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Transformation of the US Health Care Delivery System and It's Consequences for the Health Professions

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I have been asked to discuss the trends in the US health care system and in the health profession. I will attempt to do this within the time constraints, but my discussion of the issues will be superficial at best. The US system has become extremely complex, defying easy description. Its structure, functions and operations have undergone major changes which, in turn, have affected professional practice education and research.

The impetus for the system changes has been to improve efficiency, thereby reducing health care expenditures which had increased very rapidly to alarming proportions. They were a major concern in the 1970's, but in the early part of this decade it seemed that government intervention was necessary to curb medical inflation. Between 1970 and 1989, employer spending on wages and salaries, controlling for inflation, rose 1% but for health benefits employer spending rose 163% (Peterson, 1993). In the early 1990's, the US was spending 50% more on health care per capita than Canada, Japan and Germany, 60% more than most Scandinavian countries, and 70% more than the United Kingdom (Roberts, 1993). The experts forecasted that without intervention US health care spending would be up to 20% of gross domestic product (GDP) by the year 2010. In 1993, we were at 14% of GDP while the other countries mentioned were between 8% and 9%. However, despite our spending in the US, our life expectancy is shorter, and infant mortality rates are worse. So the high costs of our health care does not mean that our health is better.

The big growth in costs began after 1965 when government health care programs grew. The Medicaid and Medicare programs began then, Medicaid for the poorest segment in our population, and Medicare for the population segment age 65 years and older. In 1993, these were the fastest growing programs at both federal and state levels, exceeding expenditures for education for the first time. As these programs grew over time, since 1965, business became interested in the market that was available to the health care industry. Their entry into the industry meant that the provision of health care became a business with increased importance of the bottom line, meaning profits. Managed care was introduced which means standardized benefit packages that are sold by insurance companies to employers, both private and public, and to individuals as well. The packages are insurance plans for payment of health care, including payments to physicians, to hospitals, some nurses, pharmacies and other providers who participate in the plans.

In this decade, the high costs of health care began to affect the middle class, business and government (Roberts, 1993). As employers or corporations tried to control costs, they limited the amount of insurance they would provide,

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raised the amount employees had to pay, and excluded preexisting conditions from coverage. Many employers also discontinued health care benefits for retirees. The middle class experienced these cutbacks, and some faced loss of health care benefits due to loss of employment with corporate downsizing. Manufacturing which once provided the best health insurance was shrinking its share of all employment so that fewer people had benefits. Our occupational structure had changed, and the part that grew was in the service industries such as restaurants where health insurance is less likely to be a benefit to employees.

In government and the business community, managed care became common. In 1992, less than 40 million employees were in managed care plans (Peterson, 1998). In 1995, 161 million were enrolled in some sort of managed care arrangement. Thirty-five percent of all state government employees and 73% of the recipients of employer-sponsored coverage were in managed care plans. The consequences of managed care and corporate downsizing have been:

1. Lack of free choice of doctors and hospitals has been increasing.

2. There has been a restructuring of providers of care (Perterson, 1998). In 1986, 57% of physicians were not involved in managed care. In 1995, more that 80% had at least one such contract, and at least one-third were in group practices, which the American Medical Association had opposed previously. Physician incomes have been lowered, and more medical students are selecting primary care because managed care largely relies on primary care to keep costs down.

3. Managed care discounting has affected operations of hospitals, especially publicly supported and academic health center hospitals. The flow of funds was altered so there was less cost shifting possible. Mergers and acquisitions of hospitals occurred at a rapid pace which meant some employees lost their jobs.

4. Corporatization became dominant, i.e., for-profit enterprises, regional and national.

5. There was a rise in numbers without insurance. In 1990, 34.7 million had no health insurance, but the number rose to 40.3 million in 1995 (15% of the population). Further, 14.2% of children under 18 years of age lacked insurance.

6. There is a current backlash against managed care by the middle class and health care professionals who are demanding reform of the system.

