

A PATIENT-ORIENTED REVIEW OF HEALTH CARE
UNDER COST CONTAINMENT

by

Linda Ostreicher
B.A., Hunter College
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Signature of Author _____

Department of Urban Studies and Planning
May 24, 1985

Certified by _____

Aaron Fleisher
Thesis Supervisor

Accepted by _____

Phillip L. Clay
Chairman, Departmental Committee on Graduate Students

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INTRODUCTION

This thesis looks at how patients' interests can best be represented under the current system of health care financing. Since 1980, major changes in government policy have put limits on the reimbursement available to providers under Medicare and Medicaid. These limits made caring for Medicare, Medicaid, and uninsured patients unprofitable for providers in most states. This resulted in intensified competition between providers for profitable patients, which has altered the way caregiving is organized.

Chapter 1 describes how medical costs rose high enough to become a problem. It breaks down increases in costs into two components: increases in input costs and increase in output intensity, which includes both quality and quantity of care. Because it is often not known whether an increase in intensity does more medical good than harm, these are further broken down into desirable and undesirable increases by whether they are driven by medical or other incentives.

Most health care is not paid for by the patient who receives it. Chapter 2 shows how costs are passed from providers, through third-party payers, and ultimately to the public. It attempts to classify cost-containment efforts before 1980 by where in the payment system they took effect. This determined what they limited and where funds they saved could be redistributed. It explains why certain methods are no longer used, and helps to predict the effects

of present methods.

The physician's role is crucial in any system of health care cost containment because he makes most of the decisions of resource use for individual patients. Chapter 3 shows the conflict between physicians' professional authority and the bureaucratic authority of officials of organizations involved in health care: public health departments, hospitals, insurance companies, and government reimbursement regulators. Traditionally, their professional values made physicians lean toward overuse of resources, while bureaucrats preferred underuse. This chapter also discusses how organizations may try to make physicians share their goal of conserving medical resources.

Chapter 4 describes innovations favored by consumer health activists in terms of which shift in power they produce: from bureaucrats to laypeople, from physicians and other caregivers to patients, or from physicians to other caregivers. Changes that shift power away from physicians often use fewer medical resources than physicians would. This has made such changes popular today with bureaucrats attempting to contain costs. This chapter also examines how well the consumer health movement and its goals reflect the preferences of the rest of the public.

When I began doing research for this thesis, I intended to identify areas where the interests of patients and cost-cutters overlapped. I soon found that government cutbacks in Medicaid and Medicare had widened the split between the interests of patients with and without adequate insurance,

and that the area of overlap between the interests of the underinsured and those of cost-cutters had nearly vanished. Anyone wishing to represent patient interests must now acknowledge that different patients have different interests; in this way, the consumer health movement resembles other movements which have tried to increase some kind of equality, and have discovered that the uneven distribution of gains among their members has actually decreased that kind of equality among them.

Chapter 5 shows that the rise in health-care spending has slowed down under the new limits on government reimbursement of providers under the Reagan Administration. This does not have to result from more cost-effective methods of delivering care: there is evidence that it may come from reducing access to care for people with inadequate insurance. It is also not clear that providers have any incentive to conserve medical resources used on patients with adequate private insurance. This suggests 1. that government rate regulation should cover all third-party payers, not just Medicare; and 2. that such regulations should include some way to spread the costs of uncompensated medical care so that they do not fall so heavily on a few providers.

Chapter 5 also suggests that consumer health activists do not need to struggle very much now on behalf of patients with adequate medical coverage because competition makes providers willing to conform to their preferences. However,

the proportion of consumers who have adequate medical coverage is shrinking: unemployment remains high, government benefits are no longer adequate, and the need for long-term health care, a service many plans fail to cover, is growing as hospitals are driven to discharge patients earlier.

Having insurance is no longer enough to guarantee access to care; because of this, consumer activists must address the issue of access to care in terms of getting providers to care for the medically indigent instead of extending medical coverage to more patients. There is no legal consensus about to what extent which providers must give urgently needed care to the indigent. There is also little in the way of compensation for those providers who freely give indigent care, so their survival is often endangered. In terms of quality of care, the most useful thing consumer activists may be able to do now is to see that those alternative methods of care which were adopted by the health care system are not misused.

CHAPTER ONE: HOW COSTS ROSE SO HIGH

For over ten years, health policy makers have been trying to deal with the crisis in health care costs. During the 1970s, most experts were expecting a solution that would feature some form of national health insurance or a national health service. Once Ronald Reagan took office, the new spirit of parsimony revealed a simpler, more direct solution: to contain health care spending, simply spend a smaller portion of the budget on it.

Later chapters of this thesis will examine whose health care costs are now being contained, and why. This chapter covers a much less controversial topic: how health care costs rose so high in the first place.

It is generally recognized that there are two major components in the rise of health care spending. One is the inflation of costs of inputs; the other is the increase in the quantity and quality of health care delivered. Martin Feldstein and Amy Taylor analyzed health care spending from 1950-76, during which time it rose from \$21.66 to \$102.33 per U.S. citizen in 1967 dollars. They found only about half the increase was due to a rise in factor costs, and half of that rise was due to wages of health care workers catching up with wages of workers in other economic sectors. The other half of total health care costs they attributed to greater intensity of care, in such forms as new employees and new technology (1).

Rising medical costs are best understood in the context

of the changes in health care delivery since the turn of the century; most of them began to rise long before the latest surge in costs. There have been three changes driving them: 1. the increase in desirable services delivered; 2. the increase in undesirable services delivered; 3. the increase in the cost of inputs.

It is necessary to distinguish between desirable and undesirable increases in services delivered because medical knowledge is rarely absolute. There are many treatments whose uncertain benefits must be weighed against uncertain risks. No one knows exactly which treatments are more harmful than helpful; over the years many generally accepted treatments have been found to produce more medical harm than health.

Now that costs have become a factor to be considered in medical decision-making, medical services can be undesirable for two reasons. The traditional reason, which still matters, is that services that do more medical harm than good are undesirable. The newly valid reason is that services that cost more than they are worth are undesirable.

The phrase "services that cost more than they are worth" sounds simple, but with respect to health care services it is very ambiguous. An ordinary transaction involves only two parties, buyer and seller; a health care transaction often involves a three parties. A provider--such as a health care professional or facility--sells the service. The service is typically bought, however, by three parties: the one who chooses it, who is usually the

patient's physician; the one who receives the service, who is the patient; and the one who pays for the service, who is usually the insurer. The phrase "costs more than it is worth" raises the questions, "Costs whom?" and "Is worth to whom?"

A service can cost a doctor time, a patient discomfort, and an insurer money. The relationship between these three parties will determine whose costs effectively influence the decision. The same service can be worth different things to the three parties who compose the "consumer": the doctor's benefit might be a high fee, while the patient's benefit might be a decrease in the risk of more severe illness. Much of the controversy over health care policy concerns disputes over which parties' costs and benefits are decisive in determining whether society breaks even on a particular service rendered, given that "society" is a mixture of doctors, patients, legislators, public health officials, hospital administrators, health-care facility stockholders, taxpayers, nurses and many other parties, who are often the same people in different roles. Thus a service that to some parties falls in the category of "desirable" is often "undesirable" to others.

REASONS WHY MORE DESIRABLE SERVICES ARE BEING DELIVERED

1. Demographic change in the American population: Since the turn of the century the American population has, of course, grown; it has also grown older. The increased fraction of the population which is over 65 causes an increase in the

number and intensity of services delivered because old people are sicker than young people.

2. More chronic illness: Most of the increase in expected lifespan over the last century is due to a decrease in deaths from acute illnesses. That means, among other things, that people now live long enough to develop chronic diseases, and that once they have developed them, they can survive longer with them. Acute illnesses are vulnerable to fast, cheap measures like vaccination and antibiotics. Chronic illnesses now use 80% of all medical expenditures, because they require expensive measures like open-heart surgery and long-term skilled nursing care (2).

3. technological progress: This is related to the increase in chronic disease. Until the twentieth century, doctors could do very little for any kind of disease. It is now clear that the great conquest of the major nineteenth-century causes of death, the acute illnesses, was due more to such public health measures as clean water than to medical interventions like inoculation (3).

After World War II, a burst of progress was fueled by vastly increased spending on medical research and development. Although this had little effect on mortality statistics before 1968, it had great success in reducing pain, disfigurement and disability. From 1968 to 1975, death rates dropped 14%. The causes of death which did not decrease in frequency were those which require more of a social than a medical solution, such as homicide, suicide, and to some extent, cirrhosis of the liver (4).

4. Broader medical insurance coverage: Health care spending rose from 4.4% of the gross national product in 1950 to 10.8% in 1983 (5). It is quite likely that this could not have been financed by individual patients, who now pay only 24% of costs (6). Right after World War II, only about a fifth of the U.S. population had health insurance. By 1975, a combination of government and private insurance paid two-thirds of all medical bills (7).

During the Depression, hospitals and doctors had trouble finding enough paying patients to keep themselves in business (8). They set up nonprofit insurance companies to supply them with patients. Hospitals formed Blue Cross agencies in each state, which insured subscribers for their hospital expenses; doctors, more slowly, formed state agencies of Blue Shield, to provide coverage of physician bills.

Then came World War II, with its wage and price freezes. These made it difficult for employers to attract good employees in the wartime labor shortage. In 1942, The War Labor Board decided to allow fringe benefits up to 5% of wages, so employers began offering health insurance coverage instead of the raises they could not give. During the war, the population covered by hospital insurance grew from under 7 million to about 26 million (9).

After the war, employers didn't need to give health insurance instead of raises, but insurance was still an attractive bargaining chip because it was tax-free "income"

to the worker. Labor unions were also glad to have a new benefit they could win for their members. By 1954, 60% of the population had some form of hospital coverage, and commercial insurers had more subscribers than Blue Cross and Blue Shield (10).

At this time, to have insurance, you needed either a fairly good job--to provide it as a fringe benefit--or enough income or wealth from other sources to buy individual insurance. In 1958, 78% of households whose heads were fully employed had health insurance. Of households whose heads were retired, only 43% had insurance; where the household head was a temporary laborer, only 36% had insurance. If the household head was a housewife or disabled, the chances of having insurance fell to 32% and 29% respectively (11).

In 1965, Congress amended the Social Security Act to provide 3 levels of coverage for groups seen as needy. Medicare Part A provided compulsory hospital coverage to the elderly under Social Security. Medicare Part B subsidized voluntary insurance to cover physician's bills, also for the elderly. Medicaid, which was added as a sort of afterthought, expanded assistance to the states so that they could provide health coverage for the poor (12).

By 1974, 89% of the population had insurance; by 1982 it had levelled off at around 91% (13). Since then, it has fallen slightly, due to Medicaid cutbacks and the withdrawal of fringe benefits by employers (14).

5. The growth of the hospital's role in healing: At the turn of the twentieth century, the hospital was a special kind of

almshouse where the poor went to die. In 1930, only 1 out of 16 doctors worked in a hospital; 40% of doctor visits took place in the patient's home. In 1935, half of all the births attended by doctors still took place at home. By the 1950s, 96% of all births took place in hospitals (15).

The public image of hospitals, as any typical day and night of television will show, changed to something of a cross between a slightly ascetic hotel and a scientific laboratory. Now that most people had insurance and the hospital had become the home of the miracle cure, patients were willing to go there whenever their doctor ordered them to do so.

6. The medicalization of services: Births and deaths were not the only life events moved to hospitals. Medicine extended its territory to include social problems like alcohol and drug addiction. Many patients in mental hospitals were redefined by "deinstitutionalization" as nursing-home clients, and joined by other aged people who had formerly lived outside of institutions, but found nursing homes the best solution for their needs for care once Medicaid was extended to cover them (16).

It is unclear what proportion of health care visits have always been for nonmedical things like sympathy, reassurance, or help in facing death. It is likely that these have increased as wider medical insurance enabled people who could not afford explicit psychiatric treatment, or whose values blocked that path for them, to go to medical

services with physical complaints created by emotional needs (17).

Though services providing for long-term care and emotional needs are probably ones society is willing to pay for, there are probably cheaper ways of providing them than through the health-care system. As of 1981, 70% of nursing-home clients were paying for their care by Medicaid, which accounted for half of all nursing-home revenues (18).

REASONS WHY MORE UNDESIRABLE SERVICES ARE BEING DELIVERED

1. the technological imperative: Once a new medical technique is developed, the professional ethic of medicine encourages practitioners to use it without questioning whether it costs more than other treatments. Doctors are trained to perform any service that might improve their patients' health by any amount. A recent study found that doctors trained in more academically-oriented medical schools and hospitals ordered more diagnostic tests than others did (19).

Expensive equipment that is bought to lower costs rarely produces the savings expected by its buyers, because it receives more use than the old method because of the very advantages that inspired its purchase, which are usually either easier operation or higher quality of service. The increased use increases total services delivered, which raises society's health care expenses. The equipment also has little resale value once a newer version renders it obsolete, because all health-care providers want to use only the latest and best techniques (20).

2. perverse economic incentives of fee-for-service: Physicians usually bill their patients by the number and kind of services delivered, rather than by some unit, like years of treatment, which would encourage them to restrict services. If patients were billed a flat fee for each year of all necessary treatment, as HMO patients are, physicians would have no financial incentive to perform extra services. Under the fee-for-service system, the more services that a doctor performs, the higher his bill can be.

Doctors' performance of extra services for extra pay can also result in overuse of other resources. As of the mid-1970s, a doctor could earn 50-60% more for hospital than for office time, because he could see more patients in an hour (21). This gave doctors a nonmedical reason to send their patients to hospitals. That they sometimes do hospitalize patients for nonmedical reasons is shown by the finding that hospital admissions rise when there are fewer doctors per capita--and doctors wish to cut their workload--or when the number of empty hospital beds is high (22). Given their incentive to overuse resources, it is important to remember that while their own fees only account for 18% of medical bills, the services they order for their patients generate about 70% of all health-care costs (23).

3. Market imperfections: As described above, the buyer of health-care services can include three parties: doctor to choose, patient to receive, and insurer to pay for the service. The chain can be extended to include the employer

who buys insurance, or the politician who decides who shall be eligible for government insurance and must answer to those among his constituency who vote and pay taxes.

Which services will be delivered depends, in its simplest form, on the choices of doctors, the consent of patients, and the willingness of insurers to pay for a given service. One of the solutions often proposed to the problem of rising health care costs is to make the health care market function more like an economist's perfect market by making patients pay more of the costs of the medical care they receive.

Unfortunately, a perfect market requires consumers to have perfect information about the quality and price of the good being traded. The trouble with the cost-sharing solution is that patients don't know very much about what care and how much of it they need; this is both a cause and a result of the power of the medical profession. Physicians know something about the quality of care they deliver. Insurers know less, but have considerable experience with medical bills which gives them some knowledge of norms and trends. Patients know least and are told little about the medical facts of their treatment and even less about its cost, because doctors know very little of other providers' costs and are forbidden by professional norms from advertising their own rates (24).

Also, in a perfect market no single buyer or seller is able to influence prices. In the health-care market, there are large buyers, like Medicaid, Medicare, Blue Cross, and

Blue Shield, and even some large, self-insured employers, who are big enough to get discount prices from providers. For instance, for many years the costs of treating uninsured patients have been spread over paying patients. However, they were not added to Medicare and Medicaid bills, because the federal government is a strong enough buyer to prevent this.

Similarly, some providers are able to dictate prices to at least some of their customers. Patients who want to maintain a relationship with a family doctor cannot really comparison-shop for a hospital, because each doctor has admitting privileges at a limited list of hospitals. There also is evidence that doctors can set their own prices (25). Even in terms of insurance, patients rarely negotiate the terms of their coverage, because they get their insurance through an employer who offers them, at most, several plans, each of which already has fixed terms.

4. Capital spending: Most hospitals are still privately owned, nonprofit organizations. One economic model of hospital costs says that increased demand, from the various reasons already discussed, led to higher prices because the supply of medical services is relatively fixed in the short run. Thus, for the same quantity of product, costing the hospital the same price to produce, the hospital could charge a higher price. This it did, generating a surplus for 90% of all voluntary hospitals. Not being for-profit companies, they had no owners of equity to absorb the

surplus, so they reinvested them in expanded services (26).

It is plausible that the actions of nonprofit hospitals could have an effect on the whole health care industry, because they provide about two-thirds of all acute hospital care (27). However, I find the above theory unconvincing, because it does not explain why nonprofits raised their prices when their costs were not increasing. For me, capital spending is sufficiently explained by the technological imperative, the relocation of the medical encounter from the home or office to the hospital, and the growing pressure to develop and follow professional norms.

5. Pressure to develop and follow professional norms: Physicians have traditionally considered medicine "more of an art than a science." This is their response to the doubts engendered by the wide variation in treatment techniques between different practitioners. However, in recent years physicians have been under some pressure to choose the currently most widely accepted option. Some of the pressure comes from third-party payers, who use the new accumulation of data on the varieties of practice to determine which variety is in fact currently the most widely accepted.

Much more pressure comes from the fear of malpractice suits, against which the strongest defense is that the disputed procedure was performed in accordance with the medical norm. In 1976, the AMA declared a crisis in the malpractice situation. They surveyed their members and found that three-fourths of them practiced what is called "defensive medicine": to conform to professional norms they ordered

more diagnostic tests and procedures than they personally considered necessary. Nearly 60% of office-based practitioners claimed to have raised their fees due to the rising costs of malpractice insurance. Over 20% of them had stopped performing procedures seen as particularly risky--not because they could harm the patient but because they could lead to a lawsuit. Some insurers refused to offer insurance covering such procedures, at least for doctors who had bad records with them (28).

