

Family Practice in a Failing Health Care System: New Opportunities To Advocate for System Reform

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Medical practice, as well as the entire health care system in the United States, is in the middle of profound change. Managed care is past its heyday, and there is great uncertainty as to where the overall system is headed. Every specialty in medicine has been affected, with a resulting internal reassessment and speculation as to the respective futures of medical specialties in a time of unprecedented and unpredictable change. Such reassessment has been vigorous within family practice, as evidenced by the Keystone III Conference in October 2000 and the current Future of Family Medicine project sponsored by the American Academy of Family Physicians.

Participants in Keystone III concluded repeatedly in their discussions that it is "hard to be a good physician in a bad system." Many examples surfaced during the 4-day conference whereby valued goals of family practice could not be achieved because of system impediments. Family physicians, together with their colleagues in most other specialties, find themselves frustrated by an increasing bureaucracy and its attendant hassle factor. At the same time, in the last 20 years there has been a massive power shift from medicine to third-party payers. Furthermore, many of the values of medicine have been distorted by the steady growth of the investor-owned, for-profit health care sector, in which the overriding goal is return on investment to shareholders rather than the public interest of patients. As part of this sea change of the health care system, physicians have lost professional autonomy, faceless bureaucrats have often infringed on clinical decision making, and the physician-patient relationship

has been eroded in an increasingly fragmented system.

In its own introspective reassessment, family practice is facing many basic questions, including those dealing with scope of practice issues (eg, inpatient skills, obstetrics, procedures) and style of practice issues (eg, office-based practice without hospital work, hospitalist without a primary care base, urgent care or part-time with limited or no continuity of care). How much differentiation within family practice is desirable to meet both the self-interest of the specialty and the public interest in a sick and failing system? Because the future of our specialty is inextricably intertwined with the overall system of which it is a part, internal reassessment requires a careful look at how the health care system is likely to evolve and, indeed, which system best meets the public interest and the values of family medicine.

In view of the above, the purpose of this article is threefold: (1) to highlight the problems of our present deteriorating health care system, with particular attention to access, cost, quality, and overall performance, as well as examples of their countervailing impacts on the goals of family practice; (2) to outline four major alternatives for health care reform, together with their feasibility and likely outcomes; and (3) to suggest some constructive future directions for family practice to take a leadership role in advocating for system reform.

Portrait of Today's Failing Health Care System

Today's nonsystem is in chaos. A large part of health care has been taken over by for-profit corporations whose interests are motivated more by return on investment to shareholders than by quality of care for patients. The extent of investor-owned health care is enormous—in 1998, 85% of dialysis programs, 70% of home care and nursing homes, and 64% of health maintenance organizations (HMOs) were under such ownership.¹ Mean-

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Table 1. Problems with the US Health Care System.*Decreasing access to care*

- More than 40 million uninsured Americans²
- Only 64% of US workers insured through employer-based programs³
- 20% of uninsured cannot afford health insurance if offered by their employers⁴
- 25% of all nonelderly Americans are uninsured for at least 1 month per year⁵
- Consolidation and decreasing choice for employer-based insurance (eg, American Express dropped 164 health maintenance organizations [HMOs] nationwide in last 2 years, retaining 48)⁶
- 37% of applicants denied insurance in the individual insurance market⁷
- Growing need for increasingly fragile public safety net
- A protracted recession expected to increase the number of uninsured and Medicaid beneficiaries each by 75% by 2007⁸

Increasing costs of care

- Health spending projected to increase to 16.2% of gross domestic product by 2008, almost doubling to \$2.2 trillion⁹
- Employer-based insurance premiums up 11% in 2001
- Prescription drug costs up 14.5% in 2000⁹
- Average family health insurance premiums now \$7,053¹⁰
- For-profit hospital chains reporting huge profits in third quarter of 2001 (eg, HCA at 47%, Tenet 45%)¹¹
- Corporate greed while access declines and costs go up (eg, 23 top executives of investor-owned HMOs were paid more than \$63 million in salary in 2000, plus \$109 million in stock options)⁹
- Administrative costs account for about 26% of the nation's health care expenditures¹²

