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second edition

Understanding Health Policy

A Clinical Approach

Thomas S. Bodenheimer
Kevin Grumbach

a LANGE medical book

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Preface

Understanding Health Policy: A Clinical Approach, 2nd edition, is a book about health policy, but it is also about individual patients and care givers and how they interact with each other and with the overall health system.

We, the authors, are practicing primary care physicians, one in a public hospital and clinic and the other in a private practice. We are also analysts of our nation's health care system. In one sense, these two sides of our lives seem quite separate. When treating a patient's illness, health expenditures as a percentage of gross domestic product or variations in surgical rates between one city and another seem remote, if not irrelevant. But they are neither remote nor irrelevant. Health policy affects the patients we see on a daily basis. Managed care referral patterns determine to which specialist we can send a patient, the absence of outpatient medications in the Medicare benefit package affects how we prescribe medications for our elderly patients, and the failure of our nation to legislate universal health insurance influences which patients end up seeing one of us (in the private sector) and which the other (in a public setting). In *Understanding Health Policy,* we hope to bridge the gap separating the microworld of individual patient visits and the macrouniverse of health policy.

The Audience The book is primarily written for medical students, physicians in training, and practicing physicians, who we feel will benefit from understanding the complex environment in which they work or will work. Because of this choice of audience, physicians feature prominently in the text. In the actual world of clinical medicine, patients' encounters with nurses, physician assistants, nurse practitioners, and other health care givers are an essential part of their health care experience. Physicians would be unable to function without the many other members of the health care team. Patients seldom appreciate the contributions to their well-being made by public health personnel, research scientists, educators, and many other health-related professionals. We hope that the many nonphysician members of the clinical care, public health, and health science education teams, and students aspiring to join these teams, will find the book useful. While the book focuses on physicians, we understand that nothing can be accomplished without the combined efforts of everyone working in the health care field.

The Goal of the Book *Understanding Health Policy* attempts to explain how the health care system works. We focus on basic principles of health policy in hopes that the reader will come away with a clearer, more systematic way of thinking about health care in the United States, its problems, and the alternatives for managing these problems. Most of the principles also apply to understanding health care systems in other nations.

Given the public's concerns about health care in the United States, the book concentrates on the failures of the system. We spend less time on the successful features

because they need less attention. Only by recognizing the difficulties of the system can we begin to fix its problems. The goal of this book, then, is to help all of us understand the health care system, so that we can better work in the system, use the system, and change what needs to be changed.

Clinical Vignettes In our attempt to unify the overlapping spheres of health policy and health care encounters by individuals, we use clinical vignettes as a central feature of the book. These short descriptions of patients, physicians, and other care givers interacting with the health care system are based on our own experiences as physicians, experiences of colleagues, or cases reported in the medical literature or popular press. Most of the people and institutions presented in the vignettes have been given fictitious names to protect privacy. In three cases that have received widespread publicity, the actual names are retained: Brent McRae and John McGann in Chapter 3 and the Lakeberg twins in Chapter 13. Some names used are emblematic of the occupations, health problems, or attitudes portrayed in the vignettes; most do not have special significance.

Our Opinions In exploring the many controversial issues of health policy, our own opinions as authors inevitably color and shade the words we use and the conclusions we reach. We present several of our most fundamental values and perspectives here.

The Right to Health Care: We believe that health care should be a right enjoyed equally by everyone. Certain things in life are considered essential. No one gets excited if someone is turned away from a movie or concert because he or she cannot afford a ticket. But sick people who are turned away from an emergency room can make headlines, and rightly so. Legally, health care is not a right in the United States, though many public opinion polls reveal that the great majority of the public believes that health care should be a right. In all other industrialized nations of the world, health care is a right. This right is difficult to translate into reality; it requires the establishment of a network of health care institutions accessible to everyone and a method of financing those institutions that allows everyone to obtain needed services without regard for ability to pay. The right to health care means universal access to health care.

Naturally, this right has limits (see Chapter 13). Were everyone to receive yearly total-body magnetic resonance imaging (MRI) scans, health care costs would go through the roof. A simple statement of the right to health care reads something like this: All people should have equal access to a reasonable level of health services, regardless of ability to pay.

The Imperative to Contain Costs: We believe that limits must be placed on the costs of health care. Cost controls can be imposed in a manner that does relatively little harm to the health of the public.