REASONS FOR THE INFLATION IN INPUT COSTS

1. Increased costs of physician labor: Physicians can delegate many of their duties to hospital employees, from the nurse who inserts an intravenous feeder--a task that was once considered too delicate to be performed by nonphysicians--to the resident who actually performs the operation for which an attending physician bills the patient. The substitution of cheaper labor for that of physicians increases efficiency; the savings are not returned to society as a whole, however, as long as the doctor charges the same fee for "supervising" a treatment as for performing it himself (29). They are not even returned to the hospital in which the doctor practices if he is not on salary, since patients receive separate bills for private physicians' and hospitals' services.

2. Increase in the cost of nonphysician labor: The health care industry employs about 4.3 million workers, making it the second largest employer industry in the nation (30). This represents a large growth in the proportion of the

population that works in health care: more people are becoming hospital patients now than before 1950; and the number of health workers per hospital patient rose from 1.78 in 1950 to 3.04 in 1976 (31).

Except for those of physicians, wages of health care workers lagged behind those of workers in other sectors during the postwar period of hospital growth, partly due to a lack of union bargaining power, which in turn owed much to strong public sentiment against workers who withheld their lifesaving services during strikes. The 1960s brought new militancy to many workers, such as civil service employees, whose jobs were previously thought too essential to allow them the privilege of striking. The strong economy of this decade meant there was enough money around for some of it to go to service workers; health-care workers, whose industry was flooded with Medicare and Medicaid dollars, finally caught up with the rest of the workforce and inflation (32).

3. Monopoly power: There are two kinds of monopoly power which inflate prices of inputs to the health care industry. One is the professional power of physicians to restrict the right to practice medicine and to control most health-care purchasing decisions. I will discuss this more fully in Chapter 2, under the subject of physician as gatekeeper and professional.

For now, the major ways in which the profession can inflate prices are by: controlling the supply of physicians by credentialling and by restricting practice by physician

substitutes; controlling their own fee structure; monitoring the quality of their own services through the peer review system; and controlling the choice of which facilities are used by their referrals, even in cases where financial interest in facilities creates a conflict of interest for individual practitioners (33).

The other kind of monopoly power comes from the increasing corporatization of other health-care providers, a trend which has been accelerated by the effort during the 1970s to avoid duplication of services. This effort was intended to decrease costs by letting only the most efficient providers supply services requiring capital expenditures; unfortunately, it conflicted with basic antitrust principles by restricting competition between providers and encouraging the creation of local service monopolies.

4. Organizational slack: This is a favorite target of all parties that have to pay medical bills, and they have defined a variety of sources of it. Their consensus is that any industry run on a nonprofit basis could be run more efficiently by managers experienced in for-profit industry.

For instance, the results of a university study of intensive care units at 16 hospitals suggest that "20-25% of patients in the are 'too healthy' or 'too sick' to benefit from their unique services," which include beds costing up to \$1,000 a day (34). In 1973, an insurer found that by simplifying a transfer form from a hospital to an extended-care facility, and by extending coverage to include the

extended-care facility, it could save on total bills and end need for a hospital expansion plan (35).

Commercial insurance companies and large corporations have begun hiring auditors to check hospital bills. They have found overcharges on 90% of large bills checked, leading the president of the Washington Business Group to accuse hospitals of "utter statistical incompetence" (36).

NOTES FOR CHAPTER ONE

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CHAPTER TWO: COST CONTAINMENT ATTEMPTS BEFORE 1980

This chapter will be limited to discussion of the attempts made to cut health care costs before 1980. Until then, efforts were still being made to increase access to care by needy groups, like the poor and the elderly. Because of that constraint, would-be cost cutters were more restricted than their contemporary counterparts are. Efforts since 1980 to cut costs will be discussed in Chapter 5.

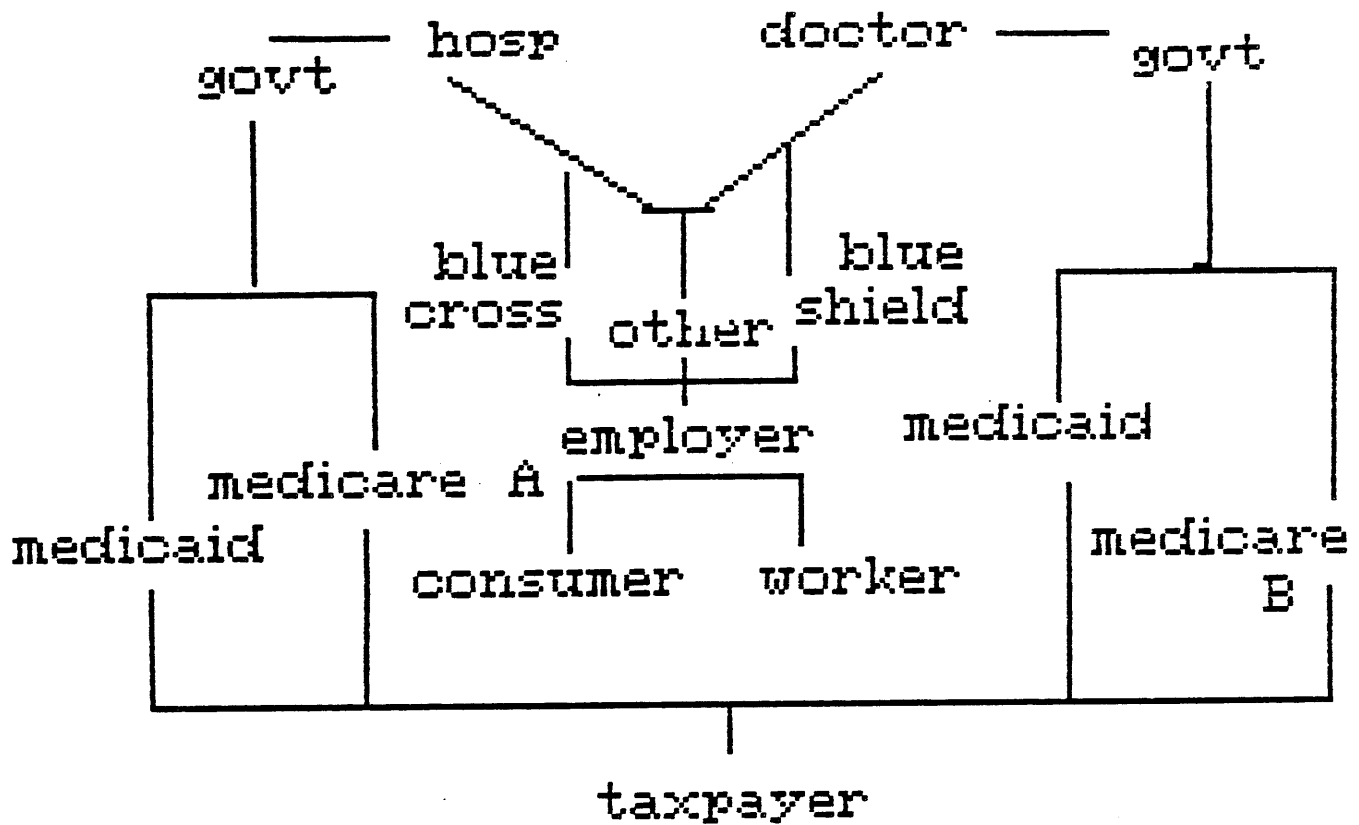
This chapter classifies cost-containment measures by the point in the chain of responsibility to pay, as shown in Figure 2-1, at which the decision is made about which services to cut. In this scheme, allocation of health-care resources can be done by the insurer, the provider, or the patient. A fourth level is that of the supplier of capital to providers. This is not included in Figure 2-1, which shows how health services actually rendered are financed, not how capital expenditures by providers are financed.

CONTAINMENT AT THE LEVEL OF CAPITAL SUPPLY:

There are three major resources on whose expansion the health care system spends most of its capital: knowledge, which is expanded by research; physicians, whose number is increased by spending on medical schools and scholarships; and facilities, which include beds, buildings, and specific equipment.

Hospitals can have three major forms of ownership. Most U.S. hospitals are privately owned, nonprofit entities, also known as voluntary hospitals. A small number are privately

Figure 2-1 How costs are passed down to the public



This is a simplified model of how hospital and doctors' charges are passed down to the public. It does not include charges paid by individual patients for their own health care and insurance. It shows who is held responsible for cost increases by the party just below it. Pressure for cost containment moves up the chart when the lower of two parties resists a passed-along increase.

owned, for-profit entities. The remainder are publicly owned by federal, state or local governments.

Regardless of their ownership, most hospitals receive some government aid for investment. Some of this comes in the form of direct grants and loans, which financed much hospital expansion from 1948 to 1974, under the Hill-Burton Act (1). Other aid comes in the form of tax subsidies, through income tax deductions for philanthropic contributions and for interest earned on tax-exempt hospital or municipal bonds.

Most medical education and research take place at medical schools, laboratories, and teaching hospitals, which also receive government support in the form of direct grants and tax subsidies. In addition, government payments for health care include an allowance for capital spending.

After World War II the government poured huge sums of money into expanding the supply of hospital beds, medical knowledge, and physicians. When the government first began to try to lower costs, it concentrated on halting the increase in hospital beds it had previously encouraged. Next, studies began to show that physicians' fees might rise rather than fall as their numbers increased, so programs to aid their education were somewhat cut back (2).

Eventually a third connection came into focus: that between technological progress and rising costs. Its precise mechanism is still not clear, but its effect has made it quite acceptable to denounce technological breakthroughs as being wasteful of health care resources.

Little has yet been said about at which level savings from not doing heart transplants would be reallocated to other uses. The uses usually discussed in this context are things like primary and preventive health care for children or food for starving people; there are, however, only two levels where funds not spent on heart transplants can be transferred to what may be seen as more pressing social needs--if we manage to agree on what those may be. One is the government, at any of its own levels; before 1980, the idea of funds being redistributed to meet social needs was fairly plausible. The other level is that of the provider, which can increase its share of care of people without insurance, for instance, if it doesn't have to buy the latest advance in magnetic resonance imaging.

In addition to its government sources, the health care industry has access to private capital markets for its capital expenditure needs. Here for-profit entities have the advantage over nonprofits, because they can sell equity as well as bonds, which gives them more control over their spending decisions. Bonds require approval by boards of directors, and in the case of public hospitals, by local residents and public officials.

Another way that government can control capital spending is to limit not the supply of money, but the avenues of spending it. Most of what was called "health planning" in the 1970s consisted of forcing providers to justify their large capital expenditures to government officials, who would then decide to grant or withhold "Certificates of

Need" without which available funds could not be spent, whatever their source.

The first Certificate of Need programs were enacted in the 1960s, by state governments staggering under the demands for their share of Medicaid payments. In 1974, Congress passed a law requiring all states to have a Certificate of Need (CON) program by 1980. Each state was to divide itself into health service areas and to create a Health Systems Agency (HSA) to make health plans for it. HSAs were to be nonprofit entities with a consumer majority on their governing boards, and memberships that were socially and economically representative of their area (3).

State governments were not always pleased about the national CON program; local consumer control sometimes involved restricting the power of more traditional local government bodies (4). The CON program had other problems as well. It was easy to circumvent: approval was only required on purchases priced over \$100,000, so anything that could be billed in subunits falling under that limit passed through. Ultimate approval was given by state governments, who were free to reject the HSAs' recommendations.

A 1980 study determined that the U.S. could save \$1 billion a year by eliminating duplication in 4 categories: CAT scanners, facilities for open-heart surgery and cardiac catheterization, radiation therapy units, and supply of general hospital beds. However, the indirect costs of CON programs, and of moving patients around to the more limited

number of service sources, would reduce or wipe out the gain. The study recommended reduction of demand for services, which has in fact become the strategy for the 1980s (5).

CONTAINMENT AT THE LEVEL OF THE PROVIDER

Varieties of cost containment differ at this level by which unit of spending they control. Simple price controls, like those imposed by Nixon in the early 1970s, are applied to the unit by which costs are billed, which is usually the service (6).

Another method, used by the British National Health Service, is to apply control at the hospital level; each British hospital's budget is fixed at the beginning of each year. In this system that nation is able to have free medical care for all for a much smaller share of its GNP than the U.S. spends on health care. The tradeoff comes in the limits of that free care: patients needing elective surgery wait on long lists for it, and capital spending is put off longer than American standards would allow (7).

During the 1970s there was much hope that the correct unit for containment had been found: the individual patient. Most innovative types of provider organizations, including Health Maintenance Organizations (HMOs) and Individual Practitioner Associations (IPAs), bill each of their patients a flat fee for a year of health care. In this arrangement, the provider assumes the risk and function of an insurer. The problem so far seems to be that, unlike insurance companies, few health care providers can deliver

services over a large geographic area, such as a whole state or the nation. For this reason, corporations whose employees are distributed throughout large geographical areas do not want the administrative headache of negotiating contracts with a different HMO or IPA in each of their plant locations, so they prefer traditional insurance companies.

Unions as well as employers object to HMOs, because HMOs negotiate directly with employers, bypassing the collective bargaining process. This may explain why HMOs are more likely to be found in nonunionized firms (8).

There is a fourth unit of health care which was not used before 1980, although the concept was being developed during the end of the 1970s. That is the episode of illness, a unit difficult to define, in theory. In practice, the hospital admission has turned out to be the most manageable unit for purposes of calculating permissible costs for inpatient hospital care. Diagnosis-related group (DRG) is the name given to the payment unit for this system; each admission results in one major diagnosis by time of discharge; this is combined with other facts about the patient, including age and secondary diagnoses, to assign the admission to one of several hundred standard groups.

I will describe the DRG system more completely in Chapter 5. In this theoretical scheme of cost-containment units I will only stress that the unit of the episode of illness presents a great many administrative problems, which

probably made it impossible to use before the present state of information-handling technology made it financially practical. Previously it would have cost more to administer than it could have saved. Also, it is still not clear how it can be applied to outpatient visits, which far outnumber the episodes of illness that generate them, especially for chronic illnesses.

Cost-containment at the provider level has different effects on physicians and health care facilities, depending on which unit is constrained. Physicians find that if a unit other than the service is used for billing, there is an economic incentive for the provider to provide fewer services than are necessary. If the constraint is on the per-patient charge, the physician will be bearing some financial risk. Physicians in these forms of practice are either proprietors or salaried employees. They personally have an incentive to skimp on services, so they are under peer review to see that they don't do so, and also to see that they don't waste resources. If the constraint is on either the hospital or the admission, physicians in independent practice have no incentive to save money for the hospital in which they have admission privileges. The hospital knows this, and has a financial stake in creating such an incentive. It does so through peer review which concentrates on making sure that physicians are not wasteful; in this case they can be trusted to maintain their own quality standards. In either case, doctors resent peer review as interference with their right to practice in

accordance with their professional judgement about what is best for the patient's welfare.

Unfortunately, peer review was one of the major components of cost-containment strategies of the 1970s and is becoming even more important now. The first Professional Review Standards Organizations (PSROs) were authorized by a 1972 federal law. This created 200 local physician corporations which were to review all admissions and hospital stays by Medicare patients, to make sure all resources used were necessary. They also had a responsibility to maintain standards of quality, but few of their resources went to that end (9).

What physicians would prefer as a focus for containing costs would be to concentrate on their own costs--in particular, those of malpractice insurance. The AMA set about "reforming" not medical, but legal practice. It succeeded in changing many insurance regulations and legal statutes: 41 states, for example, shortened their statutes of limitations for malpractice suits (10).

Hospitals also are subject to malpractice suits; some have attempted to prevent them by giving patients less drastic means of showing dissatisfaction. This led to what success there was for the patient representative program, a reform urged by the consumer rights movement which will be discussed in Chapter 4. This approach tried to discourage malpractice suits by increasing quality of care, as perceived by patients (11).

COST CONTAINMENT AT THE LEVEL OF THE INSURER:

Public and private insurers use many of the same measures to lower the fees they must pay to medical providers. Before 1980, they did little to specify how providers should treat patients, except in broad categories. Patients--and so, to some degree, providers--were informed in advance for which facilities and services insurers would pay. During the 1970s, for instance, there was a gradual expansion of insurance coverage for procedures performed on an outpatient basis; this paralleled an expansion of providers' ideas of which procedures could safely be performed on an outpatient basis.

Within broad categories, insurers might influence a provider's decisions about how to treat a particular patient: for example, a doctor might not discharge a patient from the hospital if the patient had no coverage for extended care, even if the full intensity of hospital care was no longer needed. Yet the tradition of fee-for-service payment meant that most treatment decisions were up to the physician's judgment. The size of the fee paid for the service was usually up to the provider as well, since even government insurers were unwilling to meddle with the power of physicians, for fear of creating or perpetuating a "two-tiered medical system" in which the poor received cheaper and inferior treatment.

This meant that reimbursements to providers were usually determined by what providers reported as their costs for treatment already rendered, and thus were retrospective.

The DRG, admission-based payment system is prospective, telling providers in advance what they will receive for treating a particular case. Cost control schemes based on a fixed yearly payment per hospital or per year are also prospective, but they leave the provider more leeway to allocate the payments they receive. An HMO, for instance, can decide which of its subscribers' illnesses require more resources on a purely medical basis; a hospital under DRGs has that spelled out by its insurer.

One early experience with prospective payment involved nursing homes, in the early days of Medicaid coverage of their fees. States had the power to decide on what basis to reimburse providers; unlike hospitals most nursing homes are and have always been privately owned and for-profit. Most states originally reimbursed them on a flat rate per day, statewide. The result was hardship for those with higher costs and windfall profits for those with lower costs. This gave nursing homes a clear incentive to provide the minimum care they could get away with. Both Medicaid administrators and conscientious nursing-home operators sought an alternative, and came up with cost-based retrospective payment. By 1978, all states were required to adopt a cost-based, retrospective payment system to intermediate care facilities under Medicaid (12).

