

Some Dilemmas in Health Care Policy

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HEALTH CARE POLICY IN THE UNITED STATES DOES not suffer from inattention. The volume of analyses, research studies, proposals, option papers, and interpretations of the latest crises is staggering. The amount of information produced, however, contributes little toward resolution of policy questions because the policy problem is not insufficient information or analyses but rather an inability to resolve the conflicting and competing interests among powerful actors (Alford, 1975) who dig in for the battle more deeply as the economic constraints on continuing expansion become more clear.

In the discussion that follows, I examine the increased complexity of the health care system in relation to competing interest groups and changing economic circumstances. With an emphasis on cost containment, it is difficult to promote the interests of some groups without taking resources or other advantages from those who already have them, and this establishes considerable tension in the policy-making arena. Many of the dilemmas faced arise from the unwillingness to directly confront the core issues and tensions, and the arrangements we develop to work around them. The result is that we do not resolve central problems, and our ineffectual interventions create further problems.

Although there are many data on various aspects of performance

of alternative forms of medical organization and delivery systems, as well as excellent information on the clinical advantages and costs of alternative therapeutic regimens, the intangibility of the medical effort and the lack of agreement as to what constitutes quality of care allow the debate to persist quite independently of the massive evidence that exists. The clinical mentality, with its commitment to the value of the individual experience and the personal judgment of the medical professional (Freidson, 1970), reinforces a great deal of anti-intellectualism, denial of aggregate experience, and self-serving rhetoric. Although the facts may show little benefit from surgical interventions, technological innovations, or expensive new approaches, the self-interested retort of the professional who insists that the procedure saves lives usually carries the day. Thus, for example, replicated controlled clinical trials and other studies call into serious doubt the value of enormous expenditures to develop coronary intensive care units (Waitzkin, 1979), but the personal beliefs of the hospital administrators who organize such units and the clinicians who run them are given greater credence. Whether their firm convictions reflect their self-interest or their unique perspective and view of patient care need not concern us here. The irony is that the reasoned decision not to use such services as coronary intensive care, given the public perception of such technologies, makes physicians who choose such a course vulnerable to allegations of incompetence and malpractice.

The debate on health policy proceeds alongside a growing appreciation that the value of increased medical efforts and improved technology is probably less than the public believes (Powles, 1974). Despite the enormous expenditures made for medical care, and their acceleration in the past two decades, the public continues to support increased expenditures and the further development of medical technology (Mechanic, 1979a). The public gives higher priority to the growth of medical investment than to expenditures for education, transportation, or urban problems. However jaundiced the medical care experts have become about the excesses, inefficiencies, ineffectiveness, and irrelevance of much of medical care, the fact is that the public does not share this perspective. Increased investment in medical care continues to be highly valued by the public.

If there is any point of agreement among politicians, health service researchers, the public, and medical practitioners, it is that medical care costs a great deal. Politicians and government officials face the

greatest pressures of cost because, with the government responsible for two-fifths of medical care expenditures, the tax burden is large, and the trade-offs among competing demands are difficult. Thus there is alarm about the tap on the public purse, and strong incentives exist to introduce cost containment. These incentives are buttressed by a skepticism that further investments in medical care will provide returns justifying the cost. Although most Americans don't really feel the direct pressures of cost because third-party insurance or public programs pay most of the bills, even that small proportion of the total that is out-of-pocket is disturbing. Consumers, responding in terms of where costs hurt them, naturally want more front-end coverage—more comprehensive insurance. Given the way medical payment is structured in our society, the solution to the individual consumer's perceived cost problem is to shift the basis of payment to tax-supported governmental methods.