The rapidly rising costs of health care are in part created by scientific advances that spawn new, expensive technologies. Some of these technologies truly improve health care, some are of little value, and others are of benefit to some patients but are also inappropriately used for patients whom they do not benefit. Eliminating medical services that produce no benefit is one path to "painless" cost control (see Chapter 8).

Reduction in the rapidly rising cost of administering the health care system is another route to painless cost containment. Administrative excess wastes money that

could be spent for useful purposes, either within or outside the health care sector. While large bureaucracies do have the advantage of creating jobs, the nation and the health care system have a great need for more socially rewarding and productive jobs (eg, home health aides, drug rehabilitation counselors, childcare workers, and many more) that could be financed from funds currently used for needless administrative tasks.

There is a growing consensus that health care cost increases are bad for the economy. Employers complain that the high cost of health insurance for employees reduces international competitiveness. If government health expenditures continue their rapid rise, other publicly financed programs essential to the nation's economy (eg, education and transportation) will be curtailed because government budgets are limited by the public's willingness to pay taxes.

Rising costs are harmful to everyone because they make health services and health insurance unaffordable. For example, the health care expenses of companies that provide health insurance to their employees increased by about 20% per year in 1988 and 1989. As a result, many companies are shifting more of these costs onto employees. As government health budgets balloon, cutbacks are inevitable, generally hurting the elderly and the poor. Individuals with no health insurance or inadequate coverage have a far harder time paying for care as costs go up. As a general rule, when costs go up, access goes down.

For these reasons, we believe that health care costs should be contained, using strategies that are as painless as possible (ie, that do the least harm to the health of the population).

The Need for Population-Based Medicine: Most physicians, nurses, and other health professionals are trained to provide clinical care to individuals. Yet clinical care is not the only determinant of health status; standard of living and public health measures may have an even greater influence on the health of a population (see Chapter 3). Health care, then, should have another dimension: concern for the population as a whole. Individual physicians may be first rate in caring for their patients' heart attacks, but may not worry enough about the prevalence of hypertension, smoking, elevated cholesterol levels, uncontrolled diabetes, and lack of exercise in their city, in their neighborhood, or among the group of patients enrolled in their practices. For years, clinical medicine has divorced itself from the public health community, which does concern itself with the health of the population.

Currently, health maintenance organizations (HMOs) see themselves as responsible for their enrollees who seek health care; an expanded orientation would broaden that responsibility to the provision of comprehensive preventive health care services to the entire population enrolled in that HMO. We believe that health care givers should be trained to add a population orientation to their current role of caring for individuals.

Acknowledgments We could not have written this book by ourselves. The circumstances encountered by hundreds of our patients provided the insights we needed to understand and describe the health care system. Moreover, numerous health care professionals and academics read parts of our manuscript, made wise and helpful suggestions, and encouraged us to proceed. Any inaccuracies in the book are entirely our responsibility.

Our warmest thanks go to Dr. Drummond Rennie, without whose enthusiasm the

entire project would not have taken place, and to our families, who provided both encouragement and patience. We are also most grateful for the excellent suggestions of Ginger Ayala, Trude Bennett, Andrew Bindman, Paula Braveman, Troyen Brennan, David Colfax, Joan Gill, Charlene Harrington, David Himmelstein, Marek Koperski, Donald Light, John Luce, Charles Miller, Victor Sidel, Sara Syer, Milton Terris, the participants in the writing seminar at the University of California, San Francisco Institute for Health Policy Studies, and our editor at Appleton & Lange, Shelley Reinhardt. The assistance of Michelle Won with manuscript preparation was invaluable.

Finally, Chapters 2, 4–6, 8, 9, and 16 were published serially as articles in the Journal of the American Medical Association (1994;272:634–639, 1994;272:971–977, 1994;272:1458–1464, 1995;273:160–167, 1995;274:85–90, and 1996;276:1025–1031) and are published here with permission (copyright, 1994, 1995, and 1996, American Medical Association).

Conclusion This is a book about health policy. As such, we will cite technical studies and will make cross-national generalizations. We will take matters of profound personal meaning—sickness, health, providing of care to individuals in need—and discuss them using the detached language of "inputs and outcomes," "providers and consumers," and "cost-effectiveness analysis." As practicing physicians, however, we are daily reminded of the human realities of health policy. *Understanding Health Policy: A Clinical Approach* is fundamentally about the people we care for: the uninsured janitor enduring the pain of a gallbladder attack because surgery might leave him in financial ruin; or the retired university professor who sustains a stroke and whose life savings are disappearing in nursing home bills uncovered by her Medicare or private insurance plans.

