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Senior Project on the Sociology of Health Care in America and Possibilities for Reform

by

Mark Hughes

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This project is the accumulation of research from fall and spring semester 1996-97. The final project is made up of three parts: 1) the original paper written in Sociology 344, 2) an additional paper on two types of possible reform, and 3) the final presentation. Copies of all three are included in their respective orders.
The Sociology of Healthcare
While the best course for health care reform continues to be an enigma for society, the present system and policies are changing constantly. The federal government has yet to determine its exact role in the reform movement, but business regularly exerts its influence on the development of legislation at the federal level. New forms of health care coverage have altered the nature of the patient to physician relationship and have brought the business mentality to the forefront of medicine. Concerns have arisen over the effectiveness and quality of the new programs and their ability to adequately serve special members of the population.

For years, business and medicine had an understood relationship in which each supported the interests of the other. In the late nineteenth century, these two institutions formed a "special relationship" where businessmen respected physicians' opinions on health care policy and believed that doctors generally acted out of concern for their patients (Fox 94-5). Accordingly, physicians supported business's views on other federal and state issues.

This understanding lost stability when businesses decided that health coverage was becoming too expensive, and it was no longer in their best interest to side with physicians. The field of medicine displayed its dissatisfaction with the business community when, in 1991, the American Medical Association (AMA) held an independent press conference without consulting any big
business organizations and demanded changes in health care policy (Fox 95).

An appreciation for the nature of our country's medical system is needed to comprehend the effect of changes to its structure. The delivery of our medical care is generally social in nature, as physicians attempt to build relationships with their patients. The overall system is created with certain assumptions made about health care recipients (Knos and Sultan 6). The system takes for granted that patients have the means to pay for treatment received, either independently or through a third party such as an insurance company; that patients will take the initiative to and have the resources to seek physicians' assistance when needed; that patients are competent to give themselves basic care and to recognize general symptoms of illness requiring treatment; and also that people have the mental ability to understand and the desire to adhere to prescribed physician recommendations (Knos and Sultan 6).

Our medical system also embodies certain basic characteristics. The first of these being that no specific organization governs its daily actions. Historically, medicine has always been more curative than preventative in nature, and physicians have controlled any modifications made to its practice (Knos and Sultan 14). These traditional aspects are giving way to more modern approaches, such as taking preventive measures to
avoid chronic illness; and businesses are playing a prominent role in the shaping of medicine's application.

There are basically five general occurrences that cause people to seek medical advising. One instance is that a personal crisis causes people to acknowledge their impending or current physical weakness. People may also be forced to recognize their illnesses when sickness prevents them from functioning as normal (Enos and Sultan 101). For example, a person may require more sleep than normal or become irritable and unable to concentrate on typical tasks. Another incentive may be an authority figure's suggestion to seek medical attention for a perceived illness. Finally, people may be motivated when they fear there is impending danger to their well-being or they see another individual suffering from similar symptoms (Enos and Sultan 102).

Socioeconomic status as well plays an important role in a person's perception of the medical system and its caregivers. A distinct difference may be seen between white collar and blue collar workers. While white collar employees may have the financial privileges to enjoy necessary physical maintenance, blue collar workers often don't have the luxury of investing in preventative measures and may deny indications of illness such as pain (Enos and Sultan 100). Some patients may limit their physician's ability to give them the best diagnosis and treatment because their cultural or ethnic background influences the amount of and or type of information they are willing to share with the
physician. For instance, in the Navaho culture, there is no
differentiation between types of pain, such as other cultures' perception of sharp pain or dull pain. Another deterrent may be that already self-conscious and insecure recipients are embarrassed to seek clarification or explanation of prescribed treatments for fear of appearing unintelligent or simple-minded (Knos and Sultan 101).

To compound their situation, people living below the poverty line often perceive themselves as less healthy than more financially secure people in identical physical condition. This is not to suggest that living in poverty does not carry health risks. The less fortunate don't generally eat balanced meals and often suffer from vitamin or protein deficiency. Unsanitary living conditions can lead to easy contraction of bacterial or viral infections, and the care they receive may not reach the high level of quality as that of the wealthy (Knos and Sultan 143).

Inadequacies such as these and other economic problems have placed great pressure on the political structure to enact laws to promote better care. Skyrocketing costs, increasing roughly 10 percent annually, demand attempts at containment. Total expenditures rose from approximately $130 billion in 1976 to roughly $1 trillion in 1994 (Knos and Sultan 15). Attitudes about who should receive care have evolved; the concept that only those who could fund their medical care could receive it has been
replaced by the idea that government should help subsidize the expense for the needy. Resulting Medicare and Medicaid programs have committed the government to large-scale financial backing for citizens who can't afford medical costs.