There is a distinction between the powers of government and private insurers as bearers of costs. Private insurers, Medicare, and Medicaid can all stop the passing of the

health care bill down to employers and the general public, by restructuring the incentives faced by providers. However, private insurers can redistribute health care resources only between services, types of facilities, and their stockholders, if they are commercial insurers. The government has the power to redistribute resources between categories of patients, by defining who qualifies for government insurance. Ultimately, Congress and the state legislatures have the power to distribute funds between health and other human needs.

CONTAINMENT AT THE PATIENT LEVEL:

Containment at the patient level requires patients to make more health care decisions. In this, its supporters resemble those of the consumer health movement, as in that they both call patients "consumers". Beyond these points, there is a great difference between those who favor a "free market" in health care, and those who favor giving patients more rights and powers. I will discuss these differences in Chapter 4, in reference to the consumer health movement.

In order for there to be a free market in health care, patients would need a great deal more information than they now have about their needs and the quality of care offered by different providers. Someone has to bear the costs of getting that information to consumers. Unless patients do most of that work, thereby taking on new costs, some intermediary will have to learn all the relevant information and advise the patient on those parts of it which apply to his or her situation. That is precisely what the doctor's

role is in our present, imperfect medical market.

Free market supporters may not openly wish to shift information costs to patients; they do, however, wish to shift financial costs from insurers and employers to patients. They oppose cost control involving redistribution of resources by government, either at the insurer or capital supplier level, as an interference in choices of the general public as taxpayers, consumers, workers, and patients. They consider the general public biased by present insurance coverage in favor of all the care it can get without having to pay for it. They are not concerned that letting the individual consumer decide how to allocate his own health care dollars decreases the risk-sharing benefits of allocation on a group level.

The three methods most often advised to shift financial costs to the patient are modifications of current forms of insurance: the deductible, which is an amount of medical charges below which the patient must bear the whole cost; coinsurance, in which the patient pays a fixed percent of all bills; and copayment, in which the patient pays a fixed amount on all bills. Unfortunately, it is administratively and politically difficult to set financial costs high enough to influence middle-class people without pricing health care out of poor people's reach.**46 Whatever pricing system is set, middle-class people will tend to reduce their financial burden by buying more insurance from private sources. Two-thirds of Medicare enrollees buy Part

B, the voluntary insurance that covers bills not covered by compulsory Part A. Even in Britain, those who can afford it now buy private health insurance, which enables them to avoid the waiting lists of National Health Service patients.

It is important to remember that the health care system is like a giant Rube Goldberg machine, in which a minor change in who pays for a service can cause major, unpredictable changes in the amount and kind of some other service being performed. A typical example of such a surprise is the event now known as the deinstitutionalization of inmates of mental hospitals.

Between 1956 and 1982, the number of residents in American mental hospitals dropped from 565,668 to 209,449. The predominant explanation for this was that new drugs were discovered and introduced which could chemically control behavior. These made it possible to safely discharge many patients and treat them on an outpatient basis. Another explanation is that a 1956 amendment to Social Security increased the federal aid states could get for maintaining inmates of nursing homes. Many inmates of mental hospitals needed only custodial care and may never have been mentally ill at all, just aged and frail. Most inmates of mental hospitals were in state institutions where, naturally, it cost the state money to support them. By transferring them to nursing homes, some of the cost of supporting people needing custodial care was transferred from the state to the federal government (14).

This example of change is typical of those in the

health care system in that it is hard to attribute the relative importance of three causes, which in this case are: 1. technological progress (new drugs), 2. a change in financing (increased federal support for nursing homes), and 3. a shift of public opinion and support. The shift in public willingness to support mental hospitals came from reformers who wanted to reintegrate the mentally ill into the "community."

This motive became much more prominent in the 1960s and 1970s when many social services were relocated to local providers under community control. In some cases, like the deinstitutionalization of mental hospital inmates, the centralized institutions were dismantled, but no community provider was created to take over its work. Consequently, this change led to further unexpected results, like the nursing-home scandals of the 1970s and the current discovery of the "homeless."

NOTES FOR CHAPTER TWO

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CHAPTER THREE: THE PHYSICIAN AS GATEKEEPER AND PROFESSIONAL

The physician plays a crucial role in the U.S health care system, as the person who controls the quality, quantity, and nature of health care services being delivered. Attempts to contain costs have little chance of success if they do not influence the behavior of physicians in their role as gatekeepers of access to medical services. Attempts to maintain quality of care need doctors' expert knowledge and professional authority to monitor care on behalf of patients.

This chapter will first examine the physician in his original role as the prototypical professional acting as an agent for his client, the patient. In this two-party relationship, the only incentives that drive physicians' choices are their personal ones, which include professional ideals and values, economic goals, and individual sociopolitical beliefs.

As doctors expanded the medical domain and their power within it, they gained control of most health-care purchasing decisions. This gave third-party payers a reason to look for ways to change physicians' incentives so that keeping costs down would become a factor in their decision-making. Some methods have aimed at individual physicians, but the more promising ones try to incorporate the physician into an organization and make the organization find ways to control him.

In discussing these, I will examine situations in which physicians act as certifiers and must consider the interests of parties other than themselves and patients. The physician acts as gatekeeper to other benefits besides health care. He is the final authority on who is sick and who is well for all purposes, including employment, military service, and legal compensation. Because of this, organizations which rely on physicians' definitions of illness have looked for ways to modify their decisions in the organizations' favor.

THE PHYSICIAN AND PATIENT AS PROFESSIONAL AND CLIENT

According to Eliot Freidson, a profession is distinguished by its members' autonomy. To be autonomous, an occupation must have control over a body of skill and knowledge about how to do something considered essential by an elite group in its society. The profession needs to have the authority to license its members and to control the production and application of its knowledge. If outsiders knew how to or actually did perform its tasks, they would be in a position to pass judgment on the profession, which would no longer be autonomous (1).

Physicians control medical research and education, and with them the terms of their own licensing and body of knowledge. Their task is the maintenance and restoration of health, and is considered quite essential by all members of their society, including its elite.

The autonomy of the physician encourages both patients and physicians to hold some questionable beliefs. As part of their medical training, doctors are initiated into a

subculture of very high status and taught to make life-and-death decisions. They learn to accept total responsibility for their actions, some of which must inevitably be fatal mistakes. To maintain high enough confidence to continue "playing God," they come to believe that since they are their own harshest judges, they are also their only legitimate judges (2).

Many patients accept this: illness brings out the child in some, who want their doctor to take all responsibility for healing them (3). Other patients experience a placebo effect, in which any action performed or recommended by the doctor makes them feel better. Some patients, particularly those suffering chronic illnesses, must change their lifestyle if they are to improve their health; physicians tend to think that only their authority as experts can convince these patients to follow "doctor's orders" (4). The traditional difference in power between doctors and their patients is so great that, until recently, the physician had more legal protection from his client than the client had from his physician (5).

One of the major results of the consumer health movement was the research it inspired about the role of the physician's authority in achieving patient compliance with a health regimen. The consensus reached by researchers has been that compliance is best when patients and doctors speak clearly, frankly, and in detail to each other (6). This seems self-evident, but professional authority has

traditionally blocked communication between doctors and patients. Physicians are reluctant to invite patients' requests, fearing they will be large and unreasonable, moreso than they usually turn out to be (7). Some physicians take questions as accusations of their incompetence, and think of questioners as "difficult" patients (8).

Meanwhile, patients are often already made timid and anxious by their symptoms and fears. When doctors still made house calls, patients could at least meet them on home turf; now nearly all encounters take place in hospitals or doctors' offices, further intimidating the patient. To make matters worse, the doctor usually prescribes treatment just after giving his diagnosis. Thus, by the time the patient receives his instructions, he is often too upset to understand or remember them (9). Even nontechnical phrases, like, "This will only hurt a little," have been found to mean very different things to doctors and patients (10). Family members could be useful here, since they are likely to remain calmer and to be able to aid the patient's compliance with orders; unfortunately, most outpatient visits do not include family members (11).

So far, we have seen that well-intentioned physicians' efforts to communicate with patients can be thwarted by the very authority that is the basis of patients' faith in them. The successful physician must be able to tell whether a particular patient wants him to appear omniscient or subject to human error; if he chooses the wrong behavior he will not be able to get full information or compliance from the

patient.

A medical education includes indoctrination in a whole set of professional values. One of those values is the ethical code society expects all members of the profession to follow as a condition of their continued autonomy. To fulfill his role as agent on behalf of his patient, the ideal physician is expected to: 1. provide therapy wherever he diagnoses illness; 2. do everything possible for each patient; 3. assume he has access to unlimited resources, or at least that all resources that are currently present are available to every patient; 4. treat each patient as an individual case, never weighing one patient's claim to resources against that of any other patient (12).

At the same time, students learn in medical school to rate clinical tasks and specialties according to how satisfying or prestigious they are in a value system which has little to do with patients' welfare. Problems are considered important if they are rare, hard to diagnose, and/or difficult to treat. However, problems which are nearly impossible to treat, such as chronic pain from arthritis, are often considered trivial or imaginary and not very interesting. In terms of what they do about a problem, physicians are trained to look at causes and remedies at the individual rather than the social level, which has limited their effectiveness in dealing with problems like occupational diseases and addiction. They prefer procedures which cure to those that prevent illness, and prefer

preventive medicine to "preventive welfare," which supplies fundamentals like food and housing (13).

Doctors also have preferred types of patients. The ideal hospital patient, for instance, is cheerful, undemanding, and capable of full cooperation with hospital routines; as the source of this description points out, this does not sound like a person sick enough to be in a hospital (14).

Aside from all these professional values, which medical students receive along with their other training, the physician has his individual values from the other aspects of his experience. Some of these are also widespread in the profession: most doctors are middle or upper-class, and it has been found that they share information more freely with patients close to their own social level (15). As we saw in Chapter 1, the fee-for-service system rewards practitioners for being lavish with medical resources. Finally, there are sociopolitical values that shape doctors' practices, like their views on abortion or the relative worth of the lives of people of varying ethnic backgrounds or ages (16).

THE PHYSICIAN AS GATEKEEPER TO MEDICAL SERVICES

Physicians are gatekeepers to medical services because they have a monopoly on prescribing most medicine and performing all the medical services they are willing to do. They are the dominant profession in medicine, controlling and defining all other medical professions, from pharmacist to nurse's aide. Another face of this dominance is their ability to classify a profession as not being "medical" if

they cannot control it. Social workers, for instance, have a great deal to do with the health of their clients, but are not subject to their orders as nurses are, so their work is not classified as medical, even when it takes place in a hospital setting (17).

New regions are constantly being annexed to the medical domain: substance abuse, child and wife abuse, and rehabilitation all could be dealt with by nonmedical means, and often are. However, where cooperation between professions is needed, it only runs in one direction: from the outside into the medical domain. Teachers, ministers, and social workers refer clients to physicians, but rarely receive referrals from physicians, who are not accustomed to admitting that there are problems that are soluble, but not by their own methods (18). As a result, resources meant for many social, economic, and religious problems flow through the medical system (19).

There have been attempts made in many nations to control physicians in order to limit health-care spending. Comparative international studies show that lay authorities have had little influence over the profession so far (20). In the United States alone, at least five instruments have been tried or recommended, through which it was hoped that individual practitioners could be influenced to decrease medical spending: the distribution of physicians by specialty, government red tape, other physicians, the patient, and the practitioners' own financial interest.

An early effort sought to limit the number of practitioners in specialties that accounted for more spending. For a number of years the government tried to influence medical students to enter low-cost specialties like general practice. It succeeded in reviving that specialty, in the form of family practice, but not in holding down medical spending.

As an example of how government's own red tape has been used as a cost-cutting mechanism: a Medicaid regulation requiring physicians to fill out a complicated form for reimbursement before they ordered treatment was found to lead to less and later treatment (21). The U.S. government has been trying for years to use physicians to police one another: a current effort has made Professional Review Organizations (PROs), composed of physicians, sign contracts with the federal government to reduce hospital deaths and admissions by certain percentages in designated areas (22).

Economists often recommend using the patient to limit medical spending by shifting more of the dollar cost of treatment to its subject. Unfortunately, it appears that patients can control whether they go to seek medical help, but not how much of it they will then receive.

Private physicians' financial interest is the target of current proposals to limit their fees for visits to hospital patients according to a version of the DRG schedule; a similar system would set their fees for office visits at levels determined by a classification of ambulatory visit groups (AVGs). This would mean that performing or ordering

extra procedures would earn no extra income for the practitioner (23).

There probably is no way to control the independent practitioner; that is why the American Medical Association has been defending the independence of the solo, office-based practitioner so tenaciously. It will be necessary to try the other tactic of placing the physician inside an organization and then putting pressure on the organization to find its own way to control him. Deborah Stone has suggested that it may be useful to consider arrangements that organizations other than third-party payers have already used to control doctors.

Stone distinguishes between doctors in clinical practice, whose primary duty is to the patient, and doctors in a certifying role, whose duty is to determine whether patients should be classified as sick or well for the purposes of an organization. Independent practitioners can act as certifiers, as when they give patients physical examinations for employment; the more relevant situation here is that of the doctor employed by an organization to determine whether his employer or another organization should treat a patient as a sick or well person (24).

Certifying doctors differ from those in clinical practice in that they are more likely to distrust their patients' reports. Thomas Scheff has found evidence that clinical doctors, when faced with uncertainty, use the decision rule that it is better to call a well person sick

than to call a sick person well (25). Certifying doctors are under pressure to follow the opposite rule, that patients are well until proven sick, if their organization wishes to conserve benefits that accompany the sick role.

The outcome of the conflict between the professional inclination to be lenient with patients and the bureaucratic preference for stringency often depends on the physician's relationship to the bureaucracy and the particular bureaucracy's commitment to stringency. In 1970, for example, the Social Security Administration allowed 60% of claims by final determination, while the Railroad Retirement system allowed 91% of claims in 1969 (26). If the organization is committed to restricting benefits it grants to sick people, there are three ways commonly used to influence its physicians.

Direct incentives are the simplest, but clearly conflict with professional ideals. Therefore they are not always openly advertised: an example of this is that of the company doctor who receives a bonus for keeping compensation rates down (27). Now that the public image of doctors attributes more greed to them than before, and greed has become fairly respectable, this incentive can be openly used on clinical physicians in the interests of cost containment by insurers and providers.

A second way bureaucracies control certifying doctors is by formal written standards. This was widely used by benefit-granting government programs, as when they spell out the levels of disability that qualify victims to different

levels of compensation (28). When medical criteria lists are used to grant nonmedical benefits, doctors seem to mind this standardization much less than when they are used to limit medical benefits, as by the PSROs. Stone suggests that this is because the physicians do not feel responsible for the nonmedical fate of their patients, as has been suggested above in the discussion of their preference for preventive medicine over preventive welfare (29). Written standards, popular with doctors or not, are becoming much more feasible now that PSROs and PROs have years of their own records to form into standards and computers have made the work of doing so manageable. They play a large part in current plans to limit medical spending by rate-setting.

A third way bureaucracies control certifying doctors is by having other doctors check up on them in some kind of administrative review. In this situation they are not being judged against written standards, but by the expert knowledge of a peer. This is most effective when the certifying doctor and the reviewer are both employed by the same organization and the first doctor feels free to be strict because the patient can appeal his judgment to a more lenient reviewer. The bureaucracy can easily screen appeals to at least reduce their number, thus saving resources, and the strict physician does not have to feel responsible for the fate of the patient (30). It is possible that cost-containers might decide to adopt this method, if, for instance, they put more pressure on housestaff than private

physicians to adhere to written standards; the housestaff knows that dissatisfied patients are always free to appeal to their own physicians. Providers would, however, be foolish to publicize any bias they could instill in their employees by this method.

All three methods--direct incentives, written standards, and the right of appeal--can be most effectively adapted to the needs of providers if they can put health-care purchasing decisions in the hands of a doctor whose role is limited to that of certifier. To the extent that a physician can specialize in diagnosis rather than therapy, he can feel that his employer is not interfering with his meaningful professional power, which is the prescription and performance of treatment.

The most common and costly health care provider organization is the hospital, which is different from most organizations. Before we see how the certifying role might fit into a hospital, it is necessary to determine how hospitals were organized before they faced cost-containment pressure.

Jeffrey Harris has described the hospital as two business firms in one. In this model, there is a supply side run by administrators and a demand side run by doctors (31). The supply side is made up of what are called "ancillary departments": radiology, pharmacy, operating rooms, cardiac catheterization lab, intensive care unit, and blood bank are usually ancillary departments. The demand for these departments' products is determined by physicians who are

organized into "clinical services" by medical specialties, whose members are often arranged in no particular hierarchy.

The demand expressed by the physicians of the clinical services is itself determined by the needs of their patients; the physician is the intermediary between hospital administrators and patients. An intermediary is needed, officially, because matching patients' symptoms with appropriate quantities of hospital services and supplies requires the expert knowledge of the medical profession. Actually, the physician is also needed because there is a basic conflict between the interests of patients and hospital administrators.

Like any business firm, the hospital has a capacity that is fixed in the short run. The higher the rate of utilization of things for which the hospital must pay a fixed price, like existing beds, salaried workers, and CAT scanners, the more revenue the hospital can earn on those fixed costs. Hospital administrators prefer to operate at a level as close as possible to full capacity. The needs of patients, however, are unpredictable over time. For any fixed amount of capacity, there are bound to be some patients who could derive some benefit from a larger capacity, since there will inevitably be a time when there will not be enough operating rooms, for instance, to hold all the patients who want to have surgery before their doctors go on summer vacation. For patients, it is thus

better to have excess capacity that sits idle until they need it (32).

