mammograms, which detect breast cancer. If a third of the nation's women had screening mammograms annually at the current cost of $125, the expense to insurers would be about $5 billion. Treating breast cancer costs insurers about $2 billion per year. That kind of calculation gives free enterprise a bad name.

- Uniform legal definitions of death and the rights of patients must be enacted; physicians should be required, when possible, to address this subject with patients before they become incapacitated.
- The courtroom portion of malpractice should be focused on deciding the guilt or innocence of the doctor, in order to force bad doctors out of business; the money-award portion should be handed over to arbitrators who would resist the emotional pressure to grant windfalls to a lucky few. States are moving in this direction, but again the pace is too slow.
- Sanctions against incompetent doctors and sleazy health-care facilities should be pitilessly enforced.
- It should be illegal for doctors or hospitals to refuse any emergency patient, and for hospitals to transfer any indigent for other than medical reasons. Several states have enacted laws to this effect; uniform national legislation would settle the issue.

Hospitals and doctors have protested antidumping laws, saying no responsible medical professional turns away the needy. If so, how can they object to banning that which they claim not to do?

Finally, we must learn to stop fearing change in medicine, since it has almost always been for the good. "The mood of depression about health care is totally out of proportion to the actual situation," says Dr. Thomas Lee, a cardiologist at Brigham and Women's Hospital in Boston. "Nobody sensible would want to return to the medicine of even five years ago.

"Physicians especially must stop confusing concern over their own incomes with medicine as a whole," Lee continued. "Our incomes may go down a bit, but doctors will always be well off. We will always have a kind of satisfaction no money can buy. Anyone who feels otherwise has no business treating patients in the first place."

7.