Currently, less fortunate citizens are either uninsured or are receiving federal aid in the form of Medicare or Medicaid. Those of greater wealth may enjoy coverage provided through an independent insurer or a plan provided by their place of employment. Medicare, which is governmental health insurance for the elderly, was established in 1965 and is granted and overseen by the Social Security Administration (Knos and Sultan 160). Medicare is set up in two parts; the involuntary part includes basic inpatient hospital needs and occasional provision of home health care, and the more comprehensive voluntary portion covers physician services and outpatient hospital care as well as additional home health care (Knos and Sultan 160). Medicaid grants money to the states, and through state federal programs the money is allotted and distributed. For this reason, medical benefits under Medicaid can vary greatly from state to state. Funding through Medicaid is available to the needy, including the elderly, blind, disabled, or those with dependent children; the medically needy, defined as those who can afford basic necessities but not medical services; and children under age 21 whose parents or guardians can't afford medical treatment for them.
Two of the possible improvements on the current medical coverage options are the adoption of a national health care plan and increasing membership in managed care organizations (MCUs). The nation has yet to adopt a structured national health care plan. Doing so would theoretically eliminate certain problems in the current system. A national health insurance plan would ensure access, lower monetary difficulties, control total cost of health services, and decrease waste in the system (Knos and Sultan 370). These ideas are philosophically sound, yet the government has never shown that it can feasibly eliminate inefficiency or control spending in its already vast departments.

The second option, MCUs, combines the health care provider, facility and insurance company into one integral unit. The most popular type of MCU is the health maintenance organization (HMO). There are two types of HMOs, the first of which is called an individual practice association (IPA) and makes up about 40 percent of HMOs. In an IPA, the insurance company contracts a doctor to provide a service on a case-by-case basis for a set amount of money (Ward and Bryant 655). The other approximately 60 percent of HMOs are prepaid group practices, which pay physicians on a salary basis for caring for a specified group of patients (Ward and Bryant 655). HMOs have been providing health care services to United States citizens for about 50 years and are logical providers for a host of services for Medicare
recipients because of their ability to cut costs and utilize management (Durham 481).

Yet some groups may not be so adequately served. Because HMOS are primarily intended to care for the model groups in the population, those with uncommon conditions could prove difficult to treat (Birenbaum 336). For example, advocates of the disabled worry that access to specialists under the watchful gatekeeping system might be significantly curbed, and the professionals treating them might not allot enough time for examination (Birenbaum 334). Despite such concerns, HMO operation has steadily increased.

Following the passage of federal HMO legislation in 1976, federal financial and organizational assistance was finally offered by the Department of Health, Education, and Welfare (Herrmann, Matthews and Segadelli 687). This money allowed HMOS to rapidly grow in popularity and number. In 1993, managed care plans became the major supplier of employer health care benefits. However, total enrollment in the plans was just more than 44 million, less than 20 percent of the population (Birenbaum 334). When put together, these two facts show how eager business is to support the enrollment of people in HMOS in the United States.

Financial gain for businesses offering employee health care plans is a major reason for the rise in the number of HMOS.
Enos and Sultan said of the 1973 HMO Act:

A deliberate attempt is being made to eliminate employer obligations to pay for more comprehensive coverage than a certified HMO is obligated to offer.

(328)

This type of policy shows businesses' transition from siding with physicians to operating primarily with their own interests in mind.

In the mid 1970s, the managed care system began to be more prevalent probably because of the "clean" ideology of the system (Enos and Sultan 284). Theoretically, the HMO system would not do much to change the present concept of delivery of health care nor would it lead to a form of socialized medicine (Enos and Sultan 284). Socialized medicine has long been feared by most doctors. The idea of managed care is to lower the cost of health care without much government involvement or decrease in quality (Enos and Sultan 284). However, upon implementation these hopeful hypotheses probably will not hold true. Outside of philosophy there are several pros and cons to establishing a predominantly managed care medical system.