In Harris' model, the physician is still acting in the interests of the patient. For the sake of the patient, within any given capacity, physicians have reason to compete with each other and haggle with officials in charge of the ancillary services for things that are in short supply. Harris suggests two ways risk of shortages is avoided. One way is to put the risk of a shortage outside the hospital entirely by limiting admissions so that there are never crises of excess demand. In institutions that do this, doctors feel secure enough to share pooled resources, which can then be allocated as "efficiently" as possible.

If admissions are not limited, physicians will directly face the risk of shortages. They then will learn to hoard scarce resources, often by marking certain supplies as the property of their own clinical service. This will produce pockets of excess capacity in each clinical service, which is less efficient than pooled reserves (33). The administration's power in this situation will be expressed by making rules which it will enforce to a degree that varies with the tightness of supply.

Harris claims that this model makes it clear that there is no point in putting pressure on hospitals to keep costs down if the pressure is not directed to the doctors' side of the organization (34). We have seen, however, from Stone's analysis that there are ways to transfer physicians' allegiance from patients to bureaucratic goals. One hope of

third-party payers of medical costs is that putting pressure on hospitals to contain costs will force them to learn how to make this transfer.

The transfer cannot be clumsily forced upon physicians by hospitals, for instance, refusing admitting privileges to wasteful doctors. Hospitals are dependent upon physicians to supply them with customers; traditionally their only other source has been the emergency room, which draws a disproportionately high percentage of uninsured patients (35). They are now trying to become less dependent on physicians by "marketing" their services and clinics directly to patients and entering into arrangements with HMOs who provide another source of admissions.

At this time, though, hospitals must still use less obvious methods of control on physicians; an effective one is to make clinicians feel more like the certifying doctors Stone studied. The distinction matters because certifiers have no ongoing relationship with patients and do not bear responsibility for their health and treatment.

Private physicians have eroded their own relationships with patients to the extent that they have let hospital employees take over their tasks. They no longer accept full responsibility for the patient once they become unavailable on nights, weekends and vacations. They may give orders to the hospital staff, but the staff is also under administrators' orders, which will be followed at least some of the time. The intrusion of other hospital employees into

the doctor-patient relationship means that the doctor has other relationships which require their own loyalty, especially since they are more a part of his ongoing daily life than is any particular patient (36).

Physicians are more willing to take orders from other physicians than from hospital administrators, who are therefore wise to concentrate their efforts on individual physicians who can be groomed to head clinical services. It has been common for quite a while to appoint physicians as chiefs of radiology, pathology, and lab services; these specialists have no private patients and thus no patients' interests to conflict with those of the hospital.

There are even overlapping interests of bureaucracy and professionalism; they both seek authority over the patient. The mystique of the professional is heightened by health workers under him who withhold information from patients. It does not matter whether this is a result of bureaucratic buck-passing or professional dominance; the alliance of professional and bureaucrat strengthen them both with respect to the patient (37).

Of Stone's three ways of controlling doctors, the one most conspicuously being used in hospitals now is that of written standards, as in rate-setting schemes and utilization review by peers. Salaried physicians are, of course, subject to financial incentives from hospitals. These incentives become much stronger in prepaid plans, in which a given pool of physicians and other health workers is responsible for all care at a annual fixed fee per patient.

Table 3-1 shows one of the major effects of the financial incentive or, perhaps, the lack of it in prepaid plans. British general practitioners receive a yearly fee for each of their regular patients, and often cannot charge extra fees for extra services performed. Almost one-fourth of them think the majority of their patients come to them with trivial complaints; this is in sharp contrast with most U.S. primary care physicians. The only category of U.S. primary care physicians in which a larger fraction of members thinks the majority of their patients present trivial complaints is that of the physicians in prepaid practice.

This pattern may be partly due to the fact that patients in prepaid plans have no economic deterrent to make them screen their own complaints. However, prepaid plans can use bureaucratic deterrents to impose nonmonetary costs on clients, such as long waits for appointments, or inconvenient hours or locations (38). Studies of doctors in prepaid practice have shown that they work under greater time pressure than fee-for-service doctors and give less time to each patient (39). They are less likely to agree that doctors should work long hours and sacrifice themselves for patients than are fee-for-service practitioners; they are less tolerant of patients with obesity, alcoholism, and other psychosocial problems (40).

Holding the actual health status of practices constant, physicians in prepaid practice are more likely to

TABLE 3-1 Reports concerning trivial consultations in varying practice settings

	Reporting 50% or More Patients Are Trivial %	Reporting 10% or Less Patients Are Trivial %
British general practitioners (<i>N</i> = 772)	24	12
All nongroup U.S. primary care physicians (<i>N</i> = 1148) ^a	7	36
All group U.S. primary care physicians (<i>N</i> = 310) ^a	10	36
Nongroup U.S. general practitioners (<i>N</i> = 604)	9	33
Group U.S. general practitioners (<i>N</i> = 113)	13	27
Nongroup U.S. pediatricians (<i>N</i> = 136)	9	31
Group U.S. pediatricians (<i>N</i> = 43)	9	33
Prepaid U.S. general practitioners (<i>N</i> = 108) ^b	32	7
Prepaid U.S. pediatricians (<i>N</i> = 154) ^b	29	14

^a Includes general practitioners, pediatricians, internists, and obstetricians.

^b Includes physicians in practices involving 50 per cent or more prepaid practice activity.

Source:

David Mechanic, The Growth of Bureaucratic Medicine, New York: John Wiley and Sons, 1976, p. 106.

complain that their patients' complaints are trivial if they have too little time to see patients. Under these conditions, it is not surprising that doctors have little patience with the large part of medical practice that is composed of emotional and social problems since they are trained more for technical solutions to strictly medical problem. Unlike fee-for-service physicians, those in prepaid plans cannot even rid themselves of exasperating patients by encouraging them to seek help elsewhere; "elsewhere" would be a coworker in the same plan who would not appreciate the referral (41).

Patients who chose to see private physicians, when asked why they had not chosen to switch to a prepaid plan they were offered, expressed a high value for their established relationship with their family doctor and a fear of impersonal care (42). Patients enrolled in prepaid practice, compared to private patients, showed less satisfaction with their doctor's concern for their health, his warmth, his interest, and the amount of information he gave them (43).

It is important to remember that just because physicians limit the expenditure of their own effort on patients, does not mean that they limit their use of other resources. In fact, overloaded doctors in prepaid practice have been found to save their own time by sending patients for diagnostic tests or cutting short an appointment, to be continued at a later visit (44). Although the differences between private and prepaid practitioners may be small in

percentage points, they indicate that prepaid practices succeed in changing the way physicians define the legitimacy of patients' demands.

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CHAPTER FOUR: THE CONSUMER HEALTH MOVEMENT

The "consumer" referred to in the consumer health movement is the patient, not the insurance company or the employer who pays for treatment. There is another term, "patients' rights movement," which is often used interchangeably with "consumer health movement". To me the two have slightly different connotations. I associate "patients' rights" with issues sick people confront when they deal with mainstream medical providers, such as the right to refuse care or to see their own medical records. The right of access to care without regard to ability to pay for it, to the extent that it is acknowledged, falls into this category.

The term "consumer" implies the power to choose, which in regard to health can include choosing to treat a problem in an alternative option to the mainstream medical system, or to take it out of the medical realm altogether. It also conveys a sense of the marketplace, in which dollars are needed to transform need into effective demand; for that reason I associate it more with the desire to overcome nonfinancial than financial barriers to the freedom to make health care decisions.

Many of the demands of the consumer health movement could lower costs, since they involve the use of more "caring" and less technologically intensive "curing" medical techniques. However, lowering costs is not a major goal of the consumer health movement, although it is

becoming important to some consumer groups. Advocates for the elderly, such as the American Association for Retired People, recognize that as Medicare's costs rise, it becomes less popular with taxpayers and their elected officials.

Consumer health activists' overall goal is to capture or reassign some of the power of providers. They favor three major shifts: from bureaucrats, like hospital administrators or government officials, to laypeople; from physicians to other caregivers; and from physicians and other caregivers to patients. A fourth shift of power, from physicians to bureaucrats, is already taking place as described in Chapter 3, but it is not anything consumers wanted.

SHIFTING POWER FROM BUREAUCRATS TO LAYPEOPLE

This often takes the form of decentralization. In some contexts, decentralization just moves power down the bureaucratic chain of command; in the consumer health movement, it puts power outside the bureaucracy entirely (1). During the 1960s, decentralization meant opening small neighborhood health centers to replace centralized hospitals, especially for primary care. Current decentralization takes two forms. One is the shift from public to private, often for-profit, ownership and management of facilities. The other is the transfer of functions from large institutions to community-based programs, which are located either in freestanding local facilities or in the patient's home (2). Health activists do not usually urge the privatization of public care, although they may welcome private innovations that broaden

the options available to those who can afford them. Activists have, however, founded many trailblazing community-based facilities, such as hospices and birthing centers (3).

Decentralization directly threatens the power of hospital administrators. Indirectly it threatens that of health professionals, since many community-based facilities are staffed by laypeople, often on a volunteer basis, or by paid nonphysicians.

THE SHIFT OF POWER FROM PHYSICIAN TO PATIENT

The American Hospital Association (AHA) adopted a Patients' Bill of Rights in 1973, to be voluntarily endorsed by its members (4). It is a tame document: for example, patients are protected from procedures performed upon them without their "informed consent," but verbal consent or written consent obtained without the patient's comprehension of the risk involved are both acceptable. Consent is not required at all in emergency situations or in cases where a doctor fears that giving the patient the information needed to grant consent could cause damage or irrational decisionmaking (5).

The notion of informed consent implies the right to refuse care, which has become quite common in hospitals. Most refusals were of drugs, tests and minor therapeutic measures, but some are life-threatening (6). The right to refuse life-preserving treatment is not clearly defined. When the issue has been brought to court, judges have tended

to order treatment if it will cure the patient, but not if it will simply prolong dying and do so against the patient's wishes (7).

Patients may use refusal of consent as a way to get more information (8). In an analysis of five consent forms from major Los Angeles hospitals, four were found to be as hard to read as a scientific journal; the fifth was at the level of a specialized academic magazine. Another study found that when 200 patients were asked about consent forms they had signed the day before for chemotherapy, radiation treatment, or surgery, only 60% knew what they had signed (9).

In demanding such patients' rights as that to refuse care or to see their records, patients are still depending on the physician to supply whatever care will be given. In two other modes of care, laypeople do the healing: these are self-help and self-care.

Self-care is what it sounds like: the patient tries to prevent, diagnose or treat his own illness. This includes activities physicians approve of, such as complying with their orders, as well as ones they consider dangerous, such as taking medicine prescribed for a previous illness.

To some extent, most people do some self-care; attempting to expand its scope is difficult, because while any consumer is free to decide to practice self-care, the very act of teaching or urging others to practice self-care may undermine the independence needed to do so. Linda Alexander identifies this as the double bind faced by

patients who are being trained to do kidney dialysis on themselves at home: they must learn a complex procedure in which a small mistake could kill them. This threat undermines their confidence just when they are under most pressure from their instructors--medical professionals--to act like responsible, independent people (10).

A recent survey of formal self-care programs found that three kinds of activities are most common: ones to prevent illness or increase "wellness"; "patient education," in which people learn special skills needed to cope with illness they already have; and "activated patient programs," in which patients learn social skills needed to negotiate with providers (11). These are all interventions which physicians consider harmless at worst, since they do not conflict with the use of professional treatment during illness. It is therefore not surprising that 55% of such programs are sponsored by health care providers, and that most use health professionals as instructors.

Self-help is actually misnamed, since it refers to group efforts by laypeople to give mutual aid (12). A British study of the subject found that self-help groups grew rapidly in the 1970s, at a time when organized social services were also expanding. This growth was probably due to the patients' rights movement, since the people in self-help groups tend to be atypical in a way resembling patients' rights activists: they have an unusually strong interest in whatever is the focus of the group, and a

genuine desire to help others. Key members of self-help groups draw on their own past experience to help new members, in what is called "serial reciprocity."

The purpose of self-help groups is to provide support of a kind that professionals cannot give, since it is their members' shared experience of problems which provides help. There are two kinds of problems for which self-help groups can supplement or replace medical services: the need for information and support in passing through a normal development phase, such as childbirth or retirement; and the need for help in adjusting to an injury, illness or therapeutic procedure. The very distance which health professionals maintain to preserve their objectivity and authority prevents them from giving patients reassurance that there is a way of treating what has happened to them as "normal." It is particularly hard for patients to adjust to new, chronic conditions if they have no examples to follow of how others get through everyday life with their condition. Once they have learned how to live with their condition, the chance to help others do so gives them something positive to associate with having the condition (13).

SHIFTING POWER FROM PHYSICIANS TO OTHER PROVIDERS

Almost any provider of care earns less than a physician for treating the same problem. This is one reason why physicians find it so difficult to eliminate their competition. Another reason is that physicians cannot always cure the problems of patients who can afford their

services, who then may turn elsewhere for help.

Alternative providers of care include other professionals trained in mainstream medicine, such as nurses; professionals trained in other medical traditions, such as folk healers, chiropractors and holistic healers; and professionals trained in nonmedical traditions, such as social workers and priests.

An analysis of the social functions of chiropractors from the New England Journal of Medicine is applicable to other alternative caregivers as well. They:

- provide a place to which troublesome patients can go when they leave the physician.
- legitimize the "sick status" of patients for whom doctors can do no more: to be legitimately sick, patients must be trying to get well.
- justify physicians' professional status and privilege by occasionally providing examples of incompetence which can be blamed on their lack of proper training.
- cure some patients, especially in areas in which they are more expert than doctors, as curanderos are in the emotional problems of Chicanos.
- provide more emotional support than physicians, use community support systems more, and fit in better with their clients' values.
- provide an alternate channel of innovation, as chiropractors did in the treatment of musculoskeletal problems by physical therapy (14).

MAKING INFORMATION ACCESSIBLE TO PATIENTS

Access to information about quality of care can shift power from either bureaucrats or physicians to patients. The present environment offers a new combination of low-cost, sophisticated data-processing technology with a decade of information-gathering about providers by regulatory bodies. Third-party payers are beginning to gather and distribute comparative information about provider prices to patients; some of them are including quality-of-care data in this effort (15).

Advocates of competition as a way of maintaining quality of care in the medical marketplace assume a universe of competent providers and patients with varying tastes. In this universe, freedom of choice allows dissatisfied patients to reject a doctor, not for incompetence, but for unsuitability to individual preferences. Supposedly it all gets sorted out so that patients wind up with satisfactory providers, each to his or her own taste.

Consumer health activists see the medical marketplace in a less rosy light. If some providers are not competent, freedom of choice allows patients to leave them, but does not prevent new patients from trying them, because there is no warning of their incompetence. There is little incentive for patients to undertake the effort necessary to warn others about incompetent providers. In England, where patients do not have freedom to choose their health care providers, a mechanism has been set up to process consumer complaints (16). In the U.S., where patients are free to

abandon a physician, there have been no formal alternatives less drastic than malpractice suits to influence physicians' future behavior.

This seems to be changing. A 1975 study of the possible uses of PSRO data noted that "statistical analysis now makes it possible to develop meaningful judgements about the overall performance of individual physicians and hospitals" (17). A recent federal regulation has made PRO data available to patients (18). Some consumer groups are starting to assemble their own databases on providers. In 1981, an information center in California began providing not only traditional self-care information about how to diagnose and treat illnesses, but also information on specific providers supplied to it by patients (19). The founder of this center intended it to "spotlight the bad apples" so medical consumers would know how to avoid them; understandably, physicians objected strongly to there being a database containing subjective appraisals by laypeople of the quality of their work.

Providers had a less hostile reaction to the "People's Medical Society," a group attempting to provide objective data on providers to its consumer members. Its goal is to assemble a database covering all U.S. hospitals, plus as many nursing homes and physicians as possible. The information it gathers on hospitals, for example, includes number of malpractice suits against the staff and the hospital, mortality rates for specific procedures, findings

of PSROs, hysterectomy rates, and physician/nurse staffing patterns (20).

INFLUENCES OF THE CONSUMER HEALTH MOVEMENT ON THE HEALTH CARE SYSTEM

The innovations that the consumer health movement was most successful in bringing to the health care system were those that lowered providers' costs and/or appeared likely to attract insured patients. The Patient's Bill of Rights described above cost almost nothing to adopt and put on prominent display, gives a hospital the appearance of being up-to-date and responsive to consumers, and is vague enough not to require any expensive enforcement.

Patient representative programs began in the 1960s as liaisons between hospitals and community residents. From 1976 to 1981 the number of hospitals with such programs rose from 1750 to 3084, but their function was not what health activists had wanted (21). Hospitals found patients' representatives useful to soothe discontent, not in community residents demanding more services, but in patients who might otherwise file malpractice suits (22).

More meaningful change has taken place in the treatment of childbirth, a major issue of the women's health movement, which may be the best-organized portion of the consumer health movement. However, these changes may conform more to the tastes and needs of the middle class than those of the poor.

The women's health movement had a number of goals concerning childbirth: to win women more say in decisions

about giving birth; to allow women the option of being assisted by midwives instead of or in addition to doctors; to decrease the use of drugs, surgery and technological aids like electronic fetal monitoring during pregnancy and labor; to allow family members to be present during labor; and to make the setting of birth more homelike (23).

Although 99% of infants are still born in hospitals, not freestanding birth centers, hospitals have changed to please women's health activists (24). There are only two freestanding birth centers in greater Philadelphia, but 65% of the region's hospitals have birthing rooms, and all of them now allow family members to be present during birth (25). The use of midwives is still rare, but from 1980 to 1981 it increased by 8% for in-hospital birth and 15% for out-of-hospital birth. It can be expected to increase more now that more insurance companies cover their services. General anaesthesia is rarely used today, and local anaesthesia has been partly replaced by milder painkillers. Unfortunately, without painkillers, mothers need coaching in relaxation and breathing techniques and the support of a friend or relative to deal with childbirth. Many low-income women cannot afford or do not know about childbirth education; single women may feel ill-at-ease in Lamaze classes without a partner (25).