Almost every person, whether a mother on public assistance, a working father, a well-to-do physician, or a millionaire insurance executive, will someday become ill, and all of us will die. Everyone stands to benefit from a system in which health care for all people is accessible, affordable, appropriate in its use of resources, and of high quality.

Thomas S. Bodenheimer
Kevin Grumbach

May 1998
San Francisco, California

Contents

Introduction: The Changing US Health Care System

1

When we wrote the introduction to the first edition of *Understanding Health Policy: A Clinical Approach* in the early 1990s, we characterized the health care system in the United States as a "paradox of excess and deprivation," borrowing this phrase from a published article of that period (Enthoven and Kronick, 1989). Excess and deprivation refers to the observation that people with comprehensive health insurance may receive unnecessary and inappropriate health services while those without insurance, or with inadequate insurance, may be deprived of needed care. We saw "excess and deprivation" as a paradigm—an overview within which many particular observations could be fitted.

As history progresses, paradigms shift. Unexpected phenomena occur, or new discoveries change how humans understand their world. In the past few years, the United States health care system has experienced a paradigm shift. A new overarching concept now helps to describe and influence the events dominating United States health care. That concept is "managed care."

Managed care expresses a new relationship between the payers, insurers, and providers of care in the United States. Traditionally, organized payers of health care (especially employers who pay for the health care of their employees) sent a premium to a health insurer, and the insurer paid the health care provider (physician, hospital, home care agency, nursing home, or pharmacy). Under this system, a patient's physician decided how much care a patient would receive, of what kind, and by which providers; and the providers often unilaterally decided how much to charge. The insurers simply paid the bills and, if the bills were too high, the insurers would charge higher premiums to the payers the following year.

Under managed care, organizations that foot the bill for a patient's care have taken on the role of managing that patient's care. Payers and insurers no longer simply write checks; they become involved in decisions about how much care a patient receives, of what kind, and by which providers. In addition, payers and insurers are deciding how much money providers will receive and how that money is paid.

It is no exaggeration to state that managed care represents a revolution in the health care system. In the past, providers, particularly physicians, were able to make most health care decisions and to determine their own compensation with minimal interference. Under managed care, physicians must share, and sometimes give up, decision making to insurers and payers. It is truly a paradigm shift in the health care system, a shift of major proportions.

Understanding the new paradigm requires knowledge of many basic elements of health policy discussed in this book. Particularly relevant to managed care are Chapters 4 and 5 (explaining how physicians and hospitals are paid), Chapters 6 and 7 (describing changes in the organization of health services), Chapter 9 (analyzing how managed care has an impact on health care costs), and Chapter 16 (offering a histori-

cal account of the managed care revolution). Managed care, then, is a concept that pervades all aspects of health care financing and organization. One cannot simply say that managed care is a new way of paying physicians—or a new way of organizing health services—or a new power relationship between payers, insurers, and providers. Managed care is all of these and more.

Managed care is a bit like the blind person and the elephant. To the blind person, from the front, the elephant feels like sharp tusks. Under the trunk, the elephant feels like a swaying hose. Near the rear leg, the elephant feels like a tree trunk. Depending on one's vantage point, managed care appears in different ways to different people.

Just because there is a new paradigm—managed care—within which many events in the health care system can be explained, does this mean that the old paradigm—excess and deprivation—is invalid or inaccurate? In physics, the theory of relativity explains more than the Newtonian theories, but the Newtonian laws are still accurate. Similarly, within the paradigm of managed care, the paradox of excess and deprivation continues to describe many elements of the health care system.

EXCESS AND DEPRIVATION

> Louise Brown was an accountant with a 25-year history of diabetes. Her physician taught her to monitor her glucose at home, and her nutritionist helped her follow a diabetic diet. Her diabetes was brought under good control. Diabetic retinopathy was discovered at yearly eye examinations, and periodic laser treatments to her retina prevented loss of vision. Ms. Brown lived to the age of 83, a success of the United States health care system.

> Angela Martini grew up in an inner-city housing project, never had a chance for a good education, became pregnant as a teenager, and has been on public assistance while caring for her four children. Her Medicaid card allows her to see her family physician for yearly physical examinations. A breast examination located a suspicious lesion, which was found to be cancer on biopsy. She was referred to a surgical breast specialist, underwent a mastectomy, was treated with tamoxifen, and has been healthy for the past 15 years.