7. Spiraling cost increases have slowed down. While 14%–15% of GDP went to health care previously, the proportion of GDP now is 13.7%. The overall health care inflation rate dropped to 2% in 1996. The perceived savings here is illusory though since GDP expanded rapidly during that period, and cost-shifting by employers to employees and retirees also recurred.

8. Savings that have occurred: thorough managed care has been in alcohol, drug and psychiatric treatment, drug prices and cutbacks in care generally as compared with a fee for service plans where insurers paid the prices determined by the care providers (Hefty, l993).

What drives health care costs? Many think: the cost increases are due to provider fraud, recipient fraud (Medicaid), malpractice, drug price gouging or physician income (Roberts, 1993). None of these is key. Drugs cost –8% of health care budget. Malpractice premiums minus cost less than l%. The costs are due to the fact that:

1. It is often unclear what physicians should do in a given case. They are paid by piece work so there is incentive to do more.

2. The population is heavily insured so they demand more.

Abbreviation: GDP, gross domestic product

3. We have a high degree of psychological anxiety, fear illness and death so we ask for more care with little knowledge or concern about costs.

4. Political power of providers is still another reason underlying costs such as the power of physicians. Thus, little money is spent for health promotion and disease prevention.

5. Technological change is always in process. No sooner is a new kind of technology available while another is already being developed.

6. Our fragmented and competitive system contributes to costs. Although 50% of hospital beds are unoccupied, new construction is for more beds. We have a declining birth rate but new maternity services are added so that hospitals can be full-line producers.

7. We have high administrative costs explained by a plethora of forms, heavy marketing, strategic planning, regulation and dealing with physicians. All these activities require employees, some of whom are the bosses who in turn have several assistant bosses, etc. These costs are twice as high as in Canada. In 1968, hospitals on a daily basis employed 435,000 managers and clerks to take care of l.4 million inpatients. By 1990, the daily average of patients was 850,000 but administrators, clerks and others in the bureaucracy increased 5 times to 1.2 million (Whitburn, 1993).

With these major transitions in the system, changes have followed that have affected practice. One is the changing character of the patient population in the hospital. Formerly, almost any person was admitted who was deemed by the physician to require hospitalization. This is no longer true. Physician's treatment or diagnostic plans for in-hospital are screened against criteria established by payor or insurance organizations, either government or private. If the plan is not approved, the patient must pay or some other means for payment must be sought or the plan must be altered. Minor surgical procedures are performed on an ambulatory basis, either in the physician's office or in the surgical unit of an ambulatory clinic. Cataract surgery, for example, is performed on an outpatient basis. Patients are admitted and discharged the same day. In hospitals, the consequence has been very sick patients, many of them elderly comprising the hospital population while others are provided care in the community. The latter is known as community-based care.

At the same time that these changes have been occurring, patients are being discharged earlier from the hospital, many of them with tubes still in place or with equipment that they still require. Further, they may or may not have follow-up services in the community. For instance, a colleague of mine had to be hospitalized for removal of a nonmalignant tumor in the sinus between the ear and brain. Because of the supply of nerves and blood vessels in the sinus, the surgery that was entailed was very delicate, calling for the specialized skills of a neurosurgeon. Because of inflammation of her throat post-surgically, due to intubation during the long surgery, she had difficulty in breathing so a tracheostomy was performed. She was discharged with the tracheostomy 7 days following surgery. She did not believe she was ready for discharge but had no alternative. She lived alone so she had no key person staying with her. If it were not for friends who were nurses and who could give her assistance with self-care, her recovery probably would have been prolonged.

In the past, women who gave birth in hospitals were usually discharged on the 3rd day postpartum. When earlier discharges began, the women were discharged on the 1st day postpartum in many hospitals, while some hospitals discharged these patients on the same day after delivery. These practices raised strong objections from health care professionals and others. The government stepped in then to mandate that the women and infants should remain at the hospital at least 2 days postpartum unless they themselves requested earlier discharges.

Yet another strategy to reducing costs has been downsizing or reduction of hospital per-

sonnel, which has included professional nurses and occasionally physicians. In turn, nurses have been replaced by either untrained, unlicensed assistants or by certified nursing assistants who have had minimal training, or 6 weeks on average, to perform some very basic activities.