Variable and often poor quality of care

- Many factors lead to poor quality of care (eg, denial of services, lack of primary care and continuity, unnecessary care, and neglect of psychosocial and quality-of-life issues)¹³⁻¹⁶
- A RAND review of many studies has shown these unacceptable levels of care:¹⁷
 - 50% of people received recommended preventive care
 - 60% received recommended chronic care
 - 70% received recommended acute care
 - 30% received contraindicated acute care
 - 20% received contraindicated chronic care
- The US ranks last among 13 industrialized countries for low birth-weight percentage, neonatal and infant mortality overall, and years of potential life lost¹⁸

Nonsustainable, overly complex, inefficient system with poor performance

- More than 1,200 insurers, with increasing burden of paperwork and bureaucracy¹⁹
- Market-driven private sector often in conflict with public interest²⁰
- A weak primary care base ranks the US last among 11 industrialized nations by 11 criteria²¹

while, the recession has aggravated the already critical problems facing the public safety net, not only for the uninsured but also for Medicare and Medicaid beneficiaries. Public sector facilities and providers are underfunded, and states are facing large deficits in needed health care spending. Table 1 gives examples of current problems with today's so-called system.

Given a health care system as sick as is obvious from Table 1, how can family practice ever hope to achieve its goals of providing personal, comprehensive, high-quality primary care with continuity for the population being served? Family practice patients are being buffeted by increasing co-payments, decreased or even loss of insurance coverage, changing health plans (often requiring formulary changes of their prescription drugs), and escalating costs of care that have become unaffordable for many. The maze of options under the rhetoric of increased consumer choice are bewildering, and patients often bypass primary care as they seek out specialist care in point-of-service plans.

At the same time, family physicians are struggling to continue the kind of care they are trained to provide, working harder with higher overhead and lower reimbursements as they try to keep their practices viable. In many instances, reimbursements for services provided to Medicaid and Medicare beneficiaries do not cover their costs. Advocacy for patients on a case-by-case basis against inappropriate denials of coverage by insurers takes an inordinate amount of time and energy, is often unsuccessful, and might even lead to increased medicolegal liability for the physician. Under these circumstances, continuity of care, as well as physician and patient satisfaction, suffers as family physicians and their patients try to cope with growing instability of practice settings.

Difficult as the practice environment has become in community practice, it is typically even more challenging in teaching programs, which are besieged by all these problems in addition to the need to continue teaching and research programs with their ever more challenging funding problems. Difficulties in the environments of both community practice and teaching programs undoubtedly play a large part in the decline of student interest in family practice and primary care in recent years. Decreasing student interest in primary care must be reversed if the nation's needs for a stable and effective health care system are ever to be met. As major providers for Medicare and Medicaid beneficiaries and the mainstay of many public sector practices, family physicians are critical to maintaining a viable safety net for many millions of people.

Family practice cannot meet its goals unless the health care system is reformed to allow its values to be expressed. As family practice reconsiders its own internal questions, a strong advocacy effort toward

health care reform is equally important. The question then becomes, Which of the major alternatives being discussed has the best chance of success?

Major Alternatives for System Reform

There are four main policy alternatives being promoted by various constituencies for reform of the US health care system: (1) incremental change, (2) building on the employer-based insurance system, (3) consumer choice, and (4) single-payer universal health insurance. There might be some overlap between these four, but together they subsume all the policy alternatives to improve the health care system.²² Each will be summarized briefly, including some of their main pros and cons.

Incremental Change

This overall policy, of course, has been in place in this country for more than 25 years. Its proponents argue that the health care system is essentially strong and that its problems can be addressed by incremental changes, be they matters of access, cost, or quality. Proponents also see our current system as best fitting our capitalist and individualistic society and contend that the unfettered open health care market will keep costs down. Thus, the State Children's Health Insurance Program (SCHIP) was intended since the 1990s to increase access for children in uninsured families, whereas the system of prospective payment by diagnosis-related groups (DRGs) was intended to contain soaring costs of hospital care. As is true of other incremental changes, both have proved to fall far short of their policy goals while the problems of access and cost have continued unabated.

Pros

1. It largely continues the status quo, meets the special interests of powerful stakeholders, and is therefore easiest for politicians and legislators to support.
2. It fits the individual perspective consistent with cultural norms.
3. It allows pro-market for-profit interests to prosper in the health care marketplace consistent with the traditions and values of American entrepreneurialism.