The psychology of illness, and the importance that consumers give to their own medical care, make policy formulation particularly difficult. Reasonable consumers can see the logic of more efficient distribution and organization of services, more parsimonious use of laboratories and technologies, and allocating resources in some relation to expected benefits, but when sick they want the best that medical science makes possible, and these wants are reinforced under a third-party payment system. While most people agree, in principle, that excess hospital beds should be converted or eliminated, in practice they want the principle to apply only to other people's hospitals. There is agreement that frivolous utilization and expenditures should be discouraged, but few patients ever think their own problems frivolous or unworthy of the best care available.

Population surveys suggest that most patients see physicians as responsible for rising costs and feel that they make little effort to curb high expenditures (Mechanic, 1979a). These perceptions probably arise from the public's disapproval of the high fees physicians charge, which most people become aware of only through required out-of-pocket expenditures for that portion not covered by third parties. There seems to be little awareness of, or concern for, high fees that have been paid by an insurance plan. The very high and increasing incomes of physicians, which are well advertised, also probably contribute to a sense that doctors are not sufficiently concerned. But most people tend to distinguish doctors in general from their own, and have more char-

itable views toward physicians with whom they have a personal relationship. Feeling highly dependent on such relationships, the typical patient has a strong need to see the doctor as an ally. It is such needs and feelings that reinforce the strong political influence of physicians.

From an economic perspective, consumer concerns about physicians' fees are poorly focused because such fees constitute little more than a fifth of total expenditures. Although they may be excessive, not much saving can be achieved in this sphere. More central to the problem of increasing costs are costs resulting from physician decisions, for example, the accumulation of laboratory and ancillary services, unnecessary admissions to hospitals, and excessive lengths of stay. Government policy shows recognition of this fact, as reflected in efforts toward hospital cost containment, the promotion of health maintenance organizations, and the encouragement of family practice, but such policies, with the exception of the last, have received little of the kind of public support translatable into political capital. Where public support has been intense, as in the encouragement of family practice residency programs, there has been a dramatic growth of such residencies and budgetary support for them.

Surveys of physicians, in contrast, while they reflect realization of the increasing costs of medical care, give little evidence that physicians see their responsibility clearly, and there is a disconcerting tendency for physicians to attribute mounting medical care expenditures to the poor health behavior of consumers or their tendency to misuse medical services. There is little evidence that physicians who practice under fee-for-service reimbursement are taking positive steps to limit the use of procedures of marginal value, nor is there strong indication that professional standards review organizations (PSROs) are contributing in any substantial way to cost control, despite their focus on utilization review (Congressional Budget Office, 1979). In short, neither patients nor physicians are doing a great deal about growing costs, improving the rationality of medical services, or asking hard questions about the value of existing patterns. They have little incentive to do so, and when they do it is with a clear awareness of their own economic interests.

The hospital, of course, is the focal point of most attention, but it is besieged by a growing number of conflicting pressures. With an excess of hospital beds and increased demands to reduce hospital utilization, hospital administrators are more than ever sensitive to

maintaining bed occupancy rates. This fact alone makes them responsive to demands and expectations of those physicians who can keep the beds filled. Hospitals are no more immune than other organizations to rising prices (and particularly to increased energy costs), and their administrators must struggle to gain control over decision processes that have not traditionally been theirs. The disappointing experience of incentive reimbursement experiments in hospitals is probably attributable to the faulty assumption that administrators could control the decisions of their institutions—a tenuous assumption, given the powers and prerogatives of the medical staff. To add to the troubles of hospitals is the growing unionization and militancy of many workers, including house staff. Collective bargaining agreements, and the need to conform with a wide variety of guidelines and regulations, have shifted some important economic decisions from administrative control to other parties, making the management of hospitals and priority-setting more complicated. Hospitals have been pushed into a defensive posture from which they struggle to escape. External pressures demanding accountability and more efficient operation result in a growth of the administrative component and increased centralization of decision-making. Although the intent of regulators is often to increase the range and quality of service, as well as reduce costs, under pressure administrators tend to seek risk reduction and are hesitant to innovate. The result is a reluctant accommodation to the varying pressures rather than a careful assessment and establishment of needs and priorities. Much effort goes into maintaining the illusion of compliance with demands for accountability without a fundamental change in how the hospital deals with daily demands. As pressures heighten, hospitals, like bank robbers, go where the money is, and that isn't where the most needy reside.