For people with private or public insurance who have access to health care services, the melding of high-quality primary and preventive care with appropriate specialty treatment can produce the best medical care in the world.

The United States is blessed with thousands of well-trained physicians, nurses, pharmacists, and other health care givers who compassionately provide up-to-date medical attention to patients who seek their assistance. This is the face of the health care system in which we can take pride. Success stories, however, are only part of the reality of health care in the United States.

Too Little Care Some persons receive too little care because they are uninsured, inadequately insured, or have Medicaid coverage that many physicians will not accept.

> James Jackson's Medicaid benefits were terminated because of state cutbacks. At age 34 years, he developed abdominal pain but did not seek care for 10 days because he had no insurance and feared the cost of treatment. He began to vomit, became weak, and was finally taken to an emergency room by his cousin. The physician diagnosed a perforated ulcer with peritonitis and septic shock. The illness had gone on too long; Mr. Jackson died on the operating table. Had he received prompt medical attention, his illness would likely have been cured.
>
> Betty Yee was a 68-year-old woman with angina, high blood pressure, and diabetes. Her total bill for medications, which were not covered under her Medicare plan, came to $200 per month. She was unable to afford the medications, her blood pressure went out of control, and she suffered a stroke. Ms. Yee's final lonely years were spent in a nursing home; she was paralyzed on her right side and unable to speak.
>
> Mary McCarthy became pregnant but could not find an obstetrician who would accept her Medicaid card. After 7 months, she began to experience severe headaches, went to the emergency room, and was found to have hypertension and preeclampsia. She delivered a stillborn baby.

Over 40 million people in the United States have no health insurance (Schroeder, 1996). Many are victims of the changing economy, which has shifted from a manufacturing economy based on highly paid, full-time jobs with good fringe benefits toward a service economy with lower paid jobs that are often part-time and have poor or no benefits (Renner and Navarro, 1989). Two-thirds of the uninsured are in families with an employed adult. Lack of insurance is not simply a problem of the poor but has also become a middle class phenomenon, particularly for families of people who are self-employed or work in small establishments.

Underinsurance is also a major issue. Medicare covers only 45% of the health care costs of the elderly (Aaron and Reischauer, 1995). In 1994, 19% of the privately insured population under age 65 had health insurance coverage so inadequate that a major illness would create severe financial hardship (Short and Banthin, 1995).

Too Much Care In contrast to the deprivation created by absent or inadequate health insurance, the health care sector is beset by two varieties of excess: administrative and medical. Administrative costs are rising more rapidly than the costs of the medical care being administered. In the words of Steffie Woolhandler and David Himmelstein (1991):

> Medicine is increasingly a spectator sport. Doctors, patients, and nurses perform before an enlarging audience of utilization reviewers, efficiency experts, and cost managers. A cynic viewing the uninflected curve of rising health care spending might wonder whether the cost-containment experts cost more than they contain . . . (Excerpted from information appearing in the New England Journal of Medicine: Woolhandler S, Himmelstein DU: The deterio-

> rating administrative efficiency of the US health care system. N Engl J Med 1991;324:1253.)

The price tag for administrative costs in the United States comes to an extraordinary 19–24% of the total dollars spent on health care. The US General Accounting Office (1991) estimated that 9% of all 1991 health care costs consisted of unnecessary administrative spending.

Some people receive too much care that is costly and may be harmful.

> At age 66, Daniel Taylor noticed that he was getting up to urinate twice each night. It did not bother him much. His family physician sent him to a urologist, who found that his prostate was enlarged (though with no signs of cancer) and recommended surgery. Mr. Taylor did not want surgery. He had a friend with the same symptoms whose urologist had said that surgery was not needed. Since Mr. Taylor never questioned doctors, he went ahead with the procedure anyway. After the surgery he became incontinent of urine.

> Consuelo Gonzalez had a minor pain in her back, which was completely relieved by over-the-counter acetaminophen. She went to the doctor just to make sure the pain was nothing serious, and it was not. The physician gave Ms. Gonzalez a stronger medicine, indomethacin, 3 times a day. The indomethacin caused a bleeding ulcer, requiring a 9-day hospital stay at a cost of $17,000 to her health insurer.