Cons

1. Intended changes are ineffective in meeting goals that are not sustainable and are Band-

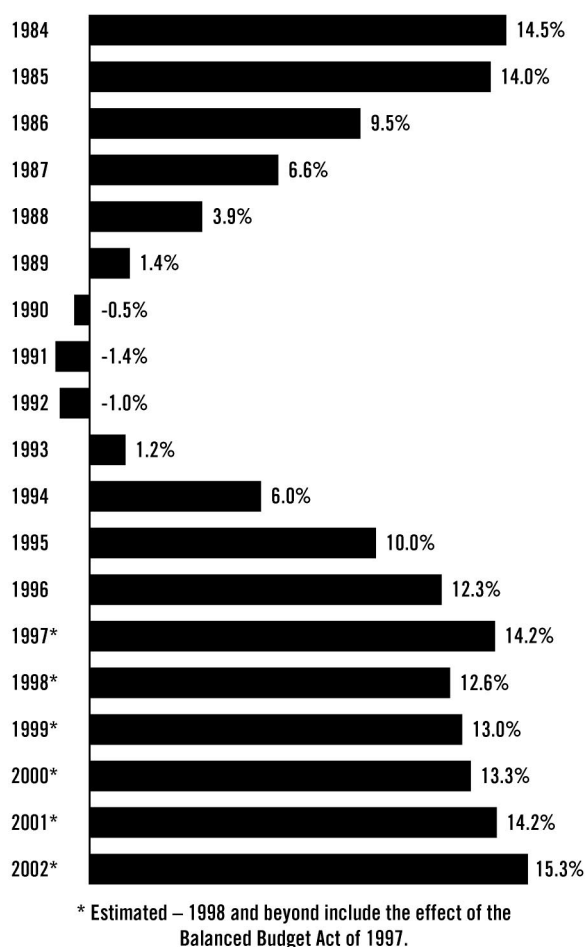


Figure 1. Aggregate prospective payment system inpatient margins: Prospective Payment Assessment Commission analysis of Medicare cost report data from the HCFA [Health Care Financing Administration] updated by VHA. (Reprinted with permission from VHA. 1998 *Environmental Assessment. Setting Foundations for the Millennium*. Irving, TX: VHA Inc., 1992:19.)

Aids with minimal or marginal effects on the underlying system.

2. Problems of access, cost, and quality persist and worsen despite 25 years or more of well-intended incremental changes. For example, Figure 1 provides ample evidence that the DRG system has been completely unsuccessful in constraining the costs of hospital care beyond about 12 years,²³ whereas Figure 2 shows soaring health plan costs during the last 10 years.²⁴

Build on the Employer-Based Insurance System

This approach would build on our employer-based insurance system, which was hastily assembled dur-

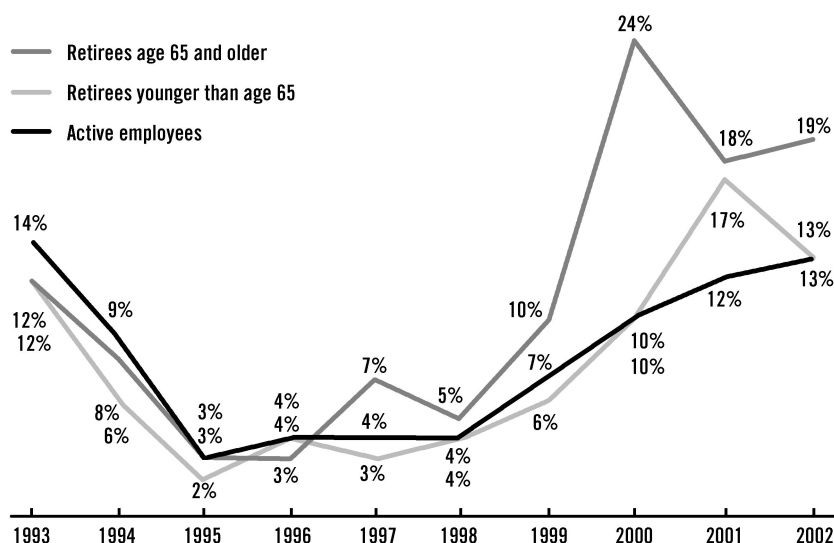


Figure 2. Average health care cost increases, 1993–2002. Source: Towers Perrin, December 2001.²⁴ Reprinted with permission from Aspen Publishers.

ing the World War II wartime economy, at the time of serious labor shortages. Its development was fueled by Internal Revenue Service rulings that employers' contributions for health insurance for their employees would be tax deductible for employers and tax-exempt for workers. Enrollment in private health insurance then skyrocketed from a little more than 1 million before the war to 60 million 10 years later.²⁵

Pros

1. It maintains the status quo; there will be difficulty in eliminating tax preference.
2. It meets the self-interest of a \$300 billion private insurance industry.
3. It is the choice of many consumers.