The Response of Government

Although much lip service is given to issues such as quality and access, when budgets get tight, cost replaces competing concerns. The name of the government game in medical care is “cost control,” and when cuts have to be made they inevitably occur at the points of least resistance. In simpler terms, this means that the poor, the old, and the chronically ill suffer. It is these groups that are funded

by budgets more vulnerable to attack, and these groups have poor political organization and limited power. The low public esteem for welfare ensures that the Medicaid program and other public programs for the poor will be scrutinized first, and the evidence is already clear that eligibility is being tightened as states and localities struggle with the need to contain cost. While the gray lobby is more effective than the representatives of the poor and minorities, Medicare is also in danger of increased co-insurance and deductibles and other limitations. When the affluent are not gaining, there is little charity. Discussions of national health insurance at such a time have risks because if it does succeed the outcome is likely to be a limited plan responsive to the vast middle class and not to the disenfranchised. If we were to bet on the likelihood of competing proposals, the odds would be in favor of catastrophic insurance, which would provide many of the wrong incentives for doctors, hospitals, and purveyors of technology (Fuchs, 1974). It is worthwhile for a society to consider and plan for the impact of catastrophic illness, but it is not wise to do so outside a broader framework of care that sees catastrophe in its proper place. But the odds are against this.

Beyond the strategy of cutting vulnerable budgets, the approach to cost has largely been at the regulatory level: utilization review, certificate of need, modification of bases for reimbursement, review of eligibility criteria, and the like. The data are not yet in, but the net savings from such efforts, if any, are probably marginal. Tightening up on the number of hospital beds leads hospitals to invest in other areas such as technology (Salkever and Bice, 1976); making it difficult for hospitals to purchase new equipment encourages physicians to organize to do so in their private offices. The medical system is a leaky vessel and plugging a hole or two displaces the pressures elsewhere.

The displacement game is played in government as well as in the private sector. Each responsible unit is concerned about its own costs and not about aggregate expenditures. Cutbacks in Medicaid eligibility may force more old people into hospitals to get their care, but someone else is paying. Dumping mental patients in the community transfers mental health costs to the social services sector, but on the health ledger it appears to be a savings. Cutbacks in support for residency training in fields such as psychiatry require new sources of funding, and departments adjust by turning away from community

programs and toward more lucrative hospital care to generate such funds internally. Physicians and medical institutions are remarkably adaptable, and they have the funds, the expertise, and the security of considerable public support to play the game well. It is primarily the marginal institutions and practitioners serving the poor that falter.

The Dilemmas of Regulation

Medicine in the United States is highly regulated and is increasingly bureaucratized, with a significant growth in its administrative infrastructure. This trend affects not only all institutional providers and units of government but also smaller medical care practices, including the individual office-based physician. Although there is a strong ideology concerning the autonomy and freedom of the physician, in fact American doctors are more highly monitored and regulated than doctors in many other countries. Such regulation comes from all units of government, reimbursement programs, and private professional groups. Comparison with the English National Health Service, a system of care believed to be highly regulated in a manner interfering with professional freedom, would indicate that American doctors are significantly more burdened with detailed rules and guidelines relating to their modes of practice and clinical work than are their English counterparts. While the English administratively establish general constraints on the economics of care, they intervene less at the level of patient care than we do. In fact, physician regulation in the United States is very extensive and applied in a way that is costly and burdensome. The need to maintain the mirage of a private sector of medical care in the United States, I believe, results in consequences opposite to those desired—a rather heavy hand of government on the process of medical care. Government must set constraints, but it need not intrude into the details of patient care.