Studies of childbirth taking place outside the hospital show that its medical outcome seems to be equal to in-hospital birth for low-risk women (26). Most women who

choose this option are middle-class, white, and older than the average mother (27). This is partly because low-income women, those under 18, and those who have not had prenatal care are screened out as high-risk cases, but women over 35 having their first child are also high-risk patients and yet are well-represented among mothers giving birth outside the hospital.

This may be an area where, if care is taken to adapt an alternative method of treatment to their needs, low-income people can benefit from it. This is suggested by the results of three studies: one of home births attended by midwives in North Carolina, and two of alternative birth centers--one in the south Bronx and the other in rural Texas. In all three, demographically high-risk women were screened to eliminate those at high medical risk; the remaining women had medical outcomes as good or better than the national averages for in-hospital delivery (28). The reports do not discuss what the women in these studies thought of alternative childbirth. In all three cases, it may have been chosen because it was the least expensive option; the average birth center charges about half of a hospital's fee for delivery (29).

Two other alternative types of care that resemble alternative childbirth are home care and hospice care. They too substitute nurses or other cheaper labor for doctors, involve friends and family in care, and take place in the home or a homelike setting. Consumer health activists favor them because they make care more personal and less

intimidating, while insurance companies interested in their potential to save money (30). These options can be expected to become more available as insurance coverage for them expands; if the consumer health movement wants to protect poor patients as well as richer ones, it will have to see that alternative care is not forced upon people who want or need more technological, professional care, or whose homes and social networks are less comforting than a hospital and its staff.

The rest of this chapter will be devoted to the question of how representative the consumer health movement is of patients, and how representative patients are of all U.S. citizens, and whether the goals of the consumer health movement reflect social values. While the consumer health movement is ultimately an offshoot of the civil rights movement, many of its members, tactics, and ideological tenets come directly from feminism and consumerism. Both of these are supported by movements which have been criticized for their white, middle-class membership, which is assumed to orient them towards white, middle-class needs.

HOW REPRESENTATIVE THE CONSUMER HEALTH MOVEMENT IS OF PATIENTS

The federal government commissioned a pair of parallel surveys published in 1982, in which national samples of health care providers and consumers were asked complementary questions about how and by whom health care decisions are and should be made.

The report shows that 51% of consumers have gone to another doctor for a second opinion on at least one occasion (32). Of those who underwent surgery, 52% based their decision on their own opinion or on a combination of their own and their doctors' opinions. Thirty-six percent of all patients have changed doctors at some time due to a disagreement, and 21% have refused a recommended treatment. A 1978 study of lung cancer patients showed that physicians and patients can have very different preferences for treatment based on the same information: cancer patients prefer less risky therapies with higher short-term probability of survival, while physicians prefer more risky therapies with higher long-term probability of survival (33).

The majority of doctors polled nationwide say that at least once a day they have to make a decision about whether a patient should be told the whole truth about his condition or treatment. For most of them, the primary reason for withholding information is that the patient would not be able to understand it. On the average, doctors think nearly one-fourth of their patients would be unable to understand the truth (34). The public, however, thinks that if a patient doesn't understand his treatment, it is always or often because the doctor didn't explain it well (35).

The responsibility of the physician to obtain informed consent before treatment and the right of the patient to refuse treatment become meaningless once physicians withhold information from patients. If most patients want to take on

all or part of the responsibility of making their own health care decisions, for which they need full information from physicians, then they are in agreement with the consumer health movement and its activists are in that sense representative of most patients.

Table 4-1 shows that most patients believe that increasing their role in decisionmaking would improve the quality of their care (36). Table 4-2 shows that most physicians hold the incompatible view that if patients disagree with them, physicians have a duty to see that those patients are persuaded to change their minds (37). These findings imply that patients' rights advocates are representing the majority of patients in demanding a bigger role in decisionmaking, and in trying to gain some power over physicians in order to do so.

HOW WELL CONSUMER ACTIVISTS REPRESENT ALL INDIVIDUAL CITIZENS

However, there are differences in opinions held by patients of different demographic groups, and in opinions held by doctors whose patients are from different demographic groups. A major finding of the Harris poll was that:

"The older, poorest/low income, and least educated segments of the public are generally the most satisfied with present disclosure practices and least interested in participating in medical decisionmaking. These population segments are also the most likely to be ill. Further analysis of the data reveals that the greater satisfaction...is related to their socially dependent status, not their greater experience with medical situation" (38).

TABLE 4-1

EFFECT OF INCREASED PATIENT ROLE IN DECISIONMAKING: GENERAL PUBLIC

Q.: Do you believe that increasing the patient's role in medical decisionmaking is likely to improve the quality of medical care, reduce the quality of medical care, or have no effect on it?

BASE	GENERAL PUBLIC												
	TOTAL	REPORTED HEALTH STATUS				EDUCATION			INCOME				
		1251	EXCELLENT	GOOD	FAIR	POOR	LESS THAN HIGH SCHOOL GRADUATE	HIGH SCHOOL GRADUATE	COLLEGE GRADUATE	\$7,500 OR LESS	\$7,501 TO \$15,000	\$15,001 TO \$25,000	\$25,001 TO \$35,000
%	%	%	%	%	%	%	%	%	%	%	%	%	%
IMPROVE THE QUALITY	64	63	65	62	59	52	66	67	56	61	66	68	66
REDUCE THE QUALITY	8	9	6	6	11	8	8	6	10	6	7	10	5
HAVE NO EFFECT	22	23	21	23	19	23	21	23	21	24	21	19	26
NOT SURE	7	6	8	8	9	15	6	4	12	9	6	3	2

TABLE 4-2

PHYSICIAN'S RESPONSIBILITY TO PERSUADE PATIENT: PHYSICIANS

Q.: When a patient disagrees with your recommendation for a particular procedure or course of treatment that you think is strongly medically indicated, do you feel that it is your responsibility to try to persuade the patient to accept the medically indicated course of action, or do you feel that you have no responsibility to do this?

BASE	PHYSICIANS									
	TOTAL	OBTAINED MEDICAL DEGREE			PATIENTS WITH SERIOUS ILLNESS			POOR PATIENTS		
		805	1966 AND BEFORE	1967 TO 1972	1973 AND LATER	0% TO 25%	26% TO 50%	MORE THAN 50%	25% OR LESS	26% TO 50%
%	%	%	%	%	%	%	%	%	%	%
RESPONSIBILITY TO PERSUADE	75	75	62	79	74	76	76	75	73	82
NO RESPONSIBILITY	6	6	6	5	5	6	7	5	6	8
DEPENDS (VOL.)	18	18	31	15	20	17	15	19	20	9

Source: The President's Commission for the Informed Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient Practitioner Relationship, October, 1982, pp. 200,211

It is possible that this satisfaction is due to lower standards; poor people make relatively few consumer complaints about anything (39). The elderly and the poor are overrepresented in the category of the less educated. Doctors whose patients are primarily poor people may have lower standards than those who treat richer people.

Table 4-3 shows that doctors work longer hours in a week if they work in hospitals, are recent graduates, treat sicker patients, or treat mostly poor patients. It also shows that doctors who work longer hours are less likely to think their patients understand what they tell them (40). We already saw that doctors who think their patients will not understand them are more likely to withhold information from them. Table 4-3 suggests that the doctors mostly like to treat poor people--overworked residents and interns in hospital outpatient departments--will withhold information from them, thinking it would take too long to explain things to them.

A possible explanation for why people with less than a high school diploma are relatively unlikely to feel their contribution would improve the decisions made about their care is that they might be right--it is possible that they would have to span too wide an information gap because of their lack of basic knowledge that high school graduates take for granted. It is also possible that the lack of a high school diploma is related to low self-esteem in general.

Table 4-3 Hours worked by physicians in various categories

Q.: Let me begin by asking you a few general questions about your practice. Including both inpatient and outpatient care, approximately how many hours do you spend on direct patient care activities in an average week?

	PRACTICE LOCATION			OBTAINED MEDICAL DEGREE			PATIENTS WITH SERIOUS ILLNESS		
	TOTAL	OFFICE	HOSPITAL	1966	1967	1973	0%	26%	MORE
				AND BEFORE	TO 1972	AND AFTER	TO 25%	TO 50%	THAN 50%
BASE	805	533	232	441	97	266	367	229	193
MEAN NO. OF HOURS	53.2	49.7	61.8	48.1	52.6	62.2	50.7	53.7	58
STANDARD ERROR	0.6	0.6	1.5	0.6	1.6	1.3	0.8	1.2	1.5

	PATIENTS						
	TOTAL	UNDERSTANDING TREATMENT			POOR PATIENTS		
		0% TO 69	70% TO 89%	90% TO 100%	25% OR LESS	26% TO 50%	51% OR MORE
BASE	805	150	270	384	500	143	107
MEAN NO. OF HOURS	53.2	56.3	53.5	51.8	51.6	52.9	62.3
STANDARD ERROR	0.6	1.7	1.1	0.8	0.7	1.6	2.3

Source: The President's Commission for the Study of Informed Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent, October 1982, page 82.

One certainty is that all the variables are interrelated--income, education, age, and health status--and that the majority position in favor of patients' rights does not reflect the views of the minority most in need of medical care. Other studies show a strong relationship between having information and recognizing a need for care (41). This is unfortunate, because it means that those who need care the most are least likely to seek it.

This may explain why the easier access to care that Medicaid made possible for the poor never brought them up to quite the same level of use as richer individuals with the same level of illness (42). A 1954 study showed that lower-class Americans were indifferent to most of 17 symptoms requiring attention, while upper-class people reacted to most of them at least 75% of the time (43). A study of Danish patients, who face no financial barriers to care, also found that people with less education and low income were more likely than others to carry on with their usual routines when they were ill. This was especially true for housewives, the self-employed, and unskilled workers, all of whom "pay" for admitting illness and obtaining care to the extent that they lose time from work, since no one compensates or replaces them during "sick" time (44).

One way of looking at this assumes that there is a "culture of poverty" characterized by short-term thinking, resignation, and a stoic acceptance of suffering. Since "culture of poverty" thinking has proved useless in most other contexts, it may be more useful to take the structural

view proposed by Catherine Riessman, which assumes that poor people would seek health care more often if they were not discouraged from doing so by aspects of the health care system (45).

Riessman notes that in the hospital outpatient clinics, emergency rooms, and public clinics where the poor get most of their care, there are long waits to see impersonal doctors who offer fragmented care. A 1972 study found that after the introduction of Medicaid, the proportion of poor patients using private physicians as their source of primary care rose from 1% to only 10%, a fact patients attributed to their belief that doctors in hospitals and public clinics were better than those in private practice (46). It is possible that the private physicians who accepted Medicaid at that time were inferior, especially those willing to open offices in locations convenient for poor people.

In 1984, however, Riessman found evidence that poor people are capable of appreciating continuity of care. One study randomly assigned some welfare families to comprehensive care and compared them to others receiving their usual fragmented clinic care. The families receiving comprehensive care showed much higher use of services, particularly preventive ones, such as postpartum and well-baby care (47). Similar results appeared studies of low-income people using 21 neighborhood health centers: these received more immunization and dental care, and used hospital emergency rooms less. At one center, the polio vaccination rate of children went from 78% to 92% in

eighteen months (48).

There is other evidence that patients who prefer to play a passive role in their health care might change their preference if the consumer health movement made more information available to them. In a study of 210 hypertensive patients and their physicians, 78% patients preferred their treatment decisions to be made by their doctors. However, 55% wanted "quite a lot" or "very extensive" information about their conditions; physicians underestimated this percentage, at 38%. As in the nationwide poll, the patients who wanted to participate more in decisionmaking were disproportionately young, white, higher income, and well educated. A new finding in this study, which followed patients through time, was that the amount of participation patients wanted increased with duration of treatment and experience with hypertensive drugs. Many of those who wanted their doctors to make treatment decisions at the time they began treatment hoped to be more active later, when they would have experience with their medications (49). This finding is particularly interesting because an earlier study found that hypertensive patients who took an active role in their treatment showed mean diastolic pressure that was significantly lower than that of more passive patients (50).

HOW WELL PATIENTS REPRESENT SICK PEOPLE

Another question that must be considered is how well patients represent sick people. As described above, low-

income and less educated people are disproportionately unlikely to seek care when they are ill (51). Therefore, to the extent it is responsive to patients and those who advocate their rights, the current health care system is tailored to the needs of educated middle and upper-income people, who are not the sickest people (52).

HOW WELL THE CONSUMER HEALTH MOVEMENT REFLECTS SOCIAL VALUES

Health care is not just an individual purchase; it is bought by the whole nation in the form of insurance and the other expenses passed through the system of payments described in Figure 2-1. A nation's decision as to whether health care is worth paying for is heavily influenced by the distribution of the real and the perceived risks of illness in that nation.

Lester Thurow has said that our system of health insurance is breaking down now because insurance is only meant for events which occur to a small fraction of subscribers to a plan. Now that most of us will live to be old, the majority of subscribers to any insurance plan will have high medical expenses at some time in their lives (52). For all the talk of home birth, pregnancy is still the most common reason for hospital admission, and everyone needs to be born. Similarly, we all hope to grow old, knowing that we are likely to have some chronic disease if we do.

Society is more willing to pay for services that more of its individual members expect to need. Thus, Medicare is a very hard item to cut from the American budget. It is politically sacred, not only because old people are

considered needy in a respectable way, or because many taxpayers have parents who benefit from it, who might turn to their children for help with medical bills if the government failed to provide it. Medicare is sacred because taxpayers want to believe that they too will someday need it, and by paying for it now, they express their desire to have it remain a benefit to which all older Americans are entitled.

It is not so easy to keep funds for maternity benefits for unwed teenagers in the budget, since nobody hopes or plans to be in the position of either an unwed pregnant teenager or her child. It is easy for taxpayers to ignore the possibility that a person in need of those benefits might be someone they care about enough to provide it for.

In chapter 1, I discussed the problem of cost-benefit analysis in regard to health, which is that it is difficult to quantify the value of a human life, especially when there is no public discussion of whose value of the particular life is being quantified. Our society often chooses to price human life at the value it has to a paying employer. This is the price most often used in legal decisions to compensate family members for a relative's death. In the case of paying for death, it is easy to see that the value of a life is probably higher for family members than for an employer. Perhaps we have refrained from incorporating this observation into legal awards out of a delicacy which recognizes that a monetary award cannot possibly compensate

a family for the loss of a member.

The case of health-care cost decisions is different. Here, money is not an inadequate substitute for a lost life, but just the thing needed to buy continued life. It is therefore appropriate to specify what a particular life is worth, and to whom. This matters a great deal in a nation where the possibility of poor health does not vary randomly from person to person. The fact that education is the best predictor of good health is probably due to education being a composite variable determined by variables like age, race and parents' income, itself determining other variables like present income and ability to communicate with doctors.

People tend to believe poverty and ill health are to some degree caused by their victims. Although a few preventable health problems, like substance abuse and violence, are more common among the poor, no voluntary acts can be shown to insure prosperity and health. "Blaming the victim" may be popular because it makes people feel safer from bad luck: if they are diligent they will be able to afford the apple a day that keeps doctors away.

At the same time, if the public is made aware that health care is being denied to a particular person because of a scarcity of resources rather than the moral failure of that person, people show sympathy for the victim. Thus people are sympathetic to patients waiting for organ transplants. Barney Clark, the first heart transplant patient, was considered a hero for "risking his life in order to save it" (53). Not only does the value of any

life differ between its appraisers; it varies over time with variations in when a cost or a risk is incurred. Like money, health has a time value: future health is devalued, for instance, by a high perceived risk of nuclear war or accidental death. Quitting smoking seems like too large a cost for many smokers to bear when compared to the risk of getting cancer in twenty years. Once a patient has cancer, quitting smoking seems less costly, because the risk he faces is no longer a distant possibility of falling ill, but a present certainty of living a shorter, more painful period of time.

According to Victor Fuchs, "the amount most people are willing to pay for a given reduction in the probability of death is positively related to the probability of death. Thus a person facing almost certain death would usually be willing to pay a great deal for even a small increase in the chance of survival; that same person, facing a low probability of death, would not pay nearly as much for the same increase in survival probability...If we seek a health care system that does what people want it to do..., we should expect considerable inequality at the margin in costs per life saved (54).

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CHAPTER 5: CONSUMER/PATIENT ISSUES IN THE 1980S

During the 1970s, the consumer health movement worked toward two kinds of equality: of patients to one another, and between patients and providers. At the time, these goals did not seem contradictory, because Medicare and Medicaid gave their beneficiaries some purchasing power over providers. Today patients with adequate insurance will find providers competing for their business, and somewhat willing to cater to their tastes. However, those with inadequate coverage will have too much trouble getting access to any services to be choosy about their quality.

In the 1970s, equal health advocates often represented consumers in health planning councils, where they found themselves on the same side as public health officials and government regulators (1). They all challenged the professional authority of physicians to decide the medical needs of either communities or individual patients.

Now that the underinsured are finding it harder to get medical treatment, their advocates will find themselves on the same side as some physicians, against government bureaucrats who are still challenging professional medical authority. In addition, advocates for the underinsured will have to side with physicians against hospital administrators, who now may pit the survival of a whole hospital against the claim of a physician to the resources for one patient. This realignment can happen when physicians continue to base decisions about use of medical resources on

traditional medical criteria, rather than the cost criteria preferred by bureaucrats.