Cons

1. Less than two-thirds of working adults are insured.
2. There are decreasing choices and higher costs for less coverage.
3. Many employers (especially smaller ones) do not offer insurance.
4. Patients lose their insurance if the job is lost; they might be locked into an undesirable job if unwilling to risk loss of insurance.
5. Risk pools are fragmented.
6. There is a high cost or even nonavailability of individual health insurance if group coverage is lost.

7. There is no chance of universal access to health care.

Consumer Choice

This latest and currently most politically popular approach is being taken by both major parties, with relatively small differences between them. This approach, if fully implemented, would replace employer-based health insurance and shift the responsibility from employers to consumers for the purchase of health insurance and payment for health services. Legislators are currently debating a variety of tax subsidies, vouchers, and medical savings accounts that theoretically could enable consumers to pay for their own coverage and services. For Medicare beneficiaries, various kinds of premium support plans are being considered.

Pros

1. As with the first two basic alternatives, this approach appeals to stakeholders attempting to maintain the status quo.
2. A pro-market approach meets the self-interests of health care and insurance corporations.
3. Politically, consumer choice is easiest to pass.

Cons

1. Access and cost problems will not be resolved.
2. Pro-market forces have already evaded cost containment while for-profit investor-owned

providers have well-documented quality-of-care problems.

3. Tax subsidies and vouchers would be too small, especially for the sick, to cover needed care.
4. The entire consumer choice model rests on false assumptions. Robert Kuttner,²⁶ a well-known health care analyst, gives us this warning of the false premises of this kind of pro-market reform:

First, it assumes that competing health plans will take a high road of offering better service, rather than a low road of risk selections and secret financial incentives to participating doctors. Second, it assumes consumers will have a free choice among competing plans. Third, it assumes that good plans will drive out the bad ones, rather than vice versa. Fourth, it assumes that plans will not acquire a degree of monopoly power. And it presumes that consumers will be adequately informed about competing plans.

Single-Payer System

Although national health insurance has been seriously considered in the United States on five occasions since 1912–1917, it has failed every time. The last attempt, during the Clinton administration in 1993–1994, proposed universal coverage by which all Americans were required to purchase a government-specified standard benefit package through a government-regulated alliance. The private insurance industry remained actively involved, and employers were to be mandated to provide employer-based health insurance. This complex and cumbersome bill of 1,342 pages was attacked from many quarters and never came to an actual vote on the floor of the House.²⁷ Ironically, a single-payer proposal was put forward at the same time by Representative McDermott (D-Wash) (HR 1200); it was the only proposal with grassroots support and the only one to pass out of committee. Modeled after the Canadian system, it was distorted and marginalized by the major media as the main debate focused on the unworkable Clinton health plan.²⁸ Close ties between the media and stakeholders in the present system were later exposed as influencing the news coverage of the single-payer proposal.²⁹

Under a single-payer system of national health insurance, universal coverage would be assured for

all Americans. The private insurance industry would be eliminated, and the program would be administered through a blend of federal and state government roles. Physicians would be reimbursed on a fee-for-service basis, while hospitals and nursing homes would have negotiated global budgets. Although likely to be attacked by some as socialized medicine, the single-payer system would really be socialized insurance. The private practice of medicine would proceed with a sharp reduction in administrative and regulatory burdens as well as costs.

Pros

1. A single-payer system would provide universal access for the entire population.
2. Cost savings would average about \$150 billion per year.
3. There would be decreased overhead (eg, Medicare 2% vs private insurance 26%).
4. It distributes risk and responsibility to finance care.
5. It improves access, costs, and quality of care.
6. It offers equity and social justice.