The growth of medical bureaucracy in the United States arises from two sources. First is the need to reimburse on an individual fee-for-service, or on a cost-reimbursement basis, large numbers of professionals and organizational providers. The billing process itself, and the paperwork necessary to monitor numerous and complex third-party insurance contracts—with varying co-insurance, deductibles, and maximum benefit schedules and with widely varying coverage

and criteria for major medical payments—boggle the mind and would have been impossible without the development of sophisticated computer systems. Although this complexity may serve insurance companies in preventing consumer comparisons, it assuredly confuses both patients and their doctors. It would be interesting to know how many covered benefits are never paid, simply because consumers are baffled or have too much inertia to contest disputed claims. In the case of professionals and institutions, the cash flow of third-party reimbursement is often a significant problem, and there are often major failures to collect available reimbursement in public institutions.

More complex than billing are the efforts of government to correct for obvious failures of the existing structure of services to deal with problems of access, cost, and quality. Since government intervention takes place within the context of vigorous interest-group politics and within a value system critical of such government intrusions, governmental inputs tend to occur at the margins rather than at the core of problems, and government activity is characterized by attempts to achieve change primarily through economic incentives. Since government pays two-fifths of the total bill, and even a larger proportion of hospital costs, the medical sector is dependent on government for its survival.

Government involvement comes, however, not through a few broad strokes but rather through hundreds of programs and thousands of guidelines and special criteria. Each program developed to attack some special categorical or administrative concern has its own specifications, conditions for eligibility, and administrative guidelines. Garnering these funds, therefore, not only takes enormous effort in information monitoring, planning, and application preparation but also requires sophistication that varies widely among localities and institutions. Even when programs are organized to assist the most needy, it is the needy with the most sophistication and organizational capacity who are best able to capture available resources.

In each instance the specific criteria and guidelines promulgated can be justified, but in the aggregate they often work at cross-purposes, and the cost involved in monitoring and compliance can be staggering. The prevalent perspective is that rules are salutary, and little consideration is given to matching up the benefits with the costs of new regulatory activity. Rules proliferate at a rapid rate, are frequently unenforceable, and government often lacks the capacity to monitor

seriously. The result is that organizations become adept at manipulating definitions, budgets, and procedures, and even the most important requirements are commonly subverted. The proliferation of trivia often takes attention from the really important issues.

Although it might be argued that the United States has followed a middle course between the harsh realities of a private medical marketplace and the bureaucratic consequences of a rationally planned system of care, this is more illusion than reality. The middle course is costly and inefficient in its administrative demands, while offering little real protection to consumers to ensure access or adequate care once they enter the system. As each new problem surfaces, resulting in public alarm, new rules are designed to confront the problem. In any individual case, the rules, although often indirect to deflate strong opposition among those being regulated, have some rationale and justification. The total pattern of regulatory activity, however, is a crazy quilt of rules that often operate at cross-purposes, require considerable resources of time and money, and undermine morale and vitality. Within institutions, it shifts power from those who provide care to financial and administrative personnel whose responsibility it is to ensure compliance and who monitor activities consistent with existing legislation and procedures. Although this may be an advantage from an economic perspective, its consequences for patient care are more dubious.

It is clear that regulation is an essential aspect of large-scale organization, and its importance increases in an environment of multiple and competing interests. Rules are attempts to specify how activities are to be carried out and are intended to substitute for protracted and acrimonious interpersonal negotiation. One approach to rule-making is to establish standards as each problem arises, on the assumption that direction is needed. An alternative is to view the regulation as an activity carrying both potential benefits and potential costs. Before new rules are imposed, it becomes necessary to calculate the trade-offs between what one achieves with a rule and the costs of imposing it on the various parties affected.