According to health services expert Robert Brook (1989):

> . . . almost every study that has seriously looked for overuse has discovered it, and virtually every time at least double-digit overuse has been found. If one could extrapolate from the available literature, then perhaps one-fourth of hospital days, one-fourth of procedures, and two-fifths of medications could be done without. (Copyright 1989 American Medical Association: Brook RH: Practice guidelines and practicing medicine. JAMA 1989;262:3027.)

Concern about the plight of the uninsured dominated discourse about health care reform during the early 1990s. By 1996, in the aftermath of defeat of legislative efforts to expand insurance coverage, growing controversy over managed care eclipsed public concern about the unsolved problems of the medically deprived. This paradigm shift has not changed the fundamental reality for tens of millions of uninsured people in the United States, but it has reduced their priority in the political arena. Increasingly, attention has been focused on the medical excess that managed care was designed to cure.

MANAGED CARE

> Kathy Fine was glad when her employer enrolled her in a managed care plan, Apple a Day HMO. Her previous insurance had failed to cover preventive services such as Pap smears and mammograms, and the HMO covered these

items. For the first time in her life, her prescriptions were largely paid by the HMO. She had previously gone to several physicians in an uncoordinated fashion, and she now had a primary care provider who coordinated her services. Her employer was also happy because employee health care costs had not risen in the past 2 years.

Ken Madden was angry. Under his old insurance, he went to a good orthopedist for his back pain, and now Dollar a Day HMO, his new insurer, had no contract with the orthopedist and wanted to send him to see a specialist way across town. Worse yet, Dollar a Day was denying him the physical therapy he needed for his back pain. When Ken read that Dollar a Day was siphoning off 26% of its income to administrative costs, high executive pay, and profits, he got even more angry.

Health maintenance organizations (HMOs), a rapidly growing form of managed care covering over 60 million people in the United States, are controversial. Most HMOs cover a broad array of services including preventive care, and many coordinate the care of their enrollees through a primary care physician (PCP). From 1994 through 1996, many employers have enjoyed relatively stable premiums for their employees enrolled in HMOs.

On the other hand, the number of complaints against HMOs is growing because some patients are denied services, especially care by specialists, which they feel they need. Since HMOs, and sometimes PCPs, may increase their profits and income by withholding services (see Chapter 5), patients are expressing growing unease over a conflict between physicians' desire to make money and their responsibility to provide care (Anders, 1996; Bodenheimer, 1996). The increase in administrative excess described above is in part related to the expensive authorization processes of managed care organizations.

THE PUBLIC'S VIEW OF THE HEALTH CARE SYSTEM

Health care in the United States encompasses a wide spectrum (Fuchs, 1992), ranging from the highest-quality, most compassionate treatment of a complex illness to the turning away of a sick person because of lack of ability to pay; from well-designed protocols for prevention of illness to inappropriate high-risk surgical procedures performed on uninformed patients. Despite the recent upheavals in health care, one fundamental truth remains. The United States still has the least universal, most costly health care system in the industrialized world.

Many people view the high costs of care and the lack of universal access as indicative of serious failings in the health care system. In 1994, only 18% of people in the United States felt that the system worked well; 81% felt that the system needed fundamental changes or a complete overhaul. Fifty-five percent believed that the wealthy always get better care than those who are less well off. Twenty percent of Americans had a problem paying medical bills during the previous year, compared with 6% of Canadians and 3% of West Germans. Only 29% of Americans had confidence in their health care institutions, compared with 45% of Canadians and 53% of West Germans (Blendon et al, 1995).

Understanding the Crisis In order to correct the weaknesses of the health care system while maintaining its strengths, it is necessary to understand how the system works. How is health care financed? What are the causes and consequences of incomplete access to care? How are physicians paid, and what is the effect of their mode of reimbursement on health care costs? How are health care services organized and quality of care enhanced? Is sufficient attention paid to the prevention of ill health, and what are different strategies for preventing illness?

How can the problems of health care be solved? Is managed care the answer? Can costs be controlled in a manner that does not reduce access? Can access be expanded in a manner that does not increase costs? How have other nations done it—or attempted to do it? How might the health care system look in the United States of the twenty-first century?

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Paying for Health Care 2

Health care is not free. Someone must pay. But how? Does each person pay when receiving care? Do people contribute small amounts in advance so that their care will be paid for when they need it? When a person contributes in advance, might the contribution be used for care given to someone else? If so, who should pay how much?

Health care financing in the United States evolved to its current status as a series of social interventions. Each intervention solved a problem but in turn created its own problems requiring further intervention. This chapter will discuss the historical process of health care financing as solution-creating-new-problem-requiring-new-solution.