Cons

1. Special-interest stakeholders would lobby against it.
2. Pro-market interests would deny its effectiveness.
3. Disinformation would be spread by media coverage.
4. It would raise philosophic concerns about “big” government.
5. Can broad-based political support be rallied, either state by state or nationally, to defeat the powerful stakeholders of the status quo?

Family Practice and Health Care Reform

The vigorous introspective reassessment now underway within family practice after three decades of development is healthy and potentially constructive for the health care system as well. Although family practice today is but one of three or four primary care specialties (and not the largest at that), the values espoused by the fledgling specialty in 1969 are enduring. Together with general internal medicine and general pediatrics, comprehensive and personal primary care of high quality could be made available to the entire population if the collective influence of these specialties could be effective.

tively brought to bear on the urgent need for major system reform.

Four external questions now facing family practice are (1) how can family practice relate more effectively to the other primary care specialties, (2) how can family practice advocate for a reformed health care system, (3) to what extent can family practice be effective in health care system advocacy, and (4) how can the primary care base be strengthened for whatever health care system evolves? All these questions are subsumed by a larger question, How can family practice best serve the community in its broadest definition—society and the public interest? I would argue for an expanded advocacy role for system reform and increased collaboration with like interests in the other primary care specialties in the belief that family practice can be much more effective now than in the past by helping to transform today's chaotic and unsustainable system that fails both patients and providers in serious ways.

The following, nonsequential steps are suggested for family practice to pursue a more effective role in health system improvement and reform:

1. Redesign and demonstrate clinical practice systems for greater efficiencies, lower costs, and improved quality.
2. Become more involved with public education concerning the inequities and problems of access, cost, and quality within today's flawed system.
3. Support and actively participate in nonprofit and public sector programs to increase access to care.
4. Avoid the buy-off by for-profit investor-owned corporations, be they HMOs, hospital chains, pharmaceutical companies, or other investor-owned health care corporations.
5. Be alert to potential, often inapparent, conflicts of interest between ourselves, our specialty, and the public interest (possible examples range widely from an investigator's role in a research project funded by a pharmaceutical company to the extent to which our organizations are, or are not, beholden to special-interest sponsors).
6. Put the public interest ahead of self-interest of the specialty in any areas where they might not be the same.
7. Become more aware of the activities of other professional organizations, groups, and agencies working toward health care reform (eg, Physicians for a National Health Program (PNHP), legislative activity in state legislatures and in Congress, Public Citizen, etc).
8. Become more familiar with advantages, disadvantages, and likely scenarios of each of the four major alternatives for system reform (suggested readings in the Appendix as a start).
9. If, after reviewing the alternatives, you conclude that universal coverage through a single-payer approach would be the most effective long-term reform alternative, join PNHP (312-782-6006) (www.pnhp.org), a growing and effective group of health care activists.

Organized medicine is now splintered into many competing specialty and subspecialty organizations and has steadily lost influence over political events. The membership of the American Medical Association includes only about 37% of the nation's active physicians and might also be perceived by many as a special interest defending the status quo. The AMA currently supports incremental change and increasing consumer choice, both of which appear certain to fail in long-term system reform. It also does not help its image to have opposed all previous efforts to enact universal coverage in the last century, as well as Medicare and Medicaid in 1965.

Family practice embraced reform of medical education and the health care system in its early development, and it has the potential to become an active and credible change agent for reform, particularly if it becomes part of a coalition with the other primary care specialties. Family physicians are typically close to their patients and communities and, if activated and focused, could become major players toward system reform. Instead of spending its energies trying to redress the problems linked to the current disintegrating health care system, family practice could more effectively serve the public interest and its own future self-interest if its efforts are targeted to basic structural reform of the system. Woolhandler and Himmelstein,³⁰ two internists at Harvard Medical School who have been active supporters of a national health program for more than 12 years, have the following to say about patchwork reform vs single payer:

Our main objection to investor-owned care is not that it wastes taxpayers money, not even that it causes modest decrements in quality.

The most serious problem with such care is that it embodies a new value system that severs the communal roots and samaritan traditions of hospitals, makes doctors and nurses the instruments of investors, and views patients as commodities. In nonprofit settings, avarice vies with beneficence for the soul of medicine; investor ownership marks the triumph of greed. A fiscal conundrum constrains altruism on the part of nonprofit hospitals: No money, no mission. With for-profit hospitals, the money is the mission; form follows profit.