Activists on behalf of the insured, on the other hand, may find their interests still coincide more with those of bureaucrats than of physicians. Health care bureaucrats are beginning to act more businesslike; among other things, they now give paying patients' wishes the weight due to consumer preferences under competition. Government officials are working toward expanding the right of alternative providers to compete with doctors and hospitals. Insurance companies are covering more alternative providers and procedural innovations, like outpatient treatment, which are favored by consumer health activists. Hospitals are responding to competition from alternative providers by absorbing them; they are granting admitting privileges to chiropractors, midwives, and other nonphysicians, and opening freestanding clinics of their own.

Those physicians most intent on marketing themselves resemble the businesslike bureaucrats in that they are free from the traditional professional reluctance to advertise and willing to allow patients to participate in decision-making.**244 Alternative practitioners, on the other hands, have a tendency to claim the prerogatives of professionals to the extent that they take over their functions: they raise their prices and the qualifications needed to join their field (2).

In this chapter I will focus on how the interests of well-insured and other patients have diverged in the 1980s, as

government cost containment efforts and increased competition between providers have altered the health care system. To do this, I will examine the relative effects of government cost containment on different providers; how successful containment efforts have been in keeping costs down and in preserving access to care and quality of care; and what role consumer health activists could play in representing the interests of well-insured and other patients.

There are two major forces behind the changes now underway in the health care industry: the imposition by third-party payers of limits on medical spending, and increased competition among providers for paying patients. It is important to recognize that increased competition in the health care industry does not automatically result in lower costs, especially in those sectors which are not yet under rate regulation but have already benefited from the relaxation of other regulations such as the enforcement of antitrust laws and the lowering of licensing standards. Many of the changes attributed by providers to cost containment could result from competitive pressure without any contribution from rate regulation.

GOVERNMENT COST CONTAINMENT

The third-party payer most concerned with rising medical costs is the government, at both the local and federal levels. The Reagan administration is reluctant to raise taxes, eager to cut spending, and ideologically in

favor of limiting federal activity. State, county, and municipal governments are in many areas subject to taxpayer revolts which limit their revenues. While there is no evidence that the public is against spending a growing share of the gross national product on health care, it does not want to pay higher taxes for this purpose.

Not only is the government short of revenue and unwilling to spend it on health care; it also bears a larger share of health care costs than it used to. From 1965 to 1980, the government's share of costs rose from 26.2% to 42.7%, with most of this growth borne by the federal government. Since 1980, the government share has dropped slightly each year, but only to 41.9% of total spending, with over two-thirds of that borne by the federal government (3). It is important to remember that the government's dependents include the elderly, the poor, and the disabled, all of whom require more medical care than the average citizen (4).

The Reagan administration has called for deep cuts in health care spending for the last five years. For 1986 it has asked for \$330.3 billion for the Department of Health and Human Services, an increase of 3.6% from 1985, which will just about cover inflation. Of this, \$202 billion will be for Social Security; to cover health care spending with the remainder, a number of austerities are proposed. The Administration wants to freeze, at current levels, Medicare payments to hospitals; the direct medical education subsidy to teaching hospitals; and payments to physicians, which are

already under a 15-month freeze. The proposed budget also increases copayments by beneficiaries for Medicare and home health services (5). It has not yet been decided how the 1986 budget will look when Congress passes it, but if the pattern of the last few years continues, the federal government will further disclaim responsibility for its medical dependents.

Each state receives federal reimbursement for its Medicaid expenditures according to a formula based on the state's per capita income, in which the maximum federal share could legally be as high as 83%. At this time, the average federal share is 55%, ranging from 50-78%. In 1982, the percent of each state's bills reimbursed by the federal government was lowered by 3 points; in 1983, by 4 points; and in 1984, by 4.5 points, for a total federal saving of \$455 million (6).

Late in 1982, Medicare regulation was altered to reimburse hospitals in most states on a per-admission basis, rather than a per-day basis. In 1983 diagnosis-related groups (DRGs) became the basis of payment amounts; they are a complex form of per-admission limit. The 15-month freeze on physician fees began in July, 1984. This year a new laboratory fee schedule will reimburse independent laboratories and physicians for only 60% of their costs (7).

THE END OF CROSS SUBSIDIZATION

The modern health care industry has been able to do as

much for as many people as it has because it has benefited from three kinds of cross subsidization. One kind is external to providers, between payers; another is internal to providers, between services; and the third is between different time periods and providers, to pay for medical research and education.

For external cross-subsidies, hospitals have traditionally charged different prices to different payers for the same services, depending on what they were willing and able to pay; thus private insurers subsidized charity care, for example. Internally, hospitals have let their profitable products subsidize their unprofitable products. Unlike most producers, they have nonfinancial responsibilities which require them to provide services which are not profitable, if they are necessary to the community served by the hospital.

In the third kind of cross subsidization, that of medical research and education, payers of bills from teaching hospitals pay now for the training of physicians whose services will be available later, in all health care settings. Here a benefit to the whole society is subsidized by only those payers covering bills from teaching hospitals.

When the government cut back on Medicare and Medicaid, providers either lost clients or had to sell them care at lower prices, which in some cases did not even cover their costs of production. They spread these losses over other payers, who passed them on to insurance buyers. The more power an employer or insurer has over a provider, the fewer

losses from government cutbacks can be passed along to them; this has shifted an increasing burden of provider losses to smaller, weaker payers.

It has also made all providers compete for the shrinking supply of well-insured patients. Under competition, providers do not necessarily have to contain costs: they need only provide more care than average to those who can pay for it and less to those who cannot. Providers' costs are only important as far as they allow prices to patients to be kept at a low enough level to remain competitive in a given provider's market.

THE LARGE URBAN PUBLIC TEACHING HOSPITAL

In a market in which competitors simultaneously struggle to attract insured patients and keep uninsured ones away, this type of provider is in a particularly bad position. The public hospital is responsible for the care of indigent patients. As private hospitals, both investor-owned and nonprofit, decrease their share of charity care, while the number of patients lacking adequate insurance increases, a shrinking share of the patients left at public hospitals are paying patients, to whom the costs of charity care can be shifted (8).

Many hospitals are losing clients to freestanding facilities and doctor's offices, because of the extension of insurance coverage to more outpatient procedures (9). Because these outpatient options can refuse care to indigents, they only take paying patients from public

hospitals, which already devote more of their resources to outpatient services than private hospitals do, while earning a lower fraction of their revenue from them (10).

In 1980, the poor were already concentrated in the 9% of all hospitals which provided 40% of their care (11). The Urban Institute has found that in 1975, community hospitals in the 100 largest cities were earning a slight surplus of 0.7% of revenues over expenses; this turned into a 3.6% deficit by 1981, which grew to a 4.2% deficit by 1982 (12).

When public hospitals are also teaching hospitals, they have more political power but higher expenses. Teaching hospitals must maintain a full range of services, even underused ones, to give students a wide range of experience. Whether publicly or privately owned, they do more than their share of outpatient treatment; if they are publicly owned, it is disproportionately used by poor patients. As Table 5-1 shows, only 15% of hospitals are teaching hospitals with more than 400 beds, but these account for 41% of all outpatient visits, while the two-thirds of hospitals that are small and do not teach account for only one-third of all outpatient visits (13). Teaching hospitals handle the more complex, rare and severe cases of illness, which require more intense use of resources. More of their work is done by or for the benefit of students, which slows it down and also requires more resources, particularly for diagnostic purposes.

Teaching hospitals have always charged high fees to privately insured patients, to pay for teaching expenses and

TABLE 5-1 Hospitals and their outpatient visits by whether they are teaching or nonteaching hospitals

CHARACTERISTICS	HOSPITALS*		VISITS	
	NUMBER	PERCENT	NUMBER	PERCENT
NONTEACHING:				
< 400 BEDS	1,754	67	30,619,772	33
400+ BEDS	89	3	3,175,539	4
TEACHING:				
< 400 BEDS	379	15	20,349,404	22
400+ BEDS	384	15	37,726,036	41
TOTAL	2,606	100	91,870,751	100

* Only hospitals with outpatient departments having 1,000 or more visits per year, who reported their cost data to the American Hospital Association, are included in this table.

Source: Mary G. Henderson and Fay L. Hannon, "Cost Elements in Alternative Settings," in Ambulatory Care: Problems of Cost and Access, Lexington, Mass.: Lexington Books, 1984, p. 182.

also to subsidize the poor patients who were needed as cooperative "teaching material". It has been supposed all along that the cost of a visit to a hospital outpatient department (OPD) was higher than that to a private physician's office: recent investigations have discovered that there is indeed a difference, and it is due mostly to higher salaries, more staff, and services provided in OPDs that are not provided in offices, such as research (14). In large hospitals, the costs of noncounterpart services have been estimated as about \$4.79 of an average total charge of \$49.41 per visit (15).

Teaching hospitals currently receive extra compensation from Medicare for their higher costs, and they often have good reputations and state-of-the-art services that attract better-paying patients than other public hospitals. Still, public teaching hospitals have the highest costs of any type of hospital, and some of them are starting to restrict the care they give to the uninsured who are not in need of emergency treatment (16).

The financial troubles of public teaching hospitals may soon worsen, because in the system the federal government is developing to use in compensating hospitals for outpatient visits under Medicare, there is not yet any provision for teaching expenses (17). Also, because of their more limited access to capital markets, public teaching hospitals may have trouble maintaining their facilities well enough to compete with private teaching hospitals.

OTHER TYPES OF HOSPITALS

Forprofit hospital chains are the ones most discussed in the news, which is not surprising: these firms consciously market their product, and one effective way of marketing is to get free media coverage for events like Humana's artificial heart transplants. Because of publicity, the growth of forprofit hospital chains may be receiving more attention than it deserves. These hospitals only own 9% of nonfederal hospital beds, which share is only up 1.2% since 1978 (18).

However, their effect is concentrated in the South and the West of the U.S.: for the five largest for-profit chains, 70% of their hospitals are in the South and 20% in California (19). Investor-owned chains frankly consider themselves responsible to shareholders rather than sick people. Some will officially treat emergency charity cases if they own the only hospital in a community, but the boundaries of the "community" and the definition of "emergency" are up to them to define (20).

Nationally, the for-profit chains have been successful at keeping out unprofitable patients. They do very little charity care and their share of Medicaid patients varies with how closely its reimbursement approaches that of other third-party payers in any particular state (21). They also are able to resist demand for unprofitable services. In services on which they just about break even, like blood transfusion, they supply about the same number of units per day as the average hospital. Therapeutic radiology, which

operates at a loss, is rarely offered by for-profit hospitals. Overall, however, they supply services at higher prices and in greater quantities per patient and per admission than voluntary hospitals do (22).

Their greatest impact on the health-care system may be their style of management, which voluntary hospitals are starting to copy in their competition with each other (23). Hospital administrators are putting a new emphasis on choosing which services to offer based on which will draw the most paying patients: sports medicine is a moneymaker and outpatient psychiatry is not (24). Some hospitals are signing preferred provider agreements, in which they receive all the business of members of a group under contract in return for charging them reduced prices. This further decreases cross-subsidization, raising the costs for patients not in such arrangements.

Another trend that shows the imprint of the for-profit chains is the increased use of contract management by hospitals suffering financial problems. While only about 1000 hospitals were investor-owned in 1980, another 300 voluntary hospitals were managed by for-profit hospital corporations (25). Hired managers can now be linked to any of the increasingly complicated aggregations of health-care facilities, for profit or not.

Contract managers affiliated with large organization can use the parent organization's market power on behalf of their client. Humana, Inc., which owns 3 of the 4 hospitals in Louisville, Kentucky, recently took over the

management of the fourth hospital--a large, urban public teaching hospital that had been losing money for several years. Humana's success in making a \$1 million profit in its first 16 months as manager has been covered by many journalists, but I only found one mention of how they had achieved it: they negotiated payments for care of the indigent that were 95% of the rate they charged private patients, which was considerably higher than their costs (26). The payments come from a \$20 million trust fund obtained from the city, county and state governments. Once the \$20 million runs out, Humana has agreed to contribute its own money to the fund.

An area where the impact of investor-owned chains is greater than their share of beds might warrant is that of capital investment. For-profit chains are attractive to investors, given their annual profits of about 20% in the past few years. The health-care industry has been doing a lot of borrowing: its long-term debt jumped 95% from 1981 to 1983, with much of that going to finance takeovers (27). One of the largest mergers outside of the oil industry may have been due to the importance of access to capital at low interest rates for hospitals. The New York Times attributed the merger of Hospital Corporation of America, the largest forprofit hospital chain and the largest buyer of health care supplies after the federal government, with American Hospital Supply Corporation, also the largest firm in its field, to HCA's need to improve its debt-to-equity ratio

from 56:44%, which it would have been this year, to 38:62% (28).

Public and private nonprofit hospitals now have to compete with for-profit hospitals for scarce capital, and their debts are increasing. They cannot sell stock in themselves, so they must borrow to raise capital. Their share of outstanding tax-exempt bonds rose from 7.6% of the tax-exempt bond market in 1980 to 11.7% in 1983; this resulted in a rise in the value of tax-exempt hospital bonds outstanding from \$3.56 billion to \$9.55 billion. Standard & Poor's is currently creating a surveillance system specifically for identifying hospitals that are bad credit risks because of Medicare cutbacks (29).

ALL-PAYER SYSTEMS

Since 1983, four states have been granted waivers from the system under which the rest of the nation's providers are reimbursed for Medicare. These four states--Maryland, Massachusetts, New Jersey, and New York--each have their own systems of regulation which differ from the national system in two major ways. They limit reimbursements from all third-party payers, not just Medicare, and they have some provision for covering free care and bad debt.

Their experience suggests that competition might be less fierce under a national system with those two features. Limiting reimbursement from all-payers means that the differential is narrowed between patients covered by government programs and private insurers. This makes government patients less unattractive, widening the pool of

patients providers can market their services to, making a truly competitive situation more feasible.

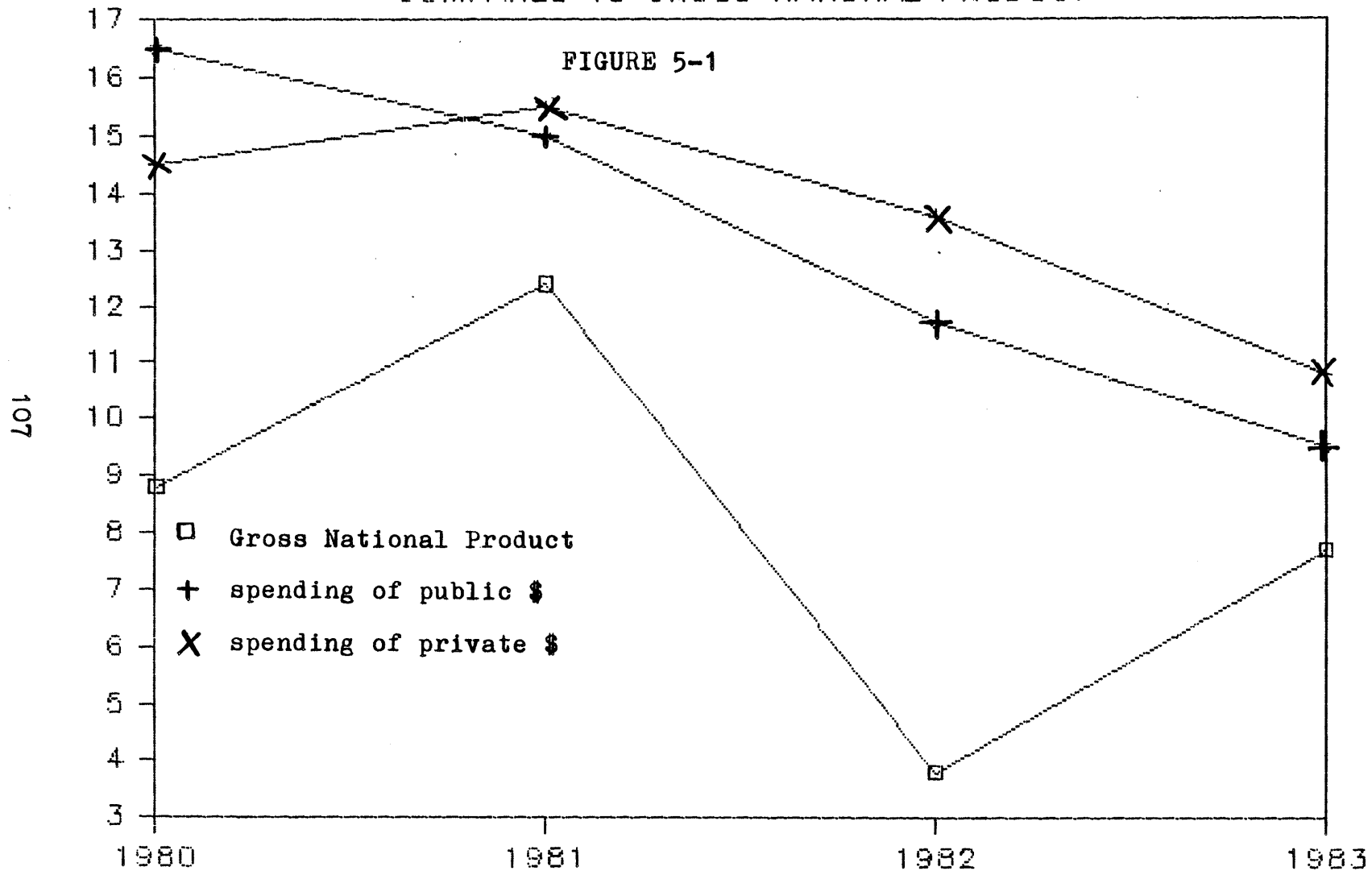
In New Jersey and Maryland, an allowance for uncompensated care is built into the rates for all hospitals. In these two states, uncompensated care is distributed fairly evenly among hospitals. In New York and Massachusetts, hospitals with particularly high volumes of uncompensated care receive extra reimbursement; this means that although most hospitals try to avoid indigent patients, there are a few that welcome them; in Massachusetts, the public hospital of last resort in Boston is on a more solid financial footing now, under rate regulation, than it had been for many years (30).