MODES OF PAYING FOR HEALTH CARE

The four basic modes of paying for health care are out-of-pocket payment, individual private insurance, employment-based group private insurance, and government financing (Table 2–1). These four modes can be viewed both as a historical progression and as a categorization of current health care financing.

Out-of-Pocket Payments

> Fred Farmer broke his leg in 1892. His son ran 4 miles to get the doctor, who came to the farm to splint the leg. Fred gave the doctor a couple of chickens to pay for the visit. His great-grandson, Ted, who is uninsured, broke his leg in 1992. He was driven to the emergency room, where the physician ordered an x-ray and called in an orthopedist who placed a cast on the leg; the cost was $580.

In the nineteenth century, people like Fred Farmer paid physicians and other health care practitioners in cash or through barter. In the first half of the twentieth century, out-of-pocket cash payment was the most common method of reimbursement. This is the simplest mode of financing—direct purchase by the consumer of goods and services (Figure 2–1).

People in the United States purchase most consumer items, from VCRs to haircuts, through direct out-of-pocket payments. This is not the case with health care, and one may ask why this is so. Economists such as Robert Evans (1984) and Kenneth Arrow (1963) have discussed some reasons why health care is not considered just another typical consumer item.

Need Versus Luxury: Whereas a VCR is considered a luxury, health care is regarded as a basic human need by most people.

> For 2 weeks, Marina Perez has had vaginal bleeding and has felt dizzy. She has no insurance and is terrified that medical care might eat up her $250 in savings. She scrapes

Table 2–1. Health care financing in 1994.[1]

Type of Payment	Percentage of Personal Health Care Expenditures
Out-of-pocket payment	20%
Individual private insurance	3%
Employment-based private insurance	35%[2]
Government financing	43%
Total	101%[3]
Principal Source of Coverage	**Percentage of Population**
Uninsured	15%
Individual private insurance	4%
Employment-based private insurance	58%
Government financing	23%
Total	100%

[1] Data extracted from Cowan CA et al: Business, households, and government: Health spending 1994. Health Care Fin Rev 1996;17:157; U.S. Department of Health and Human Services: Health United States 1995. 1996; and U.S. General Accounting Office: Private Health Insurance. (GAO/HEHS-97-8). 1996.
[2] This includes private insurance obtained by federal, state, and local employees, which is in part purchased by tax funds.
[3] Total expenditures add up to 101% due to rounding error.

NOTE: For out-of-pocket payments, the percentage of expenditures is greater than the percentage of the uninsured population because out-of-pocket dollars are paid not only by the uninsured but also by the insured in the form of deductibles and copayments and payments for uncovered services. Because private insurance tends to cover healthier people, the percentage of expenditures is far less than the percentage of population covered. Public expenditures are far higher per population because the elderly and disabled are concentrated in the public Medicare and Medicaid programs.

up $30 to see her doctor, who finds that her blood pressure falls to 90/50 mm Hg upon standing and that her hematocrit is 26%. The doctor calls her sister, Juanita, to drive her to the hospital. Marina gets into the car and tells Juanita to take her home.

If health care is a basic human right, then people who are unable to afford health care must have a payment mechanism available that is not reliant on out-of-pocket payments.

Unpredictability of Need and Cost: Whereas the purchase of a VCR is a matter of choice and the price is known to the buyer, the need for and cost of health care services are unpredictable. Most people do not know if or when they may become severely ill or injured or what the cost of care will be.

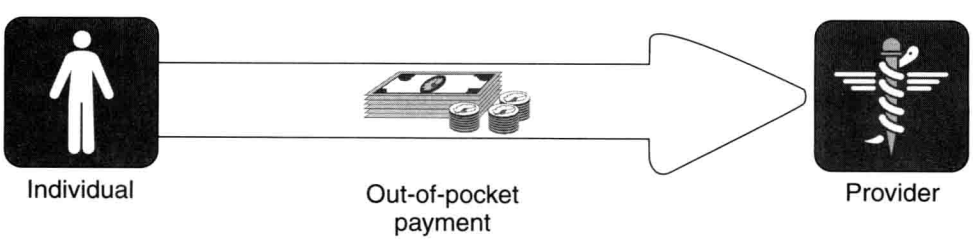

Figure 2–1. Out-of-pocket payment is made directly from patient to provider.