

AMERICA'S HEALTHCARE SYSTEM

Discussion and Analysis of Problems and Solutions

Yuri C. Feynberg, PhD

TABLE OF CONTENTS

CHAPTER 1 INTRODUCTION	1
Statement of the Problem	1
Purpose of the Study	3
Importance of the Study.....	4
Scope of the Study	4
Rationale of the Study.....	5
Definition of Terms.....	6
Overview of the Study.....	7
CHAPTER 2 REVIEW OF RELATED LITERATURE.....	9
Privatization and Healthcare in America	9
Socialization and the Healthcare System.....	20
Factors Affecting United States Healthcare	32
Market Impacts	34
International Developments	45
Globalization	58
Inefficient Business Management	62
Rising Healthcare Costs	68
Large Population of Uninsured Citizens.....	74
Citizens with Special Healthcare Needs	78

A Review of the Managed Healthcare Plan and Its Role in America’s Healthcare.....	78
Managed Healthcare	79
Managed Care and Selective Contracting	86
HMO	87
Gatekeeper versus Open Access HMOs	90
The Preferred Provider Organization	99
What the PPO Does Not Accomplish.....	103
Medicare HMOs.....	112
Two Families’ Experiences with HMOs.....	123
CHAPTER 3 METHODOLOGY	127
Approach	127
Data Gathering Method.....	131
Database of the Study	132
Validity of Data.....	133
Originality and Limitations of Data	133
Summary	137

CHAPTER 4 DATA ANALYSIS	138
CHAPTER 5 SUMMARY, RECOMMENDATIONS AND CONCLUSIONS	140
REFERENCES	141

CHAPTER 1

INTRODUCTION

Statement of the Problem

There is minimal argument the American healthcare system, as it now operates, does not adequately provide quality care for Americans. In addition, the system falls short in providing universal care for its citizens. The American system is two-tiered, with the government providing care for a population based on income and age while other citizens pay for care through privately managed, premium care insurance providers. Although different in concept and practice, both are plagued by the same problems which include: inadequate treatment for patients, diminishing quality of patient care, rising costs, inefficient management, and inadequate pay for medical professionals.

For instance, in the case of Medicaid and Medicare, in order to make a profit when receiving only \$10 to \$20 per patient treated, doctors must resort to creating a Medicaid Mill, where they often see close to 100 patients a day. This greatly reduces the time a physician has to listen and speak with patients, and thus patient care suffers. Private medical providers face rising malpractice insurance costs, forcing doctors to avoid high-risk practices, such as obstetrics and gynecology, which lessens treatment options for patients. In addition, plan administrators, not treating

physicians, often make decisions based on treatment cost, not the best course of treatment.

Rising premium costs for managed care programs carry significant implications for America's workforce. The increased financial burden on employees to make a contribution to their plans to help offset rising premiums paid by employer's cause workers to drop coverage. For every 1% increase in premiums, 300,000 individuals lose their health insurance coverage. The most glaring evidence of America's healthcare crisis is the number of uninsured Americans is approaching 50 million men, women and children. Despite opinion polls consistently showing the vast majority of Americans favor a healthcare system that guarantees coverage for all Americans, major interest groups, including labor, businesses, and of course, insurance companies that profit from the current system, have been able to stifle any true reform.

In the case of Medicaid and Medicare 65 years have passed and in the case of managed care systems 10 years have passed which indicates that enough time has passed and studies have been conducted to accurately determine where the shortfalls and successes in the current systems exist. This information can be used to begin crafting an American healthcare system that provides affordable, effective care for all citizens.

Purpose of the Study

Overall, the researcher of this study is interested in both the dynamics and specifics of America's current healthcare system and the development of a new program of healthcare insurance for American citizens. As will be shown, the only thing universal about America's current healthcare insurance system is the dissatisfaction with both government and private insurance programs shared among physicians, patients, hospitals and employers. However, the researcher will also establish there are components of these plans and the way they operate that do (or, in the case of managed care, did) work, and how; with better plan administration, these components can be used in a new insurance program.

Historically during the Truman administration in the 1950s and later the Clinton administration in the 1990s, attempts were made to create a universal healthcare system in America. As the researcher will demonstrate, in both cases the issue proved to be highly complex and often steeped in ideology. In order to create an accepted and effective universal healthcare program in America, it is necessary to understand these political and social barriers to universal healthcare. This study explores those barriers and how they have been manipulated by opponents of past plans to defeat healthcare measures. Finally, the

researcher will use this study to introduce the major components required for any viable solution to America's healthcare insurance problems.

Importance of the Study

It has been almost 14 years since the Clinton administration put tremendous energies into solving our nation's healthcare woes. Any success during this Bush administration still escapes us. This nation must succeed in fulfilling the medical needs of all United States citizens. Although the majority of the workforce is covered by managed care programs and low-income senior citizens receive treatment under Medicaid and Medicare, the care they receive is inadequate. This study will be useful in pointing out the failures and successes of America's current healthcare system using information extrapolated from data compiled from over more than 10 years of privately managed healthcare systems and 60 years of government managed programs. The information presented herein will then be used to develop an equitable and efficient universal healthcare program for Americans.

Scope of the Study

Americans largely rely upon Health Maintenance Organizations (HMO) and other private managed care providers for the provision of their healthcare. This study will review applicable parts of the social security laws, applicable portions of volumes 42 of the Code of Federal

Regulations and the HMO manual subject to the following considerations: (1) the provision of basic health services is on a basis that is available and accessible with reasonable promptness with respect to geographic location, hours of operation, and provision of afterhours services; and (2) whether the care provided is dependent upon the nature of the care needed. In addition, the researcher relies strongly upon some interviews and monitoring whether family members in Gatekeeper HMO reported lower satisfaction and the receipt of a lower quality of care than families member in Open Access HMO. Among all of the obstacles impeding full and adequate healthcare for all Americans is cost escalation. Using studies conducted comparing American systems with healthcare systems throughout the world that provide universal healthcare, the researcher will explore the impact of inadequate management, lack of business skills and globalization upon rising costs in America.

Rationale of the Study

The optimal means to solve America's healthcare dilemma lies in establishing a privatization-socialization synthesis that would provide all Americans with adequate healthcare. By thoroughly understanding conditions as they now exist, and the historical context of universal healthcare efforts in the past, the serious deficiencies of America's two-tiered system can be eliminated. A national plan can be implemented that

combines the best facets of each in its place. It is time for medical professionals, healthcare plan administrators, politicians, state and federal agencies and the American people to openly discuss this issue without overblown hyperbole or biases against big government or profit making medical organizations. This study will offer a plan as the first step in creating this dialogue. A first step undertaken in this study is to understand the expectations of healthcare services by families in managed care programs and the satisfaction of those families with the services subsequently provided. Another lies in understanding efforts to create a universal healthcare system in a historical context, particularly the use of language, in defining terms of care and forms of payment.

Definition of Terms

There are a number of terms used in the healthcare industry. Some of the terms used for this study are as follows:

- Health Maintenance Organization (HMO): An HMO can be defined as any organization, either profit, or non-profit, that accepts responsibility for providing and delivering a predetermined set of comprehensive health maintenance and treatment services to a voluntarily enrolled population for a pre-negotiated and fixed periodic premium payment.
- Managed Care: An arrangement for healthcare in which an organization, such as an HMO, another type of Doctor-Hospital

network, or an insurance company acts as an intermediary between the person seeking care and the physician.

- Preferred Provider Organization (PPO): A managed care organization of medical doctors, hospitals, and other healthcare provider or a third party administrator to promote healthcare at reduced rates to the insurers or administrators clients.
- Privatization: Privatization occurs when the government sells a government owned business to private interests. This is usually the first step in creating a competitive market for the good or service the government created.
- Socialized Healthcare: For purposes of this dissertation, socialized healthcare may be one area, in coordination with privatization wherein a (cost analysis) balance may be struck for the ultimate purpose of providing adequate Healthcare for all.

Overview of the Study

The researcher presents studies conducted on America's healthcare system to establish that America's two-tiered healthcare system lacks the capability to provide adequate patient care. The prevailing approach has everything to do with fixing privately managed healthcare and government programs. This is not the solution. The problems that exist within each system are inherent in the nature of each

program. Government bureaucracies are inefficient and susceptible to fraud and businesses established to earn profits would do so at the expense of patient care. The researcher uses data review, excerpts of reports from leading experts on the healthcare issue and interviews with patients and families enrolled in managed care programs to highlight where the problems exist. Most importantly, this data is used to determine what does work within the healthcare system. With this understanding, an effective healthcare plan that serves all American citizens can be created.

CHAPTER 2

REVIEW OF RELATED LITERATURE

The predominant healthcare problem in our nation should be understood from the health administrators' perspectives, inclusive of both healthcare providers and individuals with business skills. This issue is highly complex, and it is the intent of the researcher to thoroughly assimilate the related variables associated with America's present healthcare system and its related problems, and to provide recommendations for a solution. This section will provide a broad overview of the American healthcare system and its many related issues and problems, as well as those issues which may contribute to the solution. To this extent the solution to striking a financial balance between cost and adequate healthcare lay in striking a balance between both a socialized and privatized healthcare system. This is especially true in the privatized healthcare system where cost containment may be far more feasible.

Privatization and Healthcare in America

The healthcare system in our society is highly complex. The Clinton administration dedicated two years of effort towards developing a system of healthcare for everyone. The administration was unable to reach a consensus that satisfied the wide consortium of players and issues involved. In the current political environment of healthcare, rehabilitation

professionals must acquaint themselves with the language and strategies of the healthcare debate. Consequently the obstacles are as follows:

- 1) to define managed care and examine its components
- 2) to discuss the inherent contradictions between rehabilitation philosophy and healthcare reforms
- 3) to explore the component of public healthcare programs
- 4) to examine the merit of national healthcare for persons with disabilities

The magnitude in healthcare policy within the United States is parallel to the evolution of computer technology within the last decade. The advancements have been swift, extensive, radical and unprecedented. The changes in healthcare provision have completely reshaped the landscape of medicine and the outlined professions. Persons with disabilities have not been spared the effects. For example, public funded medical providers such as Medicare, Medicaid and Worker's compensation are increasingly being privatized through contractual agreements between the state and medical providers. These agreements often result in economic limits on services for recipients such as persons with disabilities. The aforementioned change in healthcare policy is being fueled by the public and private sector's concern for cost control. Private industry has experienced double-digit inflation in the cost of employee

health benefits. Kongsvedt (1995) stated that corporations have addressed the escalation of costs by reducing benefits or offering creative benefit packages such as managed care arrangements, for example HMO, PPO and independent private associations (IPA).

Rising costs for local, state and federal agencies have been more rapid than in the private sector. Treatment costs at county clinics and hospitals have encouraged both the state and federal government to consider reducing payments to physicians, increasing premiums paid by Medicare beneficiaries, allowing states greater control over Medicaid and persuading enrollment in private sector managed care plans. Although passage of a comprehensive reform package failed in the 104th Congress, states such as Oregon and Tennessee have made major reforms by focusing on managed care. According to Cavalier (1995), at least 12 states have been granted 1115 (a) waivers from the Healthcare Financing Administration (HCFA). The waivers enable the state to mandatorily enroll Medicaid recipients in managed care service delivery systems (Austin, 1997).

The significance of adequate healthcare coverage for all Americans, while indisputable is particularly crucial for persons with disabilities because of special healthcare needs, greater risk for higher healthcare costs, and tougher approvals for private insurance coverage.

Healthcare reform would be a natural issue for political activism among persons with disabilities and rehabilitation professions. However, disability advocacy regarding healthcare has been impaired by factors such as internal bickering, social phenomenon and minimal congressional support. The absence of a strong cheerleader in Washington's congressional circles is detrimental. The demise of the Health Security Act during President Clinton's first term temporarily derailed a national healthcare package for the country. Instead, the debate on healthcare shifted from public support for universal coverage for all citizens to a massive federalist reform movement in which reducing government became the focus. Nonetheless, discussion of universal healthcare continues to appear on the agenda.

Clearly, cost has been a major impediment to the efficacy to privatize care. Good system management can provide effective healthcare as well as improve cost containment. To begin with, a better understanding of the problem as an analogy may be in order. One may be active and vigorous yet develop an abdominal pain indicating a health problem; or may show no external symptom, yet be in the first stages of one of the chronic diseases, such as cancer, that has a long gestation period. Health and illness co-exist, with the underlying problems that may not be symptomatically apparent. Before we can determine the causes of

the tragic shortfall between our potential for superb healthcare and the faltering actuality, we need to examine the symptoms of the systemic failure in both the access and cost dimensions.

The most astounding fact about access in a wealthy nation like ours is the public asserts overwhelmingly that it believes access to healthcare is a right, yet the size of the uninsured population is nearly 36 million persons. Today, one's access to healthcare closely mirrors one's access to health insurance. The question to consider is who are all these uninsured people? Are they the unemployed? Clearly the answer to these questions is no. Although 90% of all Americans have insurance through employment, being employed is no guarantee of having health coverage. More than three fourths of the uninsured are workers or their dependents. Another two million uninsured are uninsurable because of excluded or pre-existing conditions. This partly explains another surprising finding that nearly one fourth of the uninsured are in families with incomes of \$30,000 or more.

In this study the researcher will determine how coverage can be obtained for everyone. Every American should be assured of needed medical care, whether one sees care in terms of the individual's right to receive it or in terms of society's obligation to provide. That is the principle underlying the analysis, according to Reagan (1992). The question then

becomes of the 34 million Americans that is afflicted by disease, how can we cure those without coverage? A bewildering diversity of proposals have been offered in recent years, and nothing approaching a consensus has yet emerged, but the abundance of themes can be limited to a range of types for description and analysis. There have been many proposals and each scheme to impose cost discipline on the system is at least worth mentioning. Such examinations are a necessary prelude to the recommendations offered by President Reagan regarding the elements that would be found in an optimum program for combining universal access, cost control and political feasibility.

There exists what the President Reagan referred to as a red herring of socialized medicine. The crux of the healthcare coverage reform debate turns on the appropriate mix of private and public elements. The critical questions are to determine who pays for healthcare and how and who provides it. As we have seen, the United States system is nearly unique in its private, market oriented, employer dominated financing, with thousands of different payers and plans. The appropriateness of publicly financed healthcare is accepted for the elderly and for the unemployed poor, but not for the bulk of the population.

Our system is not unique however, in its overwhelming use of the private sector to provide medical services. In fact, most western nations

combine public financing with private delivery of services. When examining the range of alternatives, consider the ordinary aspect of this combination. It is purposely confused with apparently lasting effects on public perception and the American Medical Association (AMA) sponsored public relations campaign that inaccurately portrayed President Truman's national health insurance (NHI) plan as socialized medicine. In the late 1940s the term socialized medicine was used to confuse government financing of health insurance as total government control of medical care between doctors and patients. Truman's idea was to do for the entire population what Medicare has since done for the elderly. This involves removing a major share of the financial healthcare burden off the shoulder of individual patients so they could feel free to seek care as needed. As with Medicare, NHI was designed to let the doctors remain free-for-service individual practitioners and the hospitals remain totally in professional control. With the government paying the bills, doctors would not need to provide as much charity care and sick people would not need to go without care or suffer the embarrassment of being charity cases.

In traditional social science usage, socialism means government ownership of the means of production. If we think of hospitals and doctors as the healthcare system's means of production, the Truman plan or any other in which the government's role is to pay private-sector providers on

behalf of patients is not socialized medicine. Whether a government run (as distinguished from financed) healthcare system can be effective is debatable. The socialized medicine charge sometimes revived today by opponents to any plan that is government financed is simply the red herring. It should not frighten people away from a dispassionate examination of the evidence concerning the more publicly oriented alternatives currently discussed. The public-private mix can work in ways our ideological conventional wisdom may not lead us to expect. It is not just in governmental programs that a doctor may find administrators looking over their shoulders.

Conversely, a government-financed and partly government-owned system, for example the British National Health Service, which owns most hospitals, may leave decisions about the treatment given to individual patients largely to the professional judgment of the physicians. This is because its overall budgetary controls make micromanagement unnecessary. The Medicare system illustrates another possible combination. Originated on the basis that it would leave the practice of medicine alone, it has become quite intrusive, with its Diagnosis Related Groups (DRG), Peer Review Organizations (PRO) and Resource Based Relative Value Scales (RVS). The providers remain in a private sector and are not socialized. In short, whether the financing is predominantly private

or public tells us little about incentives to provide or withhold care or about the extent to which the payer does or does not intervene between physician and patient. The most important considerations of medical effectiveness, equities, administrative and political feasibilities, cost effectiveness, compatibility with patients' rights, and physician's professional responsibilities cannot be settled by ideological sloganeering. Instead all possibilities must be reviewed.

Therefore, consideration must be made for the range of options. Major congressional action on healthcare will be in the form of enacting a specific detailed legislative plan and will include a number of compromises to bring powerful interests onboard, just as was the case of Medicare and Medicaid. Yet, whatever emerges will be recognizable as embodying predominantly one or another of the limited number of policy models or ideal types. At the most public end of the spectrum will be a national health service (NHS) in which the word service connotes government delivery of the services as well as their financing. Next in degree of public-sector involvement are NHI and Universal Health Insurance (UHI) systems. NHI is seen primarily as a publicly taxed finance insurance plan to cover the entire population, whether financed and operated by the national government or jointly by national and state governments. Extension of Medicare to the entire population is an example of an entirely

national plan. A system with zero financing from the national government and the governments of the provinces, and operation at the provincial level, exemplifies the intergovernmental type. Using both ideal types would make public discussions more precise with universal coverage the policy goal and national plans in the first sense being but one means.

However, NHI is viewed at times as national health and national health insurance systems, so one has to examine the details to see what is really meant (Reagan, 1992). Heirich (1998) approaches the problems of cost, which lay at the heart of providing healthcare for all. Heirich (1998) states, it is time to start again, rethinking what it would take to provide adequate healthcare to all Americans at an affordable price. Any proposals must take into account the real constraints on problem solving that became visible during health insurance reform efforts of the 1990s, but one must not remain stymied by these limits. Instead, one must look for ways to reframe the problem to be addressed so that circumstances work for rather than against the people. Some questions to consider include:

1. Is it possible to take advantage of the core visions that have guided previously contending strategies for reform but move beyond them?

2. Would it be possible to combine the strengths of single pair, market force and managed competition plans, doing so in ways that overcome the various fatal flaws which prevent anyone of these current health policy strategy contenders from providing a usable solution to our dilemma?
3. How can the movements towards a re-emphasis on health affect our choices?

These are some of the issues that Heirich (1998) approaches including constraints. Both the underlying ideas on which healthcare is based and the organization of care are changing, a result of larger social and economic forces. Heirich (1998) has traced both changes in ideas about health and disease that have occurred during the past half-century and changes in the organization of healthcare services during the same period. A series of social, economic and political developments at a national and international level led to new ways to organize and fund healthcare services. All industrialized nations were building their healthcare systems on the model of applied medical science, with research-based care the ideal for service delivery. In the United States, because of various political circumstances that prevented the creation of a national coordinated healthcare system, the organization of American healthcare went in rather different directions than were being pursued

elsewhere in the international economy. The result has been a technologically sophisticated but increasingly expensive healthcare delivery system that now threatens the financial stability of the third party payers, businesses and government which pay the bulk of healthcare costs. They have become captive to the constant increase in costs that are part of American healthcare. New research discoveries and renewed respect for other medical traditions around the world are beginning to change our focus for attention (Heirich, 1998).

Socialization and the Healthcare System

Proponents of private healthcare do have one constant in their argument against any plan that approaches socialization of healthcare in America. It has been shown to be inefficient overall. At the same time however, there are some positive aspects of socialization, evidenced by the Truman administration plan. Unfortunately, and in the view of the researcher, the very idea of socialism goes against the grain of the American ideological political system.

It has long been the view of the researcher the government should pay for Americans' healthcare. While it has worked in the United Kingdom, it is not the view of the researcher that America should model ourselves precisely in accordance with their system (albeit there are some elements, which we will inevitably encounter). There are other countries, as well,

wherein the government assumes the (healthcare) responsibility for all of its citizenry, including Singapore. There, it is the Central Provident Fund (CPF) along with Medisave and Medishield, complimented by Medifund, which manage the people's healthcare in a self-reliant manner. It seems to the researcher, as shall be expounded upon, there is a similarity between Medicare and Medicaid and possibly a third part. All three schemes, the Medisave, Medishield and Medifund, underpin health needs jointly. Medisave under the CPF was the brainchild of the Minister for Care, Goh Chok Tong, who was responsible for the Blue Paper on the National Health Plan. The Medisave scheme involves 6% of CPF contributions set aside for approved hospital expenses for the CPF member and nominated family members.

Locking Medisave into CPF was part and parcel of the government's concern on rising medical costs and old age adequacy is therefore logical and consistent. The Medisave scheme was refined through trial and error. It started in 1984 with CPF members allowed to settle part or full hospitalization expenses incurred at any government hospital. Full payment was permitted for classes B1, B2 and C at government hospitals, but up to 80% for class A. The National University Hospital (NUH) came into the scheme in 1985 and private hospitals in 1986. This is one example of an amalgam of both private and socialized

healthcare. In 1986, the scheme was extended to spouses, children, parents and grandparents who were Singapore citizens or permanent residents. From April of 1986 a ceiling of \$15,000, rising to \$19,000 in 1997 was set for the Medisave account. Any excess was transferred to the ordinary account.

While the CPF for the self-employed is voluntary, Medisave was mandated in 1992 for all self-employed persons with or without an income tax number. They are required to contribute 3% of their chargeable income, or 3% of \$500 into their Medisave account. The Medical Endowment Fund (Medifund) set up in 1993 is the extra safety net the CPF members can resort to if, even with government subsidies Medisave and Medishield, some citizens are still unable to pay their hospital bills. To encourage personal responsibility, greater support is given to regular contributors to Medisave who are also covered by Medishield. Priority is given to the elderly who have no or very low funds in their Medisave accounts. The government thus remains the putative provider of the last resort for the indigent, who have little or insufficient Medisave funds through subsidies and Medifund.

Support efforts to nurture the socialization process between the old and the young in Singapore include family life education programs organized by the Ministries of Health, Education and Community

Development. Family support services provided by the Ministry of Community Development (MCD) and various welfare organizations and volunteers could look into setting up and managing childcare centers, family service centers and other community based services such as home visiting, daycare and respite care. It was seen by healthcare policy in Singapore as completing a full cycle, starting with public health in the 1960s, curative health in the 1970s and 1980s, and preventive and communitarian health in the 1990s.

The government has initiated new fund schemes since 1992 to provide capital grants of up to 80% of the approved building costs and recurrent grants of up to 50% of the annual operating expenditure of voluntary private organizations. These provide institutional care for the elderly. The government ensures that family oriented policies are put in place by legislation. One such policy, The Maintenance of Parents Bill, allows abandoned parents to sue their children for financial support. The researcher notes that it is significant that an Asian government steeped in Confucian culture has gone thus far reflect the gravity of old age concern (Low, 1998). Singapore's system (such as health provision in a social context, including Medisave, Medishield and Medifund) goes far beyond care for the elderly. At the very least, it does validate the basic assertion of

the viability of the government being capable of caring for its citizens' health needs.

For purposes of this thesis, cost containment is a concern in America and in other countries as well. At this point, it may serve benefit to address cost containment in Europe as a whole. Healthcare cost containment is not in itself a sensible policy objective, because any assessment of the appropriateness of healthcare expenditure in aggregate as that on specific programs requires a balancing of cost and benefits at the margin. International data on expenditures can provide indications on the likely impact on costs and expenditures of structural features of healthcare features. Data from the Organization for Economic Cooperation and Development (OECD) for both European countries and other nations are reviewed and some policies in Europe that are directed at controlling healthcare costs are outlined (to some extent).

Questions of cost containment resolve into two distinct sorts of questions. One sort is normative: for example, what are the right level and growth rate of healthcare costs? This question in welfare economics is appropriately discussed in terms of the value of beneficial outcomes that health services produce in relation to the values of what is necessarily foregone. The other sort is positive: for example, given the available

technology, what resources are necessary in order to produce any given level of outcome?

These questions can be tackled at either the microeconomic or the aggregate level. In microeconomic analysis, the focus is on cost effectiveness, cost utility and cost-benefit analysis (Drummond, O'Brien, Stoddart, & Torrance, 1987). The aim is to make cross program comparisons of marginal costs and benefits in order to develop both the optimal mix of programs and payoff to increase spending (or the marginal lost benefits of reduced spending). The overall levels of expenditure and Gross Domestic Product (GDP) current prices in 1970 and 1987 are shown for 15 European countries as follows:

- 1970 Healthcare expenditures per capita, valued at OECD purchasing power parities averaged (neighed) \$192.
- The low is \$896 in 1987, an annual nominal growth rate of 9.6%. GDP per capita during the same period rose from \$3,347 to \$12,031, an annual nominal growth rate of 7.8%.
- The average share of healthcare expenditures in GDP rose from 5.7% to 7.3%.

The elasticity of real healthcare expenditure with respect to GDP has been calculated for several Organizations for Economic Cooperation and Development (OECD) countries for the pre and post 1975 periods in

order to compare the responses before and after the oil shock. A number of points need to be considered when interpreting results of this kind. First, some elements that must be held constant in the microeconomic concept of elasticity are not held constant in macroeconomic relationships such as these. For example, income elasticity is not the same for all income groups. The distribution of income with countries will disrupt the pure relationship. In particular, if the income elasticity rises with income and if the more unequal countries are also the richer (within the relatively high income group of the OECD countries) then the slope of the graph will be artificially high.

Newhouse (1977) was careful not to claim that factors other than income, such as the form of organization and the finance of healthcare, bore no relationship to total expenditure. Newhouse (1977) suggested there might be an association between the organizational forms of healthcare and total healthcare spending (socialization), or at least centralized control of or influence over budgets is itself a response to low income and a desire to control costs (Culyer, 1989). The observation found with this study, especially in countries that employ a socialistic approach to healthcare, wherein the government assumes primary responsibility, cost effectiveness is more often than not, successful.

Americans traditionally have expressed wariness, as have our political leaders, regarding socialization of any kind, let alone healthcare. This is more an emotional response to the dilemma rather than a practical or pragmatic one. According to Shelton (2000) talk is power as it relates to healthcare in general. It was the ability of system opponents to control the dialogue regarding reforms that ultimately determined the outcome of the 1994 debate over comprehensive healthcare reform.

This is not an entirely new argument. Shelton (2006) closes the introduction with an overview of his treatment of the specific case of the healthcare reform debate on the floor of the United States Senate in 1994, which dramatically illustrates the exercise of power through public discourse. The focus of this study will be on Shelton's (2006) valuable contributions to the important relationship between socialization and healthcare. As Shelton (2006) states, regarding the tendency toward incremental rather than comprehensive healthcare reform, it is important to assess the apparent up and down status of reform on the political agenda. There were situational features associated with each of the calls for comprehensive reform that contributed to its failure in each case. These include the power of the AMA, fears of creeping socialization and concern about the appropriate role of the federal government, all of which factored into the demise of reform demands.

Incrementalism itself may have often played an important role. As the implementation of Medicare and other management suggests, the healthcare system had been trashed or treated with band-aid approaches from time to time. Edelman and Fleming (1965) argue that incremental measures associated with major policy issues have a tendency to win over disparate interest groups. This theory seems to make sense in terms of healthcare. There has been an ongoing series of limited reforms of the healthcare systems and such reforms may have bought off those groups and interests that have occasionally called for comprehensive reform. Given some small reward from time to time, reform groups may have been effectively demobilized.

The Catastrophic Care Act discussed previously, became a hot pocketbook issue. Again, the issue of cost containment evidences itself. It seems there are both confusion and even a degree of paranoia regarding the socialization (such as reform) of healthcare, which goes hand in hand with costs. When confronted with responsibility to pay for expanded healthcare protection, many found the cost would simply be too great. Costs, the question of who shall pay for what, and many similar issues would become prominent features of the next major national debate regarding comprehensive reform of the healthcare system in the United States.

Examination of the discursive construction of such issues represents a vast potential for investigation. The ability to compare and contrast those issues and their discursive construction during the most recent reform debate with earlier periods would also be of interest. Shelton (2006), attempts to examine the most recent health reform efforts in the 1990s. It appears that healthcare reform is seen by the administration, and possibly the public, as socialistic in nature, which is anti-democratic, and therefore anti-American. At least this is the definitive tone, which consistently pervades the literature review.

Over 40 years ago, democratic presidential candidate Adlai Stevenson suggested that sickness and health should be treated in the same way as a war because they are both matters of life and death. Sickness and health have not always been treated as a war, but the question of healthcare reform in the early 1990s did have many similarities to the martial scenarios. Battle plans were drawn up on each side. Offensive and defensive strategies were developed. Considerable resources were marshaled in order to wage vigorous campaigns and ultimately there were winners and losers.

The issue of developing some type of comprehensive reform of the healthcare financing and delivery systems in the United States was not a new one. Major reform proposals had worked their way onto center stage

on several different occasions over the last 80 years. That issue emerged in full force once again in the early 1990s. Aday (1993) felt the central features of any debate or discussion regarding healthcare and reform should focus on improvements in preventive care and public health services, most would agree the real focus of attention in the early 1990s revolved around issues of cost and access. Reform advocates painted a dismal picture of both rising costs and deduction of access to the delivery of healthcare in the United States.

One can shed much light on the situation in the early 1990s by arguing the case for and against comprehensive reform of the healthcare system in the United States. The researcher proceeds to delineate a case for comprehensive reform stating that advocates of comprehensive reform of the healthcare system do not simply feel that significant problems existed in regard to healthcare but instead a crisis exists. Indeed, the term healthcare crisis became a fixed part of the vocabulary of reform advocates in the early 1990s. Although it would be impossible to identify the exact moment at which the healthcare issue came to be characterized as a crisis, it is possible to assess its development. Following the crisis claims of the 1970s, the reform demand in the 1990s came from interests on both the political left and right that were concerned about access and costs respectively. Shelton (2006) refers to the role of big government and

the crisis of big government management was laid out in detail. The potential threat was portrayed as one that could not be ignored. The Mitchell Bill would, according to opponents of the comprehensive reform legislation, expand the federal government and in doing so pose serious risks to everything Americans held near and dear, from individual freedoms to the mistrust of government. The opponents of the Mitchell proposal characterized it as radical, even as an attempt at the socialization of healthcare.

This was a crisis that most Americans knew as they were impacted by long lines, delays, high costs, and low quality. In fact, many opponents of comprehensive healthcare reform saw the Mitchell Bill as transforming healthcare into the image of the United States Postal Service. The appearance of two competing crisis distinguished the August, 1994 Senate for debate on comprehensive healthcare reform from other cases of crisis rhetoric. These are the healthcare crisis and the ineffectiveness of big government.

Studies that remained under the rubric of crisis rhetoric have tended to focus on foreign policies or international affairs. Cherwitz and Zagachi (1996) have summarized: “the sub-text of international crisis is the focus of significant scholarly investigation... rhetorical critics scrutinize the wealth of discursive features constituting the genre of crisis rhetoric”

(p. 317). The present investigation on the Senate floor debate was focused on domestic crisis situations and the healthcare issue, as characterized by reform advocates. This was clearly evidence of a domestic crisis.

Reform or socialization of healthcare will be discussed within such inflammatory political and military interventions. This factor further reflects the American mindset when it comes to reform or socialization (Shelton, 2000). This fact of this study does not distinguish between the two (reform and socialization). A more pragmatic view is considered in that whatever works and is good for the people, is the way we should go, and inevitably this points to the government taking sole control of the healthcare system.

Factors Affecting United States Healthcare

The quality of care that managed care programs deliver to their members has been questioned. For instance, the for Quality Assurance's (NCQA) third annual assessment of industry performance, the State of Managed Care Quality, the Journal of the American Medical Association (2002) concluded that United States healthcare plans have made minimal progress in improving the quality of care they provide. This study also revealed there was a wide degree of variability on key measures of clinical care, customer service and member satisfaction among plans and by regions (National Committee for Quality Assurance [NCQA], 1999). The

Third State of Managed Care Quality Report made its assessment based upon the NCQA's Quality Compass Data Base which is compiled from the organization's accreditation programs and Health Plan Employer Data and Information Set. Approximately 50% of the nation's HMO participated in the former, and 90% participated in the latter (NCQA, 1999).

Key measures of member satisfaction used by the survey included rating of health plans, receiving needed care, speed of getting care, helpful and courteous staff, customer service, processing of claims, rating of personal doctor, and overall rating of healthcare. Notably, 115 plans out of nearly 450 which data was collected and used to calculate national and regional averages refused to allow their specific scores to be made public. In a study conducted one year prior, a small number of plans refused to allow their scores to be made public. The HMOs with high scores were far more willing to go public than those that did poorly were (NCQA, 1999).

This study demonstrates there is an enormous gap between high and low performing plans in terms of the scores compiled by the NCQA. This proved to be the case where the plans shared the same physicians. This indicates the health plan itself, not demographics or physician network, can be the determining factor in whether or not critical care service are being afforded to patients. Most Americans are dissatisfied with a healthcare system that restricts their choice of care professionals,

hinders their access to care, and yet remains expensive. For example, a poll jointly conducted in 1990 by Harvard University, Louis Harris and the Institute for the Future of Citizens of 10 industrialized nations indicated out of all surveyed, United States citizens were the least satisfied with their healthcare system (Bodenheimer & Sullivan, 1998). Given the extent to which the movement for patients' rights has been spurred by patients' experiences with HMOs, a similar poll taken today would most likely yield similar results (Bodenheimer & Sullivan, 1998). Overall, several key factors must be considered when assessing the United States and healthcare.

Market Impacts

There are variables which come to bear on the healthcare issue and one of the principle points is that of the market impact on healthcare providers and customers. Going back to the late 1990's, one can trace the current state of distrust in managed care plans in part to the price volatility that resulted from the overall market explosions of that time. Toward the end of the 1990s, purchasers began to tolerate double-digit premium hikes for health plans and were beginning to agree to employee demands for open-access systems and a wider choice of doctors under their plans. These changes were brought about largely because of the unbelievable market health enjoyed across the country and the tightness of the labor

markets. The premiums had long been expected to go on rising over the next few years, as they are currently, and should be expected to continue increasing for the next few years and onward. At the end of the 1990s, analysts predicted 10% increases per year over the following two years.

Premium increases are exceeding underlying cost increases which indicate a change in the underwriting cycle. Generally, this cycle begins when cost increases are higher or lower than had been forecasted. This leads to insurer profitability divergent from the norm. When expected cost increases declined unexpectedly during the first part of the 1990s, the profitability of the industry attracted a huge influx of capital. Insurers sought to expand market shares by making low premium quotes and premium increases were lower than the increases in cost and thus profits declined. With the insurers ultimately willing to make sacrifices in the market share in order to restore profitability, the industry entered the phase of the cycle in which the increase in premium exceed the increases in cost.

The inability of purchaser's to negotiate lower premiums has also been hampered by their need to deliver attractive health plans with a broad range of options. The unusually high level of prosperity in the end of the 1990s provoked demands for higher delivery of services. Because of the seemingly limitless economy, most employers were willing to go along

with the demands of their employees. It was also observed the passing of many patient protection laws in many states around the same period added to the rise in healthcare premiums. It was noted at the same time these large increases in premiums would only be acceptable for a short period, not in the long-term.

The rise in premiums would also add to the increasing amount of doubt that many employers have in managed care. As labor markets begin to loosen slightly employers generally turn to seek options in order to deal with inflated premiums while attempting to broaden choice.

More and more employers may tend to implement fixed contribution arrangements, in which broader choices are given in the face of an unchanging price plan. This contribution plan would most often be benchmarked against the cost of the lowest priced plan. There have been many suggestions as to how employers might choose to shoulder less of the inflation in premium resulting from swings in the market. One proposal has been the institution of vouchers whereby employees are given a voucher for a set amount of coverage and select a plan on the open market, bearing any cost for more expensive services. Another option would give the employee a medical expense account from which individuals might take money to put into whatever medical expenses or plans they might choose.

Samuel W. Murphy III, Vice President and Senior Equity Analyst at American Express Financial Advisors, proclaimed there was to be a huge drive behind employee defined contribution. If consumers are responsible for spending their own dollars, it may give healthcare spending some level of control (Harris, 2000). There are always large obstacles to the implementation of improvement concepts from tax deductibility questions to the opposition of labor unions, but the potential for a more predictable budget for health benefits and perhaps decreased liability from being taken out of the medical management loop will make defined contribution more attractive, particularly if right-to-sue legislation becomes a reality. Only a portion of premium increases is being passed along to providers and what is passed along varies considerably across markets and type of provider. Farrell (2006) noted that hospital systems in large markets have secured rate increases of from 4% to 5% up to 10% from their managed care partners while many smaller stand-alone institutions have not seen their rates move in recent years. Murphy (2000) states:

They like their nonprofit counterparts have come through a period of pain. Five years ago they really did not know what managed care organizations were and how to react to them. In general, hospitals have been financially strained after going through a period of robust profitability. The pressures they face stem from unfavorable

contracts they struck with managed care organizations, rising pharmaceutical costs, reductions in Medicare funding stemming from the Balanced Budget Act of 1997 and labor shortages. (p. 1)

One widespread response by hospitals has been divestiture of costly physician practices and renewed focus on core inpatient and outpatient care. "Hospitals are actually going back and calling them-selves hospitals" (Farrell, 2006, p. 1). "They are also recouping or addressing the impact of some very bad contracting decisions they made in the mid-1990s" (Goodman, 2003, p.14).

Despite the way providers might feel, insurers recognize when providers are making too many drastic cutbacks. In some places insurers have intervened to keep providers from going out of business. Grossman (1992) stated "During our site visits we heard that plans are concerned about the financial viability of providers" (p. 2451). Insurers know that as they do better, "they need to pass on some of those revenues. The question is how much and when" (Grossman, 1992, p. 2455).

Doctors experience more difficulties in hospital systems which contribute to factors which have led to the proliferation of specialist centers, or hospitals that are specifically marketed towards one need group, such as heart patients, and so forth. Specialists have been attempting to circumvent the market impacts on healthcare plans.

Although it was heralded as signaling a new path for managed care when it was announced, most of the panelists noted a recent policy shift by United Healthcare brought about only modest change across the industry. United Healthcare replaced its traditional utilization management programs with less intrusive physician profiling in hopes of demonstrating the latter “can have a positive impact without being in the face of the provider” (Goodman, 2003, p. 15).

The analysts noted that United Healthcare was already a relatively open plan, without a gatekeeper requirement. Harris (2000) stated United Healthcare had begun by shifting the focus of its utilization management efforts to the chronically ill and big-ticket items, while trying to reduce obstacles to providing most routine care. The company found it could influence physician behavior and economize. Harris (2000) added in the same report that United hoped to reduce its \$100 million yearly budget for utilization management by implementing its new policy. Farrell (2006) stated despite United Healthcare’s claim that it had saved money, it is virtually impossible to measure whether such approaches will be more efficient and mollify doctors. Harris (2000) stated that other plans will try to move in that same direction, but progression will be slow. Meanwhile, capitation, a system many hoped would restore provider profits and autonomy is on the decline. Panelists characterized capitation as

inconsistent with the point-of-service open-access insurance plans that consumers are demanding. It has not offered plans for the predictability of costs being viewed for providers or the profits they had hoped to achieve (Goodman, 2003).

Another condition determining whether or not providers resist aggressive moves toward capitation is the increasingly litigious environment, fearing facing liability for medical restraint in a high risk environment (Harris, 2000). Murphy (2003) called capitation “another failed experiment in American healthcare” (p. 1). Furthermore, there has been an increase in the number of class action suits recently accusing health plans of a wide variety of faults ranging from malpractice to racketeering. Plans may be paying more attention to disclosing their policies and practices because of the suits, but claim they are not changing how they manage care. This is not the most feasible of propositions. If physicians were successful in gaining collective bargaining rights it could represent a real shift in the balance of power between plans and providers and could also eliminate managed care techniques doctors find onerous.

Another issue that some plans have been dealing with is the failure or poor performance of newly acquired plans. While there are many factors that affect whether these merged organizations and new

arrangements are successful, the analysts agreed that paramount among them is when the deal was implemented relative to the underwriting cycle.

Harris (2000) stated,

When you are in a healthy under-writing environment it is not apparent which newly merged organizations will be success stories in the longer run. In such an environment, you can buy some time to fix problems. But if you are skating on thin ice to begin with, and you lose track of your cost trends, you get clobbered. That happened to numerous plans over the last several years. (p. 2)

Based on skepticism with mergers across discrete markets,

Goodman (2003) stated plans that execute out-of-area deals frequently underestimate the importance of local market factors. Healthcare is similar to a market business which can be different depending on the organization, systems delivery, economic conditions, employers and consumers (Goodman, 2003). Some of these plans did not fully understand the market consequences as related to HIV and other diseases, as well as blockbuster drugs such as Prozac and Viagra. Drugs are becoming an ever-larger share of national health spending and total spending on pharmaceuticals has grown dramatically in recent years. This factor will not change, but the rate of growth will diminish in the next few

years because patents of some key drugs are about to expire and the flow of blockbuster drugs coming on the market is slowing down.

Pharmaceutical spending represents 15-25% of the total healthcare economy, but in the United States, it is only 8%. The growth in the amount health plans spend on pharmaceuticals, which has risen about 15% in each recent year, is likely to level off and perhaps decline in the next few years, as so-called three-tiered co-payments proliferate. These are systems in which enrollees pay increasing amounts out-of-pocket for a broader selection of drug choices. Consumers favor this system over closed formularies because they can get access to desired drugs if they are willing to pay the additional cost. Much of the impact of a Medicare drug benefit on the industry would be determined by how the government pays for pharmaceuticals and how it regulates the growth of that spending over the long term. Medicare could use pharmacy benefit managers (PBM) to negotiate prices for drugs, just as the private sector has done. It must be noted that market standpoints do not always follow what is scientifically foreseeable.

These predictions of a slow-down are not necessarily to be viewed as facts. New drug advances are being developed each hour and especially with genomic research advances, it is somewhat doubtful there will not be a second wave of blockbuster drugs for depression and anxiety

disorders and drugs for cosmetic concerns such as hair loss and weight control, and eventually for HIV. In addition to the pricing increases is the fact there are several companies in countries such as India who are gearing up to corner markets because they can produce drugs for a third of the cost as American facilities. This is a point which is apt to embroil healthcare plans. However, Goodman (2003) observed that PBM have worked in the private sector because they limit options within certain categories of drugs, something Medicare would find difficult politically. Although Farrell (2006) did not favor price controls, he stated it would probably take more stringent measures than PBM to keep the program from getting out of control. Further, limiting spending under such a large new entitlement would be extremely difficult (Farrell, 2006).

Everybody is getting out of capitation. The reality is - it is virtually impossible to control physicians and consumers. The threat of price controls for drugs is a chiller. If it became a greater probability, it would be very negative for pharmaceutical R & D spending. It will be difficult to move back to very restrictive health plan models because the mood of the public toward such models has been extremely negative and will remain so. (Goodman, 2003, p. 16)

Healthcare plans should be aware that if employers are faced with layoffs and corporations are not experiencing a profit, this may cause issues

(Harris, 2003). “The only way that any information technology can have an impact on care is if you get broad acceptance at the physician level — at the point of patient care” (Murphy, 2000, p. 2). It was partly Internet technology that spawned a new market era in America. It was hoped the Internet would help streamline healthcare. In spite of enormous amounts of money flowing into the information technology sector in recent years, and high hopes the Internet will carve billions of dollars of administrative costs out of the healthcare system, the analysts uniformly saw the web as an evolutionary, not a revolutionary, technology.

A part of the problem is while the Internet can be an amazing tool for those who are willing to use it; there is an obvious age barrier in terms of the medical audience that prevents some of the most needing people from utilizing the Internet as a source of medical information. Murphy (2000) states the Internet is not enough to overcome hurdles in healthcare because of the fragmented and complicated environment. It is also difficult to get physicians and other caregivers to adopt and reliably use computer-based tools. These practitioners are often so immersed in their daily routines that any new introduction of information they pick up is likely to be through seminar. It has been noted the persistent lack of standardization in health information systems raises questions about the veracity of estimates that 1/6th of the United States healthcare budget could be

saved by eliminating unnecessary paperwork. “If it was \$200 billion, the industry would have figured out how to pare down the paperwork by now” (Murphy, 2000, p. 2).

The problem on the larger scale is there are so many obstacles to integrating the largest e-companies with the medical field. The process is too long to be attractive to the ones who are capable of doing it. In the meantime, there is too much work to be done, so there would be an increased workload on personnel during a transition such as the one that would be necessary if the Internet would really be used to cut the costs of managed care. Through consortia, plans may finally overcome the most severe hurdle to building information networks: the fear doctors have of being required to have separate systems for each of the many plans they bill. The Internet’s most profound impact probably falls on insurance brokers, because the web is especially effective at finding best prices and carving out middlemen.

International Developments

International developments significantly changed the implications of healthcare innovations in the 1980s. American industries, seriously challenged within the United States by competitors based abroad, found it harder to pay its share of rising medical care costs. Major net outflows of capital from the United States occurred as a serious balance of trade

problems developed in the 1970s. The pattern of making direct investment of business capital abroad continued among formerly United States, now transnational corporations. In addition, a major escalation in the international arms race of the 1980s produced strains for the American and the Soviet economies, affecting the federal government's willingness to increase the use of public resources for healthcare. Eventually, the dynamics behind these changes were combined with events in the Soviet bloc to produce a total reordering of international relations.

Two other international developments added serious new health challenges, which the contemporary healthcare system was partially prepared to address. First, a new kind of epidemic called Acquired Immune Deficiency Disease (AIDS) swept through Africa, the United States and Western Europe, and began to make its way through most other areas of the world as well. The HIV retrovirus that produced this health problem began to reorient the way in which medical researchers viewed the health disease process and forced a re-examination of interventions focused on cure instead of prevention. Second, acceleration in international drug trafficking produced a growing problem of addiction to crack cocaine, first within the inner city areas of the United States (hit the hardest by the withdrawal of manufacturing jobs and the deterioration of older neighborhoods), then the population more generally. In short, public

health problems, which the after-the-fact disease response strategies of the American healthcare system did not address effectively, began to consume an increasing share of public revenues.

The practical implications for healthcare financing in the face of the decline of American manufacturing seen in the unfavorable balance of trade were two-fold. First, business interests were struggling desperately to lower manufacturing costs in order to be competitive internationally; thus, they had a strong incentive to control the costs of healthcare benefits. Second, because Cost of Living Adjustment Formulas (COLAs) for wage increases in American manufacturing industries called for adjusting wages for inflation four times a year, the contribution of healthcare costs escalation to inflation hurt American manufacturing industry's competitive position even more than growing costs for health benefits themselves.

These difficulties further encouraged American based transnational corporations to make direct investment abroad and to automate American production so that fewer United States employees would be needed. Combined domestic and foreign investment in the United States could not produce enough jobs to keep pace with the increase in adults of working age. Not only did the adult population of the United States increase more rapidly than domestic job expansion, but also the number of

manufacturing jobs in the United States actually declined more than 2 million between 1979 and 1987. Whereas manufacturing jobs had accounted for 35% of all non-agricultural employment in the United States in 1946, by 1988 they accounted for only 18%. These changes had direct implications for United States healthcare, since unionized manufacturing jobs were most likely to include health insurance benefits. By 1990, 37 million Americans lacked health insurance coverage of any kind.

The development of the American healthcare industry and the failure of efforts to tame or reform it are only part of the story. Over the past 30 years, a series of independent developments in scientific research, in various national and international social movements and the mainstream institutions internationally (including transnational corporations, European Parliaments, NATO and the United Nations) have opened up new ways to understand the health disease process. The new conceptions extend far beyond the confines of biochemistry and reorient our sense of the legitimate domain for healthcare policy. There were some international developments that changed the context for problem solving.

Several international noteworthy developments have helped create the circumstances in which social movements could introduce new principles for social organizations, problem identification and problem solving. Because the worldwide economic depression of the 1930s,

followed by World War II had made it difficult for young couples in many countries to start their families, the end of war led to a baby boom in many parts of the world. These children grew up in special circumstances, created by the size of the new birth cohorts and the economic, political and social changes that were occurring globally. As they grew to adulthood, a much higher percentage of them went on to study in colleges and universities.

The common experiences of young adults in most countries and the easy communication and travel that became part of the international scene in the 1960s gave them an outlook that often differed strikingly from that of their parents. A generational perspective more global in focus and more critical of contemporary institutions and practices became the view of this age group. Finally, the post war demilitarization of Germany and Japan has left others free to develop their economies without the burden of arms race expenditures. The growing success of German and Japanese competitors motivated American-based and transnational competitors to experiment with new approaches to healthcare (which was consuming an increasing percentage of their profits). In addition, the different political arena in Germany allowed its baby boomer generation to raise a series of questions that began to resonate around the world,

helping spawn international movements that addressed issues of environmental health (Heirich, 1998).

The repetitive and important issues of the requirements of business management for these healthcare providers are absolutely necessary, yet too often elusive, or deficient. The researcher further scrutinizes this all important (business management) aspect of providing adequate healthcare which means adequate reconciling of available monies. As previously indicated, there exist many dimensions to this highly complex issue, which the Clinton administration was incapable of reconciling throughout the course of the first administration. In fact, the last three decades of the 20th century saw an evolution of the health policy agenda in which governments became increasingly concerned with controlling the costs of healthcare, or at least the proportion of those costs borne by public treasuries.

The much less buoyant economic and fiscal clients that characterized advanced industrial nations after the oil price shocks of the 1970s and the rise of global competition, constrained the ability of governments to meet the level of public expectations for public programs established in more bountiful times, not only in the healthcare arena, but more generally. Additionally, over the course of this period governments, to varying degrees in different nations, became dissatisfied with blunt

budgetary limits as a mechanism of cost control. They began to consider ways in which the incentive structures of public programs, especially and including health insurance programs, could be changed to ensure that public funds were being spent to the greatest effect.

The common themes of this agenda were expressed in quite different ways and with many different results across the nations. In Britain, the United States and Canada, the experience of the 1990s sweeping policy change in the first policy stalemate and turbulent market transformation in the second and relative stability in the third exemplify the range of this difference. The policy episodes of 1940s in Britain and the 1960s in the United States and Canada had established systems. Each with a different and distinctive inherent logic that left these three nations differently poised for change at the turn of the last decade of the century. The hallmark of American health policy has been its incrementalism.

In contrast to the cases of Britain and Canada, in which major episodes of policy change established enduring organizational frameworks for the delivery and financing of healthcare, United States public policy both directly and indirectly fostered continuous organizational change in the healthcare arenas. During this time, private actors responded and adjusted to the incentives and constraints established by incremental policy changes. American public policies maintained private markets as

the predominant mechanism for the provision of health insurance and for healthcare delivery. Efficiency and equity improvement were sought through regulating and supplementing markets, not through supplanting them.

Approximately 62% of Americans continued to be covered by health insurance purchased on the private market, subject to both federal and state regulations that fluctuated over time with a focus on stringency in 1993. On market mechanisms for the financing of healthcare (taxes and social security contributions) remained confined to a minority of the population, about 23% who are insured under the Medicare and Medicaid programs for the elderly, the disabled and the indigent. The substantial and slowly growing minority of 15% of the Americans, up from 13.7% in the 1980s, had no healthcare insurance at all.

Even in the marketing-oriented system, purchasing decisions nonetheless became increasingly collectivized. In the first place, although the public's share of health expenditures was low relative to other OECD nations, it nonetheless made federal and state governments a substantial presence in the healthcare market. Second, private health insurance was largely employer based. In 1993, 86% of Americans with private health insurance acquired it through their employers. The employer-based character of the system was facilitated by a key feature of the policy

framework, which allowed employers to deduct the full cost of providing insurance coverage to their workers for tax purposes. Employers who chose to self-insure for the purpose of providing healthcare coverage for their workers were shielded by federal legislation from state regulation of their healthcare plans. Large employers were major purchasers of health insurance and self-insuring large employers were major purchasers of healthcare.

Healthcare delivery systems, like the system of healthcare financing, were also organized on market principles. It was composed of independently organized providers of care who offered their services on the market, subject to various forms of regulation by governmental and professional bodies. Government owned facilities, primarily public hospitals constituted a small and declining proportion of the total. It is the logic of entrepreneurship which generated a cycle of increasingly complicated market strategies and regulatory responses that encouraged the rise of for-profit entities in an arena once dominated by professional practices and not-for-profit insurers and providers. Perhaps this led to an increasing reliance on hierarchical mechanisms on the part of both state and private financial actors. In the process, reliance on mechanisms of collegial control and the power of the medical profession were dramatically reduced.

The singular features of the system that developed were marketed from the 1960s to the 1980s and up to the Clinton administration. This included the rise of managed care, the regionalization and nationalization of markets, and the growing role of for-profit enterprises. Next, it traces out the implications of these developments in reducing the historical medical dominance of the politics and economics of healthcare. In addition, it more generally demonstrates how the logic of the system transformed the political terrain on which the next major attempts at policy change, the Clinton initiative of the 1990s, which had to be contested (Tuohy, 1999).

As indicated, the emphasis of lowering costs and the healthcare system was a global phenomenon. In fact, lowering costs worldwide for respective countries superseded the healthcare system. Herein lay an important (global) illustration of how escalating costs and concerns for international expenditures (respective to individual countries) were primary on the global agenda. As a result, the ability to provide healthcare suffered.

This was not only an American phenomenon, but also a global one. According to Amin, Hagen, and Sterret (1995), cooperating to achieve a competitive advantage has recently become a trend in the operations of corporate America and corporations worldwide. Further, cooperating to compete has been adopted into non-profit organizations as well. For

example, universities are cooperating with other universities and corporate organizations to strengthen their competitive advantage. For years external growth in the form of mergers and acquisitions has been an integral element of corporate strategy both in the United States and abroad. Today, multi-national firm alliances are touted as critical mechanisms for competing in global markets and coping with the increasingly rapid pace of technological developments. Although the number of global corporations appears to be increasing dramatically, they are known to be unstable, prone to failure and difficult to govern.

There is a complementary aspect of the aforementioned with other observations made previously in this section. While the healthcare market represents hundreds of billions of dollars in this country alone, there exists an equal growth disparity regarding lack of both business and healthcare savvy, understanding, or interests which equates into the ability to provide all Americans with adequate healthcare. Furthermore, the solution to the problems oppressively impact America's healthcare system and is a need to know how to financially balance and support adequate healthcare. This balance extends equally to financial realities as it does to the providing of adequate healthcare.

HMO has justifiably received much criticism, as will be explained later in this section. This is largely because those who are running it (such

as the insurers); manage physicians and their profession much as they do financial checks and balances. This, unfortunately, allows for a huge gap or void in the otherwise necessary equilibrium, for example, financial realities, vis-à-vis adequate healthcare. Privatized healthcare may contain costs as well as ensure healthcare access for everyone; however a strong sense of business management savvy must be coupled with healthcare savvy for the ultimate and long-term health of America's healthcare system, financial stability, and the ability to ensure that everyone may receive adequate healthcare.

Amin et al. (1995), firms are said to be motivated to pursue cooperative relationships when the synergies outweigh the externalities, such as technological dissemination and reputation erosion. Cooperative arrangements such as joint ventures are particularly conducive to organizational learning or the transfer of organizationally embedded intangibles such as knowledge, organizational routines and skills, reputations, experiences and good will. Global mergers and acquisitions are becoming an essential tool in the new direction of the world economy. However, the question to consider is where does this leave the health of the United States healthcare system. Errunza and Sembet (1981) have reported increasing integration in the international capital market. Reng and Van de Ven (1992) stated rapid changes in technology, the

competitive environment, firm strategies and other pressures are prompting many firms to seek cooperative relationships with other firms. Porter (1985) suggests that firms are pursuing a diverse set of objectives that require cooperation because they involve reciprocal dependencies. These objectives include gaining access to new technologies on market, benefiting from economies of scale in joint research, production and marketing and gaining complimentary skills by tapping into sources of know how located outside the boundaries of the firm.

Other advantages of cooperating include sharing the risks for activities that are beyond the scope or capabilities of a single organization and gaining synergy by combining the strengths of firms in ventures that are much broader and deeper than a simple supplier relationship, marketing joint venture or technology licensing arrangement. Comparable provisions seem to be employed by organizations that contract out in restructuring or downsizing their organizations or by governmental agencies engaged in the privatization of public services (Amin et al., 1995). Amin et al. (1995) further attempts to examine the effectiveness of cooperating to achieve competitive advantages in a global economy. Comparable provisions seem to be employed by organizations that contract out when restructuring or downsizing their organizations or by governmental agencies engaged in the privatization of public services

(Amin et al., 1995). Basically, Amin et al. (1995) examines the effectiveness of cooperating to achieve competitive advantages in a global economy.

Globalization

There exists more than one downside associated with the globalization of the healthcare system. The consolidation of industry mergers must be accompanied equally by strong business savvy in order to realize optimal healthcare for everyone. Earlier, the researcher made reference to the serious deficiencies associated with HMO regarding the business acumen of many system managers. Aaron (1991) predicted three stages in the future debate over healthcare. The first stage will be a period of rising numbers of individuals with declining access to care. The evolution of the private managed care market, coupled with payment limits under Medicaid and Medicare, erode the payment cross-subsidies for providers that have traditionally financed care for those who are care-covered. The second stage is a period of growing popular discontent, and the third is action, in the form of a public utility model in which health delivery systems meet the needs of the population (Aaron, 1991).

Aaron (1991) makes two points that are important. First, markets and especially consumers are dynamic, and can rapidly alter any scenario. Managed care is a direct response from purchasers of care-

employers, government and consumers. However, market pressures may shift if consumers become increasingly concerned with quality and access. The new delivery system, including managed care organizations, will have to evolve and adapt to those concerns. Alternatively, such concerns can lead to great pressure for federal government intervention, specifically if states fail in their oversight responsibilities of the variety of new healthcare delivery systems.

Secondly, the political process should also be viewed as a dynamic variable. We should not passively accept a period of declining health coverage and rising discontent. The problem should not be exaggerated by taking legislative actions such as severe cuts to Medicare and Medicaid spending to speed the coverage loss, under utilization and cost shift. Instead, we should reform these programs by limiting cost growth and updating their design for the next century without drastically reducing coverage and shifting cost to the private sector.

Finally, bipartisan insurance reforms that make group health insurance more accessible and affordable should be enacted. Aaron (1991) predicted that powerful forces would ultimately expand the role of government in the financing and delivery of healthcare. These forces include: continued increases in the number of uninsured Americans, growth of Preferred Provider Organizations (PPO), and increasingly

tightfisted Medicare and Medicaid payments to hospitals and physicians. In describing Medicare's payments to hospitals, Aaron (1991) characterizes the modest increases allowed since 1984 as inadequate to cover increases in actual costs. That characterization is potentially misleading. Yet, this study attempts to highlight all association to maintaining the financial and healthcare equilibrium, which is vital to patients and healthcare providers. This is by no means out of the reach of careful planning, re-planning, and reforming to ensure a much greater and accurate effort that can successfully fill the needs of the two-fold objective.

One element of a hospital's costs that is not covered by Medicare payments is the cost of care to those without health insurance. That omission is intentional however, dictated by the rules established in original enabling legislation. To cover a fair portion of the cost of care for the uninsured, Medicare would no longer be an insurance program for only the elderly and disabled. Aaron (1991) continues with the theme which he entitles Regulation and the Competitiveness Card wherein he states denouncing the ham-fisted regulations as easy enough. Nivola(1991) takes the argument a step further by showing how regulatory irrationalism may in turn trigger protectionism (an implicit tax on imports) and corporate downsizing because regulation may act as an implicit tax on labor. In effect, interest groups and businesses try to offload the cost of

burdensome rules, leading in turn to more inefficiency further down the line.

In one respect, Nivola (1991) seems to misstep boundaries.

Clumsy regulation is particularly damaging. Nivola (1991) states:

and the intensifying pressures of globalization just as strategic industrial policies might contribute to their comparative commercial advantages (and disadvantage), so eccentricities in native legal cultures or regulatory styles may no longer be of little consequence in the global consequence. (p. 1255)

Certainly dumb regulation is costly. But unless regulation is especially costly to export-oriented businesses, the cost that it exacts through trade (globalization) is a mere subset of the cost it exacts throughout the economy. Globalization is mainly beside the point if a