As a consequence of these changes that have affected practice in the hospitals as well as community clinics, professional nurses have had to assume increased responsibilities. Not only are the patients very ill and still requiring monitoring, but also the nursing assistants must be carefully supervised. Essentially, professional nurses are accountable for care of the patients but have fewer opportunities to observe and to interact with the patients. They must rely on nonprofessionals to be alert to patient responses and to report them accurately and in a timely manner to the nurse.

Increased responsibilities have also meant fewer opportunities for patient education, a primary function of the nurse. Because discharges occur so early, discharge planning is often not as thorough as it should be, and in some cases it needs to begin before admission. The growth in ambulatory care facilities has meant increased demand for primary care nurses as well as physicians for community-based practice. Nurses' training in community health nursing which is pertinent to outpatient or ambulatory care nursing may or may not have been a strong component in the educational program, however. Programs for patient education, coordination of services with the hospital and in the community, and knowledge about the community have need to be developed such as cultural patterns, health status, life styles and other characteristics of the community. Further, primary nursing means that assessment and differential diagnosis skills, both physical and psychological, must be a substantial part of the nurses' competencies. These are not to be equated with home health care though they are useful for that practice.

Nursing education programs were not fully prepared for these changes. Students were being instructed for the practice of nursing in a relatively slower paced, stable environment in which a one-to-one relationship with the patient was paramount, and was heavily oriented to hospital care. However, the urgency for curriculum changes was made evident by our nursing leaders, and the programs responded quickly. Most schools have either completed or are completing the time-consuming process of curriculum change now. The goal is to give more emphasis to primary care content through both separate courses and integration of some of the content in other courses. The clinical experiences, too, have been revised to incorporate more community health and primary care experiences. Although development of critical thinking abilities has been an important consideration in teaching methods, how these cognitive skills be fostered in the instructional process is also being given more attention. The increased complexity of patient care makes use of critical thinking imperative.

Medical education, too, has changed to include more primary care experience for students and residents. I mentioned the Medicare program earlier, which provides for health care of those 65 and older. Medicare funds have contributed to medical training since the program began but now mandates residencies in primary care, whether family practice, internal medicine or primary care. That is, a certain proportion of the training monies that support medical residents must be allocated to those training for primary care. In nursing, too, a certain proportion of monies that the government provides for clinical training at the master's degree level is designated for those in practitioner training. This means specialization in some area of primary care whether in adult health, pediatrics, midwifery, geriatrics or psychiatric/mental health nursing.

The current issues which continue to confront us and are basic to controlling health care costs are: i) Health care cost containment means health income limitation. Who will pay? We can control the supply but not the demand. We need to understand and acknowledge that cost controls, affordability, accessibility and universality of care are interrelated. We need to deal with all these factors. Otherwise, we can not make effective change in the system; and ii)

We need to deal with the unrealistic expectations of the public. We don't want to pay for health care and to have limits on our choices of physicians and other providers. We want the best possible care without impact on our economy or our taxes, and we want access to care for all.

The American public needs to be educated about the facts of health care and to be given opportunities to discuss these basic issues. Because these are difficult, it is unlikely that our politicians will provide thoughtful leadership. They are difficult issues because they force us to reflect on our value systems regarding equality, our responsibilities for those who are less fortunate than we, our sense of fairness, and willingness to give up some advantages in order that others may have benefits. Reflections on the values we hold will bring to our awareness our attitudes toward the elderly, handicapped persons, immigrants and other special populations. Perhaps you can understand that the basic issues regarding health care are not favorite topics for discussion. We cannot continue to resolve them incrementally though because health care costs are again getting out of hand. Therefore, we can only hope that current distractions from addressing these vitally important issues will be resolved quickly so that health care reform will be given highest priority on our national agenda.

We expect our students to participate in the decision-making process because they will be our health care providers in the near future. The system should be one that enables them to provide care that will effectively promote the well-being of those who seek their services.

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