A related issue is the level at which it is most appropriate for administrative authority to be applied. Certainly central government has the informational resources to make economic and organizational calculations to define broad principles and necessary constraints. Centralized authority, however, has great difficulty in successfully mon-

itoring, or even understanding, the complexities and contingencies at the service level, and intrusions into these areas often have perverse consequences. Moreover, when the inflexibility and inappropriateness of specific guidelines are perceived by those who must apply them, the result is often not only a subversion of central authority but also, and even more important, a loss of its legitimacy. Effective regulation, thus, tends to be restrained. It sets constraints but delegates more specific decisions to those who are responsible for delivering the necessary services. If it does not undertake responsibilities that it cannot monitor or enforce, it is more likely to protect its credibility.

Alternatives to the Regulatory Muddle

There are basically two radical alternatives to the proliferation of government rule-making. The first truly allows a private sector to exist within some specified boundaries but with minimal detailed interference. The second grants total funding to medical providers to take responsibility for the needs of defined populations and, although the range of services and coverage is mandated, the health care unit itself has great discretion in the establishment of procedures, priorities, resource allocations, or whatever. In each case, government sets the value framework but remains detached from the day-to-day operations of medical care.

The private marketplace is a radical alternative, because such a marketplace is at present almost nonexistent and would be difficult to establish (Mechanic, 1978). Although the price and responsiveness of some types of medical programs and services might be favorably affected—e.g., the structure of medical insurance plans, the cost of drugs and medical devices, or even the fees for particular surgical procedures—the core aspect of medical care, involving the physician's assessment of patients' complaints and the sequence of decision-making and treatment, is not likely to be much affected. Yet this is the essence of the medical care process, and the aspect of care of greatest concern to both patients and physicians.

Proponents of the marketplace approach see it as the best means of maximizing allocative efficiency and believe that any major problems of equity can be approached through selective subsidy or income redistribution. Stimulating the marketplace, they believe, requires

considerable deregulation of professional controls and exclusive practice domains, encouragement of advertising, and stimulation of consumer power in deciding the allocations of their medical dollars. Government subsidy, thus, would come in the form of economic entitlements that the consumer could exchange for varying types of insurance plans or service mixes. Thus incentives would exist to encourage economical decision-making; patients would share in the costs or benefits when they selected more or less expensive medical alternatives. While government might set boundaries and constraints on what trade-offs take place in the system to avoid catastrophic situations that consumers fail to anticipate, consumers would have considerable discretion as to the type and amount of services they purchase, and thus what the cost would be to them. Under the proposal by Enthoven (1978), for example, consumers would have a minimum acceptable level of subsidy to which they could add amenities or not, depending on their personal inclinations and circumstances.

The marketplace models assume responsiveness of the institutional sector (including health insurance plans, hospitals, and professionals) to the new economic climate in which consumers have incentives to economize, but there is little evidence that the types of responsiveness envisioned could actually occur. One must assume that consumers would make informed economic choices on the basis of economic interests rather than habit, inertia, or psychological considerations, and that large providers would feel pressured to compete in offering more economical and efficient plans. One must also assume that such providers have and could use their institutional powers to effectively constrain physician decision-making. Although the theory has a certain plausibility, it depends on many uncertain assumptions and a radical restructuring of existing institutional arrangements and practice patterns. It would certainly require a great deal of momentum to get there from where we are at present. Also, the model requires too many changes from many actors to enlist strong political support.

The alternative approach, more consistent with existing organizational forms if not with prevalent social ideologies, is to put increasing economic constraints on the medical sector, creating pressures for professionals and organizational providers to reestablish priorities and operating procedures. Under this approach, government could deal with basic equity issues by extending entitlements to consumers but would deal with cost problems by budgeting decisions, and not by

more direct interventions. Payments could come in the form of capitation or negotiated budgets. In contrast to explicit mandates on how funds could be expended and for what purposes, each medical unit would be encouraged to assess its responsibilities and priorities for meeting them. In short, autonomy would be protected but in a constraining environment in which efficiencies would be required.