In our society, some aspects of life are off-limits to commerce. We prohibit the selling of children and the buying of wives, juries, and kidneys. Tainted blood is an inevitable consequence of paying blood donors; even sophisticated laboratory tests cannot compensate for blood that is sold rather than a gift. Like blood, health care is too precious, intimate, and corruptible to entrust to the market.

The United States is odd man out among all industrialized Western nations in not having universal coverage through a system of national health insurance. We have a seriously flawed system that meets the needs of for-profit corporations but not the interests of patients and providers. All patchwork reforms are cruel illusions of constructive changes supported by pro-market special interests without regard to the needs of society. As family physicians, members of our professional organizations, and citizens, we have the biggest opportunity in our lifetimes to stand for the public interest on the right side of history.

Access to health care is a complex matter, and a national program of universal health insurance would not by itself entirely resolve the problem. Eisenberg and Power³¹ have observed the analogy between access to health care and electrical current passing through resistance. Access might drop, even with an insurance card, with any voltage drop, such as whether primary and secondary services are available, whether needed services are covered, whether any language barriers divide patients and providers, and whether patients' choices are informed. There is wide consensus, however, that insurance coverage is the single, most important factor in assuring access to health care for our population.³²⁻³³ In addition to improving access more than any incremental change in our history, a

single-payer national health insurance program could be expected to simplify the administrative burdens now faced every day by patients and providers alike, transform medically necessary health care services from commodities rationed by class and income level to widely available essential services, improve population-based outcomes of care, and save costs at the same time by eliminating the high overhead and profits of the private, investor-owned insurance industry.

Single-payer health insurance is the only affordable alternative to provide universal access, as has recently been shown in California, where nine alternative plans for providing universal access have been carefully analyzed through a micro-simulation model by the Lewin group. Only the single-payer plans saved money (\$8 billion per year) while still providing comprehensive care, including prescription drug coverage and long-term care, for the state's population of 31 million people. The other options, which included various public expansions, individual and employer tax credits, employer and individual mandates, and combination approaches, all failed to provide universal coverage, were not comprehensive, and still cost more money.³⁴

Support for universal single-payer coverage is growing rapidly and is likely to increase even faster in the recession and post-September 11 environment. Examples of growing support include the 9,500 members of PNHP; members of the American Medical Women's Association were 2 to 1 in favor of single-payer insurance; preference of a single-payer health care system by 57% of more than 2,100 medical students, residents, faculty, and deans in US medical schools (a 1999 study with an 80% response rate)³⁵; single-payer bills moving forward in several states; and the Health Care Access Resolution (House Concurrent Resolution 99) drafted by the Congressional Universal Health Care Task Force and introduced in the House of Representatives in June 2002. This resolution has 86 co-sponsors, is supported by a broad coalition of faith communities, labor, advocacy and consumer groups, and health professionals, and directs Congress to enact legislation to provide comprehensive health care for everyone by October 2004.³⁶

It has been an honor and privilege to give this year's G. Gayle Stephens Lecture. It is only fitting to close with this insightful perspective of where we are today.³⁷

Among the lessons that ought to have been learned during the last 30 years is that the “natural” evolution of change is not necessarily in the public interest; that the *bête noir* of change is not necessarily “socialized medicine” as the AMA tirelessly warned us for decades—compared with the draconian intrusions of industrialized medicine on free choice and privacy—and that organized medicine, hospitals, and medical schools are not dependable fountains of wisdom and leadership in the midst of change. Our “expert” institutions and organizations have exposed themselves as bastions of resistance, self-interest, and exploiters of the public purse. More than anything else they resemble the medieval clergy in maintaining their death-grip on privilege, power, and self-aggrandizement.

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Appendix: Suggested Reading

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1. PNHP (Physicians for a National Health Program) quarterly newsletter, 29 E. Madison, Suite 602, Chicago, IL 60602.
2. Health letter. Public Citizen Health Research Group, 1600 20th Street, NW, Washington, DC 20009 (www.citizen.org/hrg).

Other

1. Quote of Day.(QoD). Available daily from Don McCanne, MD, retired family physician in Orange County, Calif, and current President, Physicians for a National Health Program (don@mccanne.org).