Again, an important plus for the advancement of HMOs as the major reform direction is the basic principle on which they are based, providing more accessible care for a lower cost. On the surface, physicians have just as much to gain as the consumer with working only fixed hours and being almost guaranteed a
certain number of patients (Enos and Sultan 307). This seems to benefit a physician who wants to live a more normal life in terms of hours spent at work. Recent studies have proven that soundly run HMOs may lower hospital usage as much as 40 percent (Herrmann 691). Naturally, a reduction in hospital time would lower overall costs associated with health care. The idea of smaller cost to the consumer is echoed in the article by Ward which states that "the primary advantages of HMOs from the standpoint of consumers are likely to be cost, comprehensiveness, and accessibility" (656). Finally, HMOs may improve preventive care by creating specific economic incentives for doctors to maintain their patients' good health (Durham 482). However, physicians should already have the best health of recipients on their minds.

The growth of managed care has not been without heavy criticism and negative points to counter the positive aspects. In the beginning, no good model for HMO structure existed. Thus, many doctors were skeptical about exactly how a managed care system would work and what the logistics of starting one would be (Enos and Sultan 311). Young aspiring doctors who had a lot of time and money invested in their education were not sure if HMOs could provide the salary they desired (Enos and Sultan 312). At first, this concern might seem petty since it involves the amount of money that the doctor will make. However with certain debt to repay, new physicians need security in their earnings. Probably the most disturbing and important issue for physicians is the
likelihood that some of the decision making power will be taken from them and given to administrators (Enos and Sultan 318).

Consumers have had legitimate concerns from the beginning as well. The two major issues for them are maintaining a high standard of quality care and being satisfied with the overall medical experience (Enos and Sultan 323). These are important because the formation of HMOs as the primary source of care may alter the traditional patient to doctor relationship which is so important to recipient satisfaction. Under managed care, physicians would have financial incentive to spend less time with each patient so that more could be seen. This is because the doctor is reimbursed on a per case basis regardless of time spent with any one patient. Overall satisfaction of patients has been shown to be based largely on qualities such as privacy, genuine caring of doctors, and ability of physicians to just listen (Enos and Sultan 323). All these attributes might be compromised under an HMO model.

Many formulas for success of HMOs have been suggested. Integral to the organizations' prosperity is strict cost control, which will ensure premiums remain competitive (Herrmann, Matthews and Segadelli 687). Caution must also be taken to ensure that HMO physicians are exposed to enough of a variety of patients' health problems to give them experience and well-rounded expertise (Brush and Moore 717-8). One way to satisfy this need is to use "a method of allocating patients to residents called
curriculum-based patient assignments," which allows residents to treat a diversity of problems (Brush and Moore 717-8).

In order to survive, HMOs will have to offer "a broad range of cost-effective acute and chronic care services to a diverse population," paying particular attention to the growing elderly population (Durham 482). To do this, effective methods of measuring their performance, from cost to the individual status of each member, must be developed (Durham 482). Also, methods of ensuring physicians gain experience and express interest in treating those with disabilities or special needs should be in place. One possibility is to offer continuing medical education credits to be earned through seminars for HMO physicians (Birenbaum 335).

The field of health care will continue to change as long as the perceptions that the costs of service are too high and that service is inaccessible to many needy individuals remain. Political pressures are forcing some type of reform. However, most of the policies written and adopted have been and will continue to be the result of big business' influence. Although managed care organization may lower the overall cost of health care and in some cases to the consumer, the conception of these plans was came from the business community trying to protect their interests. The satisfaction of patients with their health care delivery will decline the personal physician to patient relationship is devalued due to time and money restrictions
placed on doctors by the business executives who can only practice "bottom-line" medicine.
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Possibilities for Reform
The direction reform of the health care system in the United States should go is a very controversial issue. Many of the powerful elite have much to lose by changing the system while others might benefit greatly. Health care professionals and insurance companies are making lots of money in the present system. They are resistant to change. However, businesses are loosing money by having to provide expensive health benefits to their employees. Therefore, they want the price of health care to either go down or the burden of providing insurance to be taken away from them. Neither side is right, but some type of reform is needed based on some basic statistics. There are many ideas out there, but two, global budgeting and managed competition, have the most ideological promise.

The U.S. spends more money than any other country per year on health care. By itself, this does not seem to be that big of a deal since we spend more money on most things than any other country. However, the satisfaction rate on people in America is lower than any other country (18). It seems there should be a direct relationship between the amount of money spent and the level of approval in a country. Disappointingly, there are also 36 million uninsured citizens in the U.S (20). Once again it is difficult to understand why over 10 percent of the population has no health coverage. Finally, the amount of money spent on health care in America has risen from $130 billion in 1976 to over $1 trillion in 1994 making up about 12.5 percent of total expenditures every year.
Global budgeting is simply an annual negotiation on spending caps (44). This negotiation could be at the level of a hospital or a group practice. By doing this, the details of daily operations would be left up to the doctor as long as the limit was not exceeded. The system would be analogous to the statement "global budgeting is like building a fence" instead of using leashes for all the cows in the field (45). This choice for reform would hopefully begin to reverse the psychology of healthcare decisions back to the conservative practices of old (46). So much stress is placed on doctors not to "miss" anything that often unnecessary tests or procedures are performed to cover the liability of the physician.