From the perspective of needed regulation, however, how is the public to be assured that their needs will be met? How can one ensure access to entitlements, sensitive and responsive care, and a willingness to treat patients equitably? Only the naive would assume that medical institutions and professionals under pressure would necessarily come to decisions in the public's interest, particularly when the public interest may be in opposition to their own. Yet, we know from present experience how difficult it is to regulate relationships between medical institutions, professionals, and patients, and what a costly burden these regulatory activities can be for all concerned.

There is no obvious solution to such issues, only some possible options. The alternatives are not optimal, but they may be satisfactory compromises that can be modified over time and may work better than current regulatory approaches. First, any system in which patients are linked with particular providers on a capitation or budgetary basis should make it simple for patients to shift providers easily on the basis of relatively short notice. While this may create some administrative burdens and instability of budgeting, the organizations and providers most affected would be those with the most dissatisfied patients. Such structural support for consumer choice increases the possibilities for countervailing influence relative to the power of professionals. Such influence is maximized when information about providers is readily available and can be disseminated easily. Individual consumers do not have the resources to obtain adequate information, but representatives of consumers such as union welfare funds, consumer organizations, or even official groups such as health systems agencies and state insurance departments might be encouraged to play a larger role in bringing pertinent considerations and performance data to the attention of constituents. As such organizations become more expert in monitoring medical services, they might develop considerable bargaining power to affect provider priorities.

At the level of professional work, the absence of direct regulation leaves many possibilities for abuse. We have few guarantees that

physicians remunerated within a capitation structure would not devote less effort to patients, shorten their hours, concentrate their attention on more "attractive" and more "interesting" patients, or give unequal care to patients from different ethnic or social groups. Indeed, we have research findings suggesting that all these results might well occur (Mechanic, 1979b). In addition to countervailing pressures already noted, other incentives toward good performance are possible. For example, the fact that institutions, clinics, or medical groups are paid on a capitation basis does not require that professionals need be. Any of a great variety of options exist to reward productivity, professional commitment, and patient responsiveness through remuneration or other means. I believe we require serious study of how best to reward physicians and other professionals within a capitation reimbursement system.

Realistically, only professionals in the same settings are likely to be acceptable arbiters of institutional rewards; thus rewards must be allocated by peers or by administrative officers of the plan, the medical group, or the hospital. The controls of colleagues or peer groups among physicians have not been found to be particularly effective (Freidson, 1975), but the conditions for such control may change. Colleague control is likely to depend on three factors: 1) goodwill among professionals and a desire to improve professional practice; 2) some reasonable degree of agreement as to what is unacceptable practice; and 3) situational or structural pressures to undertake peer regulation within the colleague group. I am inclined to believe that the first condition generally exists in most settings and, although there are substantial disagreements on quality standards, a consensus concerning unacceptable standards can be reached in a general sense. What has been most problematic in the past, and may be in the future, is the unwillingness of peers to sanction one another. However, if and when medical units are required to function within more constrained budgets, the actions of the wasteful begin to affect the options of all. Such circumstances may be more conducive to peer or even administrative controls than in the climate of the past where there has been enough fat for all.

In sum, it is difficult to be very optimistic about the possibilities of constructive change in a context so complicated, so fettered with entrenched traditions and deeply felt interests, and so perverse in its incentives. Pressure on the dollar, however, has produced a need for

readjustment and provides an opportunity to reshape some of the conditions affecting practice. The process is, of course, fiercely political, with strong contenders. Serious dangers exist that, in the readjustment process, poor and minority groups will lose some of the ground gained in the 1960s and 1970s, and advocates of these groups must remain vigilant.

There is a consensus on two points: that there is a formidable cost problem and that regulation is a growing burden. Perhaps a constructive compromise is possible by reducing regulatory pressures as the health sector demonstrates a willingness to work within a more controllable reimbursement policy and to take responsibility for developing internal processes of accountability consistent with concern for reasonable access, quality, and equity.

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