Medical Gridlock and Health Reform

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The Eisenhower Center
for the Conservation of Human Resources
· Studies in Health Policy ·

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 1994 by Westview Press

Published 2018 by Routledge
52 Vanderbilt Avenue, New York, NY 10017
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

Library of Congress Cataloging-in-Publication Data
Medical gridlock and health reform / Eli Ginzberg.
p. cm. — (Eisenhower Center for the Conservation of Human
Resources studies in health policy)
Includes index.
ISBN 0-8133-2040-2
1. Health care reform—United States. I. Series.
RA395.A3M43 1994
362.1′0973—dc20 93-46403
CIP

ISBN 13: 978-0-367-00951-9 (hbk)

To Margaret E. Mahoney,
a friend of many years,
with affection and appreciation

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Preface

With a few exceptions the chapters that comprise this book have been previously published in health care journals, most of them within the past two years. Accordingly, this volume can be viewed as a follow-up to *The Medical Triangle: Physicians, Politicians and the Public,* which Harvard University Press first published in 1990 and reprinted in paperback in 1991.

The early 1990s saw the U.S. health care system under intensifying pressures and strains because of steeply rising expenditures, an increase in the number of uninsured persons, and a range of other challenges, including increasingly severe pressures on the government and employers, the principal payers for health care. As a consequence of these and other dysfunctional developments, I was encouraged to explore and assess many of these new developments and to make my findings more broadly available by publishing them in various health policy periodicals. They are here reprinted to enable the interested reader to become acquainted with my assessments of the transformations underway in the financing of U.S. health care and in the delivery of services on the eve of an era of major health care reform.

Except for minor changes in wording and an updating of an occasional statistic, the chapters in this volume do not differ from the articles as they were originally published. However, I want to note explicitly that I am indebted to Miriam Ostow (Chapter 16) for agreeing to let me include our joint effort in this collection under my name.

I want to add that my collaboration with Miriam Ostow covers three decades; as head of the health care studies of the Eisenhower Center staff, she has contributed in greater or smaller measure to all of the chapters, not only to the one acknowledged above, and for this collaboration I am deeply in her debt, intellectually and personally.

The Eisenhower Center for the Conservation of Human Resources, Columbia University, which I direct, has been fortunate to have received financial support for research from a number of the nation's leading foundations concerned with health policy. I acknowledge with gratitude the support of The Robert Wood Johnson Foundation, The Commonwealth Fund, The Pew Charitable Trust, and The Josiah Macy, Jr., Foundation.

In the assembling and editing of the chapters I was greatly assisted by my long-term associate, Anna Dutka, who assumed most of the responsi-

bility for taking the discrete pieces and helping to transform them into a book.

For their preparation of the original articles for publication and for overseeing the multiple stages of guiding this volume through the press, I want to express once again my deep appreciation for the splendid assistance that I received from Sylvia Leef and Shoshana Vasheetz, long-term mainstays of the Eisenhower Center staff.

Eli Ginzberg, Director
The Eisenhower Center for
the Conservation of Human Resources
Columbia University

Introduction

About a year ago, Victor Fuchs remarked that from being the nation's leading incrementalist, I had become a leading eschatologist. Fuchs was fully justified in pointing out the radical shift that had occurred in my thinking about the changing U.S. health care system as we entered the early 1990s. As a longtime student of the changing health care scene I had observed, or had read about, many forecasts of radical changes looming on the health policy horizon that time had proven wrong.

Every decade or two the passage of national health insurance appeared to be imminent—it was part of Theodore Roosevelt's platform when he ran for president on the Bull Moose ticket in 1912. Each time the proposal reemerged, the last being in 1976 when Jimmy Carter included it in his successful presidential bid, I was certain that it was no closer to enactment than it had been in 1912, 1935, or the late 1940s.

My reaction to health care cost escalation provided other evidence of my incrementalist approach: In the post–World War II decades, when health care expenditures mounted rapidly, most analysts forecasted that the expenditure trend would inevitably level off once health care outlays, which had amounted to 4.5 percent of gross domestic product (GDP) in 1950, rose to 10 percent, but I saw no reason why such a leveling off should occur. True, President Richard Nixon had issued a national alert in 1969 when current expenditures approached $75 billion (up from $43 billion in 1950 adjusted for inflation) and accounted for 7.5 percent of GDP. In the president's view, a continuation of such expenditure increases threatened the financial stability of the U.S. health care system and even the effective functioning of the U.S. economy. But it seemed to me that the president's warning had been premature and exaggerated. In fact, although health care expenditures continued to accelerate, the health care system continued to function and the U.S. economy did not falter. My incrementalism was reinforced when the ratio of total health care outlays to GDP crossed the 10 percent line in the mid-1980s and kept increasing.

I made some rough projections in 1990 that indicated that if the United States remained on its present course, national health care expenditures would exceed the trillion-dollar mark by mid-decade and the 1.5 trillion-

dollar mark not too long thereafter. This was a major shock to my incrementalism.

This arithmetic exercise explains why I altered my approach from incrementalism to one of eschatology. It made no sense to me that the nation was on the way to spending $2 trillion by the year 2000 on health care. It was by no means clear that the payers could find the additional sum; and it certainly made no sense for the United States to devote 21 percent of its GDP to health care. President Nixon was premature in raising his alarm when the ratio approached 7.5 percent, but now that it threatened to be three times as large only a few years hence, it seemed to me that the time had come to warn about serious trouble ahead.

The foregoing abbreviated comments about my "conversion" provides a starting place for introducing the reader to the twenty-one chapters that follow, arranged in four major subdivisions. In my review of the principal themes contained in each of the major sections, I hope to provide the reader with a map of the terrain, which will make the volume more accessible.

Part One: The Changing Health Care Scene—The Longest View

The five chapters in this section explore the insights that can be gained for a current understanding of health care and its policy directions by a review of relevant events since World War II. Chapters 1 and 2 draw upon my service as Chief Logistical Advisor to the Surgeon General of the Army during World War II. The analysis is based on firsthand knowledge and experience.

The remaining three chapters look briefly at the unique American experience of delivering health care to veterans in a separate hospital system; at how health reform contrasts with other reform efforts in employment, housing, and education; and at how the current and prospective reforms are likely to affect the future of health education.

Part Two: Health Care and the Market

These seven chapters explore many critical dimensions of the current health care system within the context of health care reforms already underway or those looming ahead. Chapters 6 and 7 provide a lengthened perspective on the reform proposals that are now competing for attention. Chapters 8, 9, and 10 deal sequentially with critical dimensions of the extant system: personnel, nonprofit organizations, and high-tech medicine. Chapters 11 and 12 deal with more conceptual issues involved in competition and global budgets.

Part Three: The Poor and the Uninsured

The four chapters in this section single out for evaluation a dominant issue confronting the American people—how to improve the access of the poor and the near-poor to essential health care—and deal seriatim with selected dimensions of the subject. Chapter 13 focuses on current and prospective financing issues connected with improved access for the poor. Chapters 14 and 15 explore briefly the problems of health care access for the poor in New York City and for the nation's Hispanic population.

Chapter 16 seeks to demonstrate that although the introduction of universal health insurance may be a necessary step to assuring health care access to all, it is not sufficient by itself to remove such nonpecuniary barriers as the reluctance of physicians to practice among the poor or the lack of interpreters to facilitate conversation between English-speaking physicians and foreign-speaking patients.

Part Four: Toward Health Reform

These five chapters explore themes critically important to the understanding of the forces impeding or facilitating the transition of the present U.S. health care system to its future contours. Chapter 17 explores the question, Why has health reform been so slow? Chapter 18 reviews the many different interest groups that have a major stake in health reform and provides a partial answer to the question above. Chapter 19, on the future of health care reform, is addressed primarily to physicians to help them recognize major societal forces that are more potent than their professional concerns, even though the latter are still important and will continue to be. The penultimate chapter is a review of recent efforts to seek directions as to where we are and where we should be heading in health reform. The final chapter provides a brief overview of President Bill Clinton's proposals for health reform, advanced in the spring of 1993. It gives a larger perspective and considers what history and analysis can contribute to such an evaluation.

PART ONE

The Changing Health Care Scene: The Longest View

1

Everything I Know About Health Care I Learned in the Pentagon in World War II

A reasonable question to ask is, How did a thirty-two-year-old draft-eligible nonphysician happen to become the Chief Logistical Advisor to the Surgeon General of the Army who had forty-five thousand physicians under his command in World War II? The answer is simple: In 1942–1943 I was working for General Brehan B. Somervell, the commanding general of Army Services Forces (ASF) and the Surgeon General's boss; one of my early assignments was to report on how the Surgeon General's Office (SGO) used resources. My analyses came to the attention of General Raymond Bliss, the assistant surgeon general in charge of operations, who subsequently (summer of 1943) "borrowed" me for the task of developing a reorganization plan that would enable him to prepare effectively for the two-front war. When the plan was ready, the general suggested that I head the new organization, the Resources Analysis Division, whose personnel would report directly to him.

During the course of the next three years I learned a great deal about the planning and administration of the largest medical operation in this nation's experience. At its peak, on a single day it had 600,000 patients occupying hospital beds throughout the world, tended by a work force of over 600,000 nurses, ward personnel, and civilian support staff. Together, patients and workers accounted for approximately one out of every seven persons in the United States Army. What follows are some of the more important lessons I learned that have stood me in good stead in the years and decades since the end of the war.

Lesson One: The Risks of Planning

In developing the reorganization plan, it became clear to me that the SGO was not prepared to hospitalize and treat the large numbers of battle casualties

that would be returned to the United States once major invasions had been launched on the European continent and in Japan. Accordingly, the initial task that I faced was to develop a plan to cope with this priority need.

Early reconnoitering disclosed that there were no reliable data to support such a planning exercise. True, Colonel Albert G. Love of the SGO had produced some estimates based on the experience of World War I, but it appeared highly improbable that the invasion of Europe would repeat the pattern of trench warfare used in that war. More recent data were available from the invasion of North Africa, but they were of limited use in calculating the probable casualty rate from a cross-channel operation. By dint of good luck, the other SGO consultants and I had gotten our hands on some information based on the westward push of the Soviet armies, but to our consternation they covered only surgical cases, not medical illnesses. A Russian soldier who took sick had to fend for himself and seek help from the civilian sector; the Soviet Army provided care only for battle casualties.

The absence of a reliable statistical base, however, did not relieve me of the responsibility of carrying through the planning exercise. It was necessary to project the number of general hospitals, specialty services, specialist assignments, and various other requirements of the Army medical system. In the end, my staff and I estimated that on D Day plus six months the system would be responsible for 181,000 patients.

Examining the operating data six months after D Day, I found that we were within half a percentage point of our original estimate. I checked not only the total patient load but also two critical determinants: the number of casualties and the length of time that patients would be hospitalized. It turned out that I had vastly overestimated the number of casualties and vastly underestimated the average length of hospitalization. Clearly, these compensatory errors were my salvation, but what if they had been compounding errors? Lesson: Good planners are more likely to be lucky than smart!

Lesson Two: The Allocation of Limited Tonnage

In the early spring of 1944 General Charles P. Gross, the chief of transportation, called a high-powered conference to review the allocation of tonnage for priority needs. I was the SGO's representative and it was my job to get sufficient tonnage to assure the safe evacuation of the battle-injured. I made my pitch, not once but several times, until General Gross made the trenchant observation that if he deflected tonnage from bringing ammunition in, he could use all of it to move the injured out. Lesson: The availability of medical care is critically important for the morale of troops, but having ammunition to fight the enemy is a higher priority for the Army.

Lesson Three: Physicians Want to Keep Busy

One of the major challenges that faced the senior consultants to the SGO was the need to restrain physicians, especially during the buildup phase of the Army, from doing too much for the patients under their jurisdiction. Every couple of weeks a bulletin was sent to the field, advising physicians not to do procedure A, B, or C because aggressive therapy would probably delay the return of the serviceman to active duty. Hard as it is to believe, circumcision was the most frequently performed surgical procedure during World War II. My preferred explanation for this counterintuitive fact is that even in the absence of monetary gain, physicians wish to keep busy. Lesson: Underemployed physicians will lead to overtreated patients.

Lesson Four: Staff Field Hospitals with Adequate Numbers of Nurses

The only specific "order" that General Bliss gave me during our three year association was to be certain to have the field hospitals, which would be the sites of initial care for battle casualties, well staffed with competent nurses. Bliss was convinced that nurses often made the difference when it came to whether a patient would survive or succumb.

I set about seeking volunteers for overseas duty, and many of those who responded were regular Army nurses with long years of service. Then I ran into an unexpected barrier. The ASF staff told me under no circumstances to send women over the age of forty abroad. Their reason: "You know, they go nuts at that age!" Although I tried hard to dissuade them from this arbitrary interdiction, I lost. They *knew* that older women went berserk! However, I learned an important lesson from the deployment of nurses in the United States Army. Through their proper utilization as patient-care managers rather than as providers of bedside nursing, they were able to make a greater contribution to the quality of hospital care. Civilian hospitals more than forty years later still need to learn this lesson.

Lesson Five: Health Care Versus Morality

The Women's Army Corps (WAC) had over 151,000 enlistments during World War II. It separated about 7.5 percent of the corps because of pregnancy. The policy of the SGO was to provide prenatal, delivery, and postnatal care to WACs who requested it. During the early months that this policy was in effect, the SGO encountered strong objections from the director of the WACs, Colonel Oveta Hobby. The director was hoping to be promoted to general and had concluded that publicity about pregnant WACs would prove