There are a few problems that might be faced using global budgeting as a system. Competition between providers might be blocked since a limit is set and no real differences may be seen between different insurance plans (46). This type of plan also does not guarantee from where the decreased cost would come (47). Theoretically, the reduced cost would come from more efficient usage of medical resources, but the reduction could come from less service and increased waiting lines. Also, the increased pressure on the system to expand to meet the needs of every individual may not allow such limits to be set at the beginning of a year (47). Predicting the cost may be impossible.

Managed competition is a system which uses market forces to improve efficiency and control costs (47). Under this system, the consumer would choose between competing comprehensive plans probably with HMOS under the plans. The difference in managed
competition and really the way it is now would the instituting of a sponsor (48). The sponsor would be a "middle man" who made sure the consumer was informed about the different possibilities with the opposing plans and also work with the insurance plans to negotiate better coverage. Plans would be allotted money based on the types of people who enrolled in the plan and their likely risk factors. This would keep individual plans from only accepting "healthy" people who would rarely need medical attention. This philosophy is known as "risk-rating" (49).

In conclusion, either of these two systems would be better in many ways than our present system. The bottom-line is that the United States is spending too much on a healthcare system with which a majority of people in the country are dissatisfied. The biggest problem with reform is the reality of changing such an enormous system. As a result of the size, the healthcare system in America will, no matter what the course of action, be difficult to reform.
Works Cited

The Final Presentation
While the best course for health care reform continues to be an enigma for society, the present system and policies are changing constantly. The federal government has yet to determine its exact role in the reform movement, but business regularly exerts its influence on the development of legislation at the federal level. New forms of health care coverage have altered the nature of the patient to physician relationship and have brought the business mentality to the forefront of medicine.
Outline

I. History

II. Medicare and Medicaid

III. HMOs

IV. Reform

   A. Indicators of need

   B. Possible options
History

1. The Big Business/Medical Field Relationship

2. Our system and the assumptions it makes

- The system
  --- social in nature
  --- delivered through formation of physician/patient relationship

- Assumptions
  --- patients have means to pay
  --- patients will take initiative to seek care
  --- patients able to provide themselves basic care
  --- patients competent and will desire to follow prescribed treatment
3. Reasons people seek medical care

1) personal crisis

2) illness prevents normal activities

3) see impending danger to well-being

4) an authority figure suggests treatment

5) see another person with similar symptoms who is "sick"
Medicare and Medicaid

Medicare

-established in 1965 for the elderly
-has two parts an involuntary part and a voluntary

Medicaid

-federal money granted to states and states distribute
-for the needy which include elderly, disabled, poor, or children under 21 whose parents cannot afford treatment for them
HMOs

Two Types:

1. IPA (Individual Practice Association)
2. Prepaid Group Practices

--The Rise of HMOs

--Business Aspect

Pros and Cons:

Positives

- Ideologically "clean"
- Basic principle sounds good
- Physician benefits
- Examples of cost reduction
  --hospital usage
- May increase preventative care
Negatives

- Originally, no good model

- Decision making power taken away from doctors

- Standard of Care

- Consumer Satisfaction
Reform

Indicators of need:

1. Spending versus Satisfaction

2. 36 million uninsured Americans

3. 12.5% of economy goes for healthcare

4. Expenditures went from $130 billion in 1976 to $1 trillion in 1994

Two possibilities for reform:

--Global Budgeting

--Managed Competition
Global Budgeting

Global Budgeting is basically the annual negotiation on total spending caps.

- Ceilings are set and details are not controlled
- Would hopefully reduce cost while allowing clinical freedom with less government regulation
- "Like building a fence" instead of using leashes
- Aim to change psychology of healthcare decisions to more conservative practices

Problems:

- may block competition
- does not insure where reduced cost would come from
- expansion pressures may "blow the lid off"
Managed Competition

Managed Competition uses market forces to improve efficiency and control costs.

- Consumer chooses between competing plans
- The "sponsor"

Problems:

- Depends on strength of plans within
- Could not be implemented everywhere