It is cost-effective for government to concentrate its dependents in as few facilities as possible, so that it will have enough purchasing power with those facilities to influence their prices. The disadvantage of concentration is that such facilities may come to specialize in treating unprofitable patients, which can mean practicing medicine that is inferior, particularly in its responsiveness to patients' emotional needs; in Chapter 3 we saw how compliance with doctors' orders, and through it medical outcome, can suffer from such a lack of responsiveness.

THE SUCCESS OF GOVERNMENT REGULATION IN HOLDING COSTS DOWN

Since 1980, actual government health care spending has continued to rise each year, but as Figure 5-1 shows, the rate at which it is rising has decreased. State and local

PERCENT CHANGE IN US HEALTH SPENDING COMPARED TO GROSS NATIONAL PRODUCT



The Robert Wood Johnson Foundation, Updated Report on Access to Health Care for the American People, Special Report, 1983, pp. 5-7.

governments cut the rate of their rise first, in 1981; the following year their rate of spending increase rose when the federal government cut back sharply on its share of costs. In 1983, both state and federal levels showed a decline in their rates of spending increase (31).

From 1977 to 1982 Medicare's hospital bills rose by 18% annually, on the average, while all hospital bills were rising by 14.6%. In 1983, the Medicare increase to hospitals was only 10%, which is much closer to the overall hospital spending increase of 9.1% (32). Last year hospital admission rates dropped by 5%, and average hospital occupancy rates dropped to 68% nationwide, from a 1980 level of 76% (33). After increasing by an average of 3.5% each year from 1974 to 1982, the number of patient-days of those over 65 years of age increased by only .1% in 1983 (34).

However, when the health care system is constrained in one area it expands in another, like a balloon. While Medicare's hospital costs were being contained, its physician bills rose by 17.6% in 1983, which was half again as high as the overall rise in physician bills (35). Last fall, the federal government announced its intention to regulate Medicare reimbursement to physicians for visits to their patients in the hospital under the same DRG system used for all other bills of inpatients. Now it seems that more services are being performed on an outpatient basis, especially by physicians, either in offices or in the growing number of freestanding facilities, each offering a narrow range of services, which are now competing with

hospitals (36).

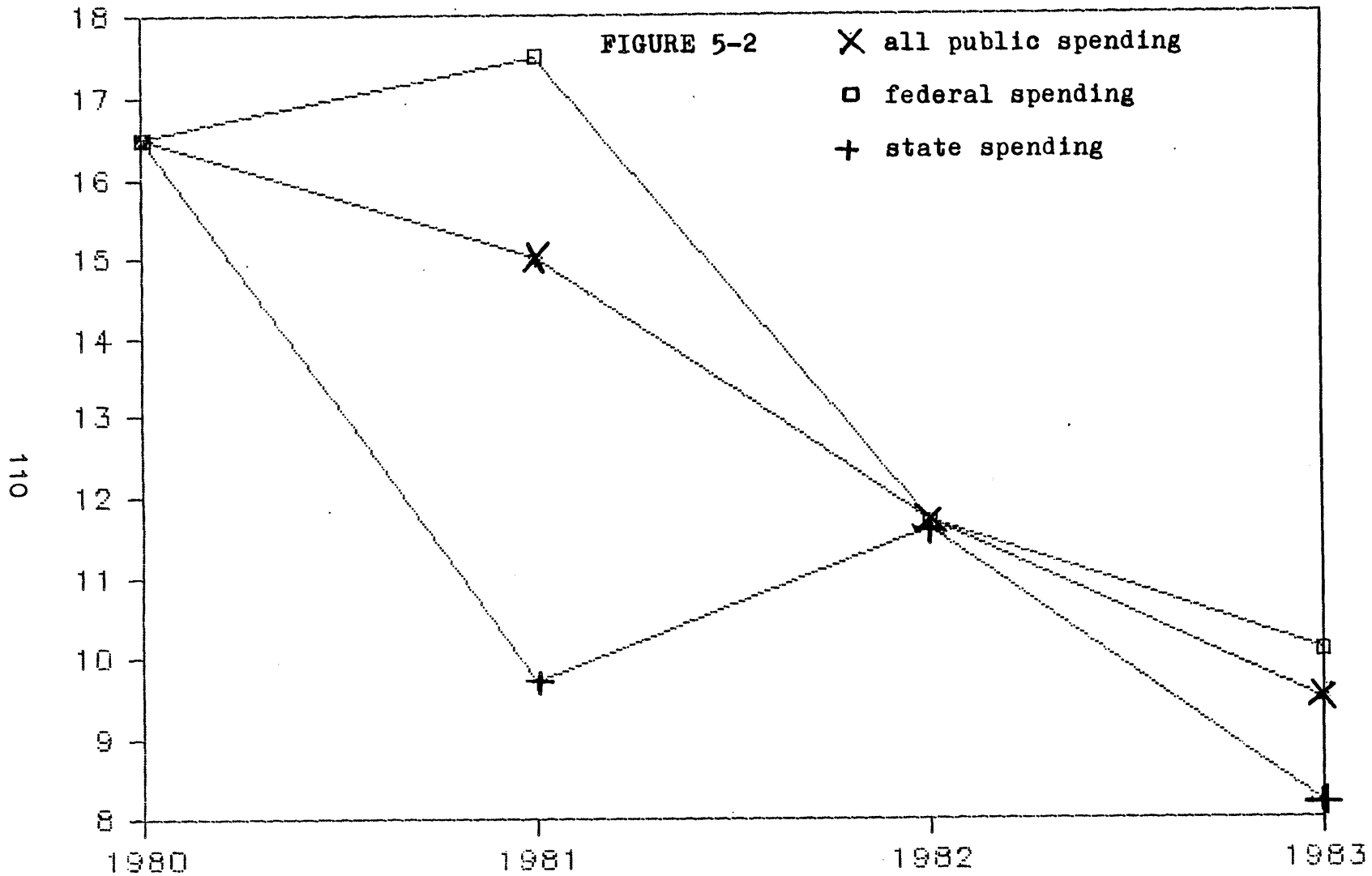
In industries whose high startup costs bar entry to the field of competition, there is a familiar pattern in which a period of price competition, which eliminates weak contenders, is followed by an oligopolistic situation in which a few large producers cooperate among themselves to keep prices up while they compete only on the basis of advertising claims. It is possible that hospitals will follow this pattern; already 35% of them are in some form of linked system (37).

If this does happen, the only costs that will be successfully contained will be those for services which have been removed from the hospital setting. The barriers to entry into the office-based physician's practice and the freestanding clinic are still low enough to allow competition among them to survive. From 1980 to 1984, the number of freestanding clinics approximately doubled, to 249 (38).

Figure 5-2 shows that, since 1981, the rate of increase in health spending has decreased for both public and private payers. A sign of the effectiveness of government regulation is that the rate of increase in government spending has been less than that of private spending during that time (39).

A comparison of states with DRGs only for Medicare with the four states in which charges to all payers are regulated could be expected to show private costs in the all-payer states rising at a slower rate than in the Medicare-only

PERCENT CHANGE IN US HEALTH SPENDING



The Robert Wood Johnson Foundation, Updated Report on Access to Health Care for the American People, Special Report, 1983, pp. 5-7.

states, if the regulation was effective. Unfortunately, there is not even agreement yet as to whether all-payer systems have saved or wasted Medicare funds. The report by Johns Hopkins for the four states indicates they have saved Medicare about \$1 billion, because their overall costs are rising 4 to 6 percentage points less than those of other states (40). The report prepared for the Health Care Financing Administration (HCFA) by the Federation of American Hospitals estimates average costs per hospital admission in the all-payer states at \$3,300, while in other states, the corresponding cost was \$2,600. According to the HCFA, this discrepancy resulted in unnecessary Medicare spending of \$340 million in 1982 alone (41).

A survey of hospital administrators shows that most of them expect a prospective payment system to be extended beyond Medicare to all third-party payments (42). The all-payer states which are not using the DRG system are scheduled to start using it in 1986. The expectation of hospitals under both kinds of regulation that they will soon be living under the other kind may further blur the distinction between the effect of all-payer regulation and that covering only Medicare.

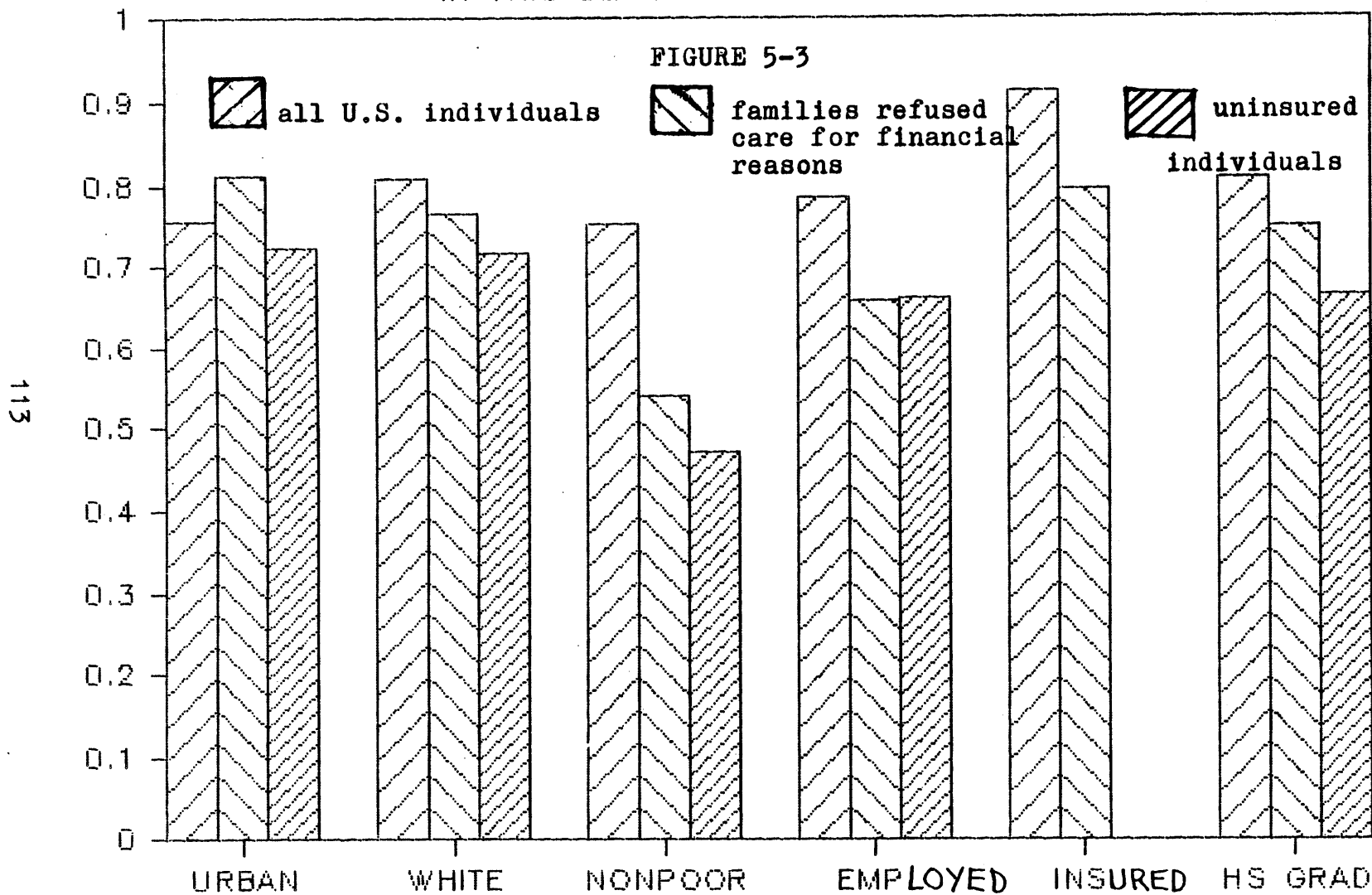
THE EFFECTS OF GOVERNMENT REGULATION ON ACCESS TO CARE

Medicare is offering less attractive payments for specific services, but it is still available to everyone who has always been entitled to it. In 1981 and 1982, state governments responded to the growth of their share of Medicaid bills by restricting their definitions of who was

eligible for it, and for what types of services (43). There has been a lot of opposition to this on behalf of the poor, the providers who care for them, and county and municipal governments who are left with the remaining costs. A number of court decisions have affirmed the responsibility of state and local governments for the medical care of the indigent (44). State officials are now considering expanding access to care again, to be financed by Medicaid, state or local government revenues, or state pools of hospital revenues (45).

I have been referring to a category called "underinsured," in which I include the uninsured, Medicare and Medicaid beneficiaries, and people with inadequate private insurance, particularly of the kind that is limited to major inpatient procedures. This is a hard category to measure because Medicaid varies from state to state, and the inadequacy of private insurance varies with the service needed. A 1982 national survey approximates this category with the functional definition, "families refused care for financial reasons" (46). The characteristic that most distinguishes this group from all underinsured is that "families refused care" had to have had a member, probably sick, who sought care during the previous year. In Figure 5-3, this group is compared with uninsured adults and the population as a whole. This shows that both uninsured adults and families refused care for financial reasons resemble the general population in being mostly urban, white, employed,

% OF THOSE IN ACCESS CATEGORY IN THIS DEMOGRAPHIC GROUP IN 1982



Source: The Robert Wood Johnson Foundation, Updated Report on Access to Health Care for the American People, Special Report, 1983, pp. 5-7.

and at least high school graduates. The largest difference is the poverty of nearly half those refused care and more than half of the uninsured, compared to the general population, of which less than one quarter are poor. More surprising is the fact that nearly 80% of families refused care for financial reasons had insurance, which must have been inadequate for their health care needs.

It would not be very expensive to give medical coverage to a large share of the uninsured because most of them are not very sick. Employers can legally exclude, from their insurance plans, workers who are under 25 years old, have worked less than three years for the firm, or are nonresident aliens. Not surprisingly, the most likely people to be uninsured are 18 to 24 years old, work for only part of the year, and live in the south and west (47).

Many local governments are considering extending medical coverage to indigent children and pregnant women, hoping that this will keep their own costs down, because these are the two demographic groups for whom the evidence for the cost-effectiveness of preventive medicine is most convincing (48). Immunizations can prevent most childhood illnesses now, and prenatal care has been estimated to save about two to ten dollars for each dollar spent on it, because the lack of it appears to result in an increased rate of low birth weight infants who often can only be kept alive by the extremely expensive technology of neonatal intensive care (49). A similar group that is already on Medicaid, that of AFDC mothers and their children, has been

found to generate only about 25% of Medicaid spending although they make up 66% of program beneficiaries (50).

When underinsured patients seek care, all hospitals with emergency facilities are supposed to provide at least enough emergency care to stabilize the patient before transfer. This is not a firmly established legal principle, however, and the phenomenon called "dumping," or "economic transfer," appears to be growing.

There are three varieties of dumping: direct refusal of care, inappropriate referral, and that resulting from disposition problems (51). The most clearcut is the direct refusal of care to patients who lack insurance if they cannot pay a fee or deposit before admission. Even some public hospitals are turning away patients who are not emergency cases (52).

In Illinois, Medicaid only covers the first \$500 of hospital expenses. Private hospitals there deny Medicaid patients all inpatient care, all outpatient care except renal dialysis, chemotherapy, and burn treatment, and all drugs except those required to maintain life (53). As the local public hospital of last resort, Cook County Hospital had 6000 patients transferred to its emergency room from other hospitals in 1984, an increase of 500% from 1979. Unfortunately, emergency cases often need followup care. For the last two years, 400 patients were referred to its General Medicine Clinic each week, although the clinic could only accept 120. No one knows what happened to the others,

or what will happen to all the referrals now that the clinic can no longer handle any new patients (54).

Many states place responsibility for indigent care on counties, which has led to disputes when patients cross county lines for care. They have to do so, in many cases, because their own counties have no free care available (55).

The distinction between direct refusal of care and inappropriate referral is as vague as the legal obligations of hospitals to provide care to the underinsured. Some hospitals prefer to tell patients that appropriate specialists are not available, or that the public hospital has better facilities; sometimes the local ambulance service knows better than to bring underinsured patients to a private hospital (56). Within the same hospital, different caregivers may have different criteria for admission. In Los Angeles County, physicians who investigated the medical outcome of economic transfers to the local public hospital reported the case of:

a 36-year-old uninsured Hispanic man who was found after a beating and taken to a private hospital where he lapsed into a coma. The private hospital chart documents that two neurosurgeons refused to see the patient despite urgent requests from the emergency room physician. After transfer, the patient was found to have a fractured skull and cerebral contusions. He did not regain consciousness (57).

Disposition problems arise when a patient needs long-term care less intensive than that provided by an acute-care hospital, but the patient has no coverage for it or there are no places open in extended-care facilities. Under the DRG system of Medicare payments, hospitals have an incentive

to shorten the patient's length of stay, because they are compensated a fixed amount for each admission, however long the length of stay. Since the DRG system was introduced, the average length of stay for patients over 65 has fallen from 9.4 to 7.5 days (58). In New York, however, where hospitals are compensated by the day rather than by the admission, the average length of stay of over-65 patients is 13.9 days (59). The need for long-term care is so acute that over three-quarters of chief executive officers of hospitals are planning to add or expand a home health care service (60).

A North Carolina public health official claims that home care providers and nursing homes are now getting patients too early, and that they are not staffed to deal with the sicker patients being referred to them by hospitals now. It would be in the states' interests to verify whether this is true, because these early discharge placements shift costs from Medicare to Medicaid, where the states must pay a share (61).

QUALITY OF CARE

For patients with enough insurance to gain access to the health care system, the competition that results from cost containment has broadened the range of available services. Cost containment itself has improved quality where it coincides with objectives of the consumer health movement. To insured patients, the most threatening aspect of rate regulation may be that it sometimes uses the same people to monitor quality and quantity of services used.

On the state level, quality and quantity of care for Medicare hospital inpatients are being monitored by Peer Review Organizations (PROs). These were created by Congress to replace Peer Standards Review Organizations (PSROs), which ended in 1983. Each state has a PRO, usually composed primarily of physicians, often from the old PSROs. Each PRO must sign a contract with the federal Department of Health and Human Services, in which it sets 8 objectives: 3 are to be related to limiting unnecessary hospital use and 5 are to monitor quality of care. They are intended to focus on areas in which hospitals or physicians vary widely in their practice patterns (62).

Like DRGs, the PROs do not yet deal with outpatient care. It is hard to imagine how the federal government will enforce a prospective payment system for office-based care. If it succeeded in creating an incentive for physicians to use fewer resources, it is even harder to imagine how it would then monitor quality of care in the office setting.

PROs have at least two reasons to judge their fellow physicians by strict standards. Their contracts are for two years only, with renewal contingent on how satisfied HHS is with their success at achieving their objectives. HHS threatens to supplant them with PROs from the insurance industry, so they can rationalize their strictness by the logic that however strict their review is, insurers would be even stricter.

New York State is under review by a PRO, even though it is not regulated by DRGs, but by its own all-payer system.

Under current regulation, New York hospitals are reimbursed by the day, rather than by the admission. Since last November, when its review process began, the PRO has disallowed 10.6% of the Medicare bills in the state, and 13.9% of those in New York City. One of their objectives is to reduce the average length of stay of Medicare patients in the state from 13.9 days to something closer to the 7.4 day national average (63).

In order to see whether quality of care is being maintained, it is helpful to see how individual health care facilities train and motivate people to follow cost containment guidelines. Physicians are the hardest people for health care bureaucrats to control, so it could be expected that the first resources whose use administrators try to cut would be those not controlled by physicians.

The first thing that administrators cut back on is labor costs. Although the nurse-to-bed ratio affects patient care directly, changing it does not interfere with physicians' decisions. In community hospitals nationwide, both nonprofit and investor-owned, the ratio of full-time nurses to staffed beds is down (64). A University of Maryland study found that higher use of part-time nurses led to a faster turnover among full-time nurses, who were burdened by a larger share of administrative and teaching tasks because the part-time nurses were unfamiliar with hospital procedures (65).

Some changes administrators have made have long been

standard practice by management in other industries, such as stretching out maintenance and vendor payment schedules, maintaining lower levels of inventory, and joining with other facilities in buyers' groups (66). These decisions are easy for administrator to implement because they do not involve trespassing on medical territory.

Once they have to make changes that involve medical decisions, administrators can legitimate them if they can attribute them to something other than the desire to contain costs. Many are explained as improvements in care, for the reasons described below. They must first be accepted by insurance companies, and then by physicians or whoever sets licensing standards for providers of the innovation. Physicians are quicker to endorse innovations which increase their practice than those which take away their clients. Thus the professional organization which represents surgeons has endorsed outpatient surgery, which has given its members the option of opening their own day surgery centers (67). The association representing obstetricians and gynecologists has not endorsed the use of birthing centers employing midwives, although that representing public health doctors has (68).

Some of the most dramatic changes in the health care system under cost containment can be described as concessions to the consumer health movement:

1. The use of nonphysician substitutes for physician labor: Health activists encourage this not because it is cheaper, but because physician

substitutes are less professionally distant from patients and more qualified to deal with aspects of illness which do not interest physicians.

2. The substitution of outpatient for inpatient care: Day surgery, in which the patient goes home on the same day as the operation, is now 35-40% of all surgery (68). Outpatient care is preferred by health activists because it is less intimidating, less disruptive of the patient's life, and it exposes the patient to the risk of hospital-caused illness for a shorter time.

3. The use of community-based facilities instead of centralized institutions. These are preferred if they are responsive to community pressures; among other things, this means that they must be welcome in the community. They are intended to integrate the patient into everyday life as much as possible.

4. More questioning of the need for surgery: the women's health movement, in particular, fought to make such operations as hysterectomies, Caesarian sections, and mastectomies less routine. One of the few questions on which the women's health movement took a stand explicitly favored by poor and minority women was their surgical sterilization, which they criticized as often taking place without their informed consent.

Insurance companies welcome consumer opposition to surgery and many of them encourage patients to get a second opinion before surgery by covering either the second opinion or surgery performed after it to a greater extent than surgery performed without it.

5. more preventive health services: several industries have sprung up to satisfy consumer demand for preventive health services. Health activists like preventive care because it can involve self-care or self-help. Unfortunately, consumers in search of health maintenance are exposed to much fraud and unintentional misinformation, some of it physically dangerous: phony health foods, drastic diets, and incompetent exercise instructors are common. In an effort to find legitimate sources of preventive care, consumers are often limited to self-help groups and nutritionists that are connected with hospitals, which cancels out the self-care aspect of prevention.

6. Home health products for diagnosis and treatment: it is easier to control the quality of these products than of those to prevent illness, since they can be more definitively tested. Health activists favor them because they save patients a visit to a physician or clinic, and the tests also inform patients of the results as soon as

possible, shortening the time of anxiety.

Sometimes cost containment is the only available reason for challenging traditional medical practices. This means doctors have to be taught how much spending their decisions generate, and made to care about this.

Several years before DRGs came into use, a California hospital held a two-year trial of a program intended to teach staff doctors how to keep costs down. The doctors were sent to lectures, received their patients' bills and price lists of commonly used resources; and were counseled by auditors on the relative costliness of different procedures. This program succeeded in cutting lab costs by \$65 on the average bill of \$3,000; when the program's cost was figured in, the net saving was only \$3 per patient (70). The experiment did not last long enough to find out if eventually program costs would decrease and saving increase.

Today hospitals seem to be instructing physicians in cost containment more by feedback on actual choices made than by prior theoretical instruction. The methods used vary in which information they provide to physicians, who provides it, and how much power the informer has over physician behavior. Some tactics used include:

1. Giving nurses the responsibility of seeing that the private physicians update a patient's chart with any new diagnosis, especially when the patient has overstayed the average length of stay associated with his original diagnosis This

solves the problem of physicians not caring about DRG regulation because it affects only hospital bills, not their own bills.

2. Giving ancillary departments the responsibility of questioning physicians' orders for unusually expensive resources, and for seeing that physicians perform time-consuming tasks in order to get the resources.

3. Having a utilization review committee of nonphysicians inform physicians of the statistical norms of resource use they are expected to follow, starting at the time of the patient's admission.

4. Having a utilization review committee of physicians publicly criticize patterns of deviation from statistical norms in care that has already been delivered, without naming the particular physicians who have done so (71).

An interesting feature of the first three ways above is that they all use nonphysicians to control physicians, thus bypassing professional loyalty. An unforeseen advantage of extending professional privileges to nonphysicians is that they gain more authority to judge physicians' behavior. Much utilization review is done by nurses, and in a recent malpractice case, a nurse was accepted for the first time as the expert witness against a physician.

The changes administrators can make that please other personnel the most are those expanding their services,

especially in directions that do not involve capital spending, which might be subject of state CON review. Some of the services in favor now are long-term care, alcohol rehabilitation, sports medicine, and chronic pain-control. These new services are an improvement for patients, as are the new types of facilities which offer less red tape and waiting than hospitals, but a wider range of services and hours covered than solo practitioners. New facilities and services are only profitable if they provide something that patients want.

Unfortunately, competition also forces unprofitable services and facilities to close down, and they may be unprofitable not because they are underused, but because they are overused for the low level of payment they earn. Hospitals are eliminating services that are labor-intensive and that draw a large share of underinsured patients, such as pediatrics and outpatient psychiatry.

THE ROLE OF CONSUMER HEALTH ACTIVISTS

The consumer health movement has never been very well organized because health care is a difficult issue to organize around (72). Most people do not use health services as part of their everyday lives, and those who do are hard to mobilize because they are usually chronically ill or disabled.

Those issues of the 1970s which were meant to improve care were especially hard to use as focal points of collective action, because their stress on patients' control

over health was widely interpreted as individual patients' control. The only area in which public responsibility for health has been acknowledged is that of access to care, which was less of a problem in the 1970's than it is now.

The ways in which patients can now influence the health care system fall into two categories: those in which activists can improve the care available to them as individuals and those in which activists can improve care for a whole category of patients. The individual methods cannot do much to improve access: assertive behavior by individual patients does not change hospital policy about providing charity care. Emphasis on the responsibility of the patient for his own health can hurt the case of those seeking access to care, as when an official of the Department of Health and Human Services can claim that smoking, drinking, and drug abuse by pregnant women are more important factors than federal budget cuts in the increase in infant mortality in certain areas (73).

Activist patients are most likely to know about those beliefs of the consumer health movement that have been incorporated into conventional wisdom, as doled out by newspaper advice columnists and radio talk-show doctors. Patients who feel that they are responsible for their own health will probably start by following advice that is easily available and uncontroversial, such as to be assertive with physicians, get a second opinion before surgery, take fewer medicines rather than more, or eat a low-fat, high-fiber diet. Individuals who can put more

effort into their health care can draw on resources built up by self-help and self-care advocates, who have created a number of information and referral services. These are not very well publicized or linked with one another, so a patient must make some effort to find them. Like the People's Medical Society and the Boston Women's Health Collective, they provide facts on diseases and those who treat them. They differ from most consumer information sources in that they must disclaim any intention of making recommendations that could be interpreted as prescribing treatment or endorsing practitioners because they are legally barred from doing so. A recent federal regulation giving consumers access to PRO data also set a \$1,000 fine for divulging information about individual physicians (74).

The problem of access to care is possible to tackle on the level of collective action. Health care activists of the 1970s made several demographic groups aware that their members had a particular interest in health issues: women, the elderly, and the disabled are examples of these. Now there are organizations, like the National Women's Health Network, that specialize in such a group's health care needs, and the more general organizations deal with health among other member interests.

The individual actions that have the greatest group impact are those which establish legal precedents that expand the rights of other patients. In 1973, the Joint Committee of Accredited Hospitals adopted a Patient's Bill

of Rights, which they never enforced, or even required the facilities they accredited to endorse (75). Recently, an Arkansas judge cited that bill of rights as the basis for his ruling that private non-profit hospitals owed the same emergency care to indigents as public hospitals did (76).

ALLIES IN SEEKING ACCESS TO CARE FOR THE UNDERINSURED

During the 1970s, large urban public teaching hospitals were exactly what the equal health advocate opposed. Their outpatient clients received fragmented care from a constantly changing staff of inexperienced doctors (77). Their inpatients might be treated by expert faculty members, but were also used in demonstrations for students, and the faculty members, as academics as well as physicians, had two kinds of professional authority over clients.

Now these same large public teaching hospitals are often the only providers in a region who will treat the medically indigent. They are treating a clientele with a much higher concentration of underinsured people. Their prestige and political connections help them to stay financially viable, and their commitment to professional standards and traditional opposition to bureaucratic authority give them the incentive to maintain high standards of care for an unprofitable clientele. The need to keep large public hospitals alive can be a unifying issue for providers who wish to keep caring for the underinsured. The National Association of Public Hospitals recently filed suit against the head of the federal Department of Health and Human Services on the grounds that Congress ordered HHS to

give special consideration to hospitals serving a disproportionate share of Medicare and medically indigent patients. Its co-plaintiffs include three health-care workers' unions, a nurses' professional organization, the Catholic Health Association, and the California Association of Public Hospitals (78).

Unions have a strong interest in opposing cost containment because there have been so many layoffs at hospitals. Although the shift from inpatient to outpatient services means there will be more jobs available in physicians' offices and freestanding facilities, these jobs do not pay as well hospital outpatient departments and their staff-to-patient ratio is lower (79). Humana, Inc., attributes much of its financial success to the fact that labor costs make up on 36% of its budget, as opposed to the nationwide average of 51% (80).

Nurses, unionized or not, have particularly strong reasons to support demands for access to care. A survey of community hospitals showed that over 85% of hospital chief executives thought nursing was an important area to cut, not because it was inefficient, but because it was such a large part of the labor force (81). Nurses are having a very difficult time trying to turn themselves into professionals, because they have no exclusive control over a body of knowledge and skill. For the same reason, their efforts to unionize have suffered from the ability of the hospital to parcel out their functions among other workers, since they

have no exclusive ones (82). The nursing specialties that have been most successful at gaining prerogatives formerly limited to physicians are those that allied themselves with patients. As one nursing journal advised, "Nurse-midwives...have shown us the power of combining forces with consumers in changing health practices and delivery patterns. Nurses in other areas might follow their example" (83).

Last summer, the largest nurses' strike ever took place in Minneapolis-St. Paul, a city with a large number of competitive prepaid health plans. Six thousand nurses from 15 hospitals struck for six weeks in protest of the layoffs of senior staff in order to replace them with cheaper junior staff (84).

Another category of providers whose interests make them favor increased access to care, especially in public teaching hospitals, is that of medical students, interns, and residents. During the late 1960s and the 1970s, housestaff in large cities were forming unions, which won the right to strike against voluntary hospitals in 1974 (85). Residents and interns provided the bulk of care to inner-city patients, and felt they were overworked and received too little training in return for their service. Their demands broadened to include patient-care issues such as increased nursing and clerical staffs, more translators, and new equipment. In New York, a group called the Committee of Interns and Residents brought together a coalition of unions and community groups around joint worker-patient

demands. A housestaff union in Los Angeles struck for and won a \$1.1 million patient-care fund, half of which came from a foregone increase in their salaries (86).

Medical students, residents, and interns have the same professional motives as other physicians to resist bureaucratic tampering with their standards of care. Layoffs of nurses and other staff add to their workload. Those of them who work in public hospitals are also the practitioners most directly in contact with the patients who suffer from cost containment. It is therefore possible that there will be a renewal of housestaff activism in support of patient-care demands.

Local and state governments may also support demands for increased access to care if they are being billed for inefficiently delivered charity care. It is not in their interests to have most charity care done in large, expensive teaching hospitals. Some state governments are trying to link permission for expansion by private hospitals to increased provision of care for the poor. Massachusetts required four major private teaching hospitals to agree to increase their share of Boston's charity care in return for the right to perform liver transplants (87). New York State negotiated for four years to get a teaching hospital to agree to repay permission to expand by helping a small public hospital in Harlem to improve its patient care and teaching, by opening new wings offering several unprofitable services, and by making itself more available to provide

emergency care by building a new emergency room and joining the city's ambulance system (88).

State governments only have this power over hospitals if they retain their Certificate of Needs programs. Several states have already let them expire: Arizona received applications for 1200 new beds in the week after it let its CON program lapse (88). Most states still have CON programs, but some are contracting rather than expanding their powers (89).

RECOMMENDATIONS

This is an appropriate time for consumer health activists to concentrate on expanding access to care and maintaining quality of care, rather than improving quality of care in the directions favored by consumer activists. Competition has made providers eager to offer services patients want; the quality of care issue is not whether innovations will be tested, but whether they will retain their original value when produced by cost-conscious providers. Access problems seem to be confined to a minority of patients, but they are potentially problems for the majority. Most Americans are only a job away from being uninsured. If states did extend Medicaid to the unemployed, Medicaid and Medicare coverage no longer are enough to guarantee access to care. Even many people with private insurance do not have enough to cover catastrophic illness or the well-publicized, very expensive techniques now being developed for treating common illnesses.

Many people may also find that they need but cannot

find or pay for extended care because, for the first time since the Medicare and Medicaid began, hospitals are in a hurry to discharge patients; during the intervening years, a much larger share of the population began to live in households in which there is no family member who can provide extended home care. For the first time, the majority of Americans live in one or two-member households, and the majority of married women work.

State governments seem to be willing to encourage new supplies of extended care; consumers can try to direct government funding away from for-profit providers and toward such community-based alternatives as respite care and tax deductions for people caring for invalids at home. Consumers can also encourage state governments to enforce Hill-Burton obligations and to keep community health centers and small community and rural public hospitals open, because these are less expensive providers of charity care than teaching hospitals.

On the community level, they can see that the unprofitable services--obstetrics, pediatrics, emergency care and outpatient psychiatry--remain available in some facility that serves the underinsured. The federal government can be encouraged to extend cost controls to all payers and to outpatient services as soon as possible, to discourage inefficient distortions that have probably developed under the current limited system.

Consumers can probably rely on governments and public

hospitals to collect data that will be useful in monitoring quality of and access to care. Local infant morbidity and mortality rates are already closely watched and have inspired policy changes. Physicians in public hospital emergency rooms are keeping track of transfer rates. The rate of hospital readmissions from long-term care can reveal whether patients are indeed being discharged from acute care too early.

Health activists themselves will probably have to continue to assemble any comparative data they wish to use to judge the quality of care offered by individual providers. As small public hospitals and community health centers close, consumers are the ones who will have to arrange any remaining integration of medical services with informal social support systems, such as those including clergy and ethnic healers.

The consumer health movement is used to issues faced by laypeople confronting experts. The broader consumer movement has more experience with the problems of individuals confronting large organizations. If they can get the right of patients to some standard of health care firmly established, health activists may find the experience of other consumer groups more useful in demystifying medical insurance coverage and big health-care business than it ever was in demystifying medicine itself.

NOTES FOR CHAPTER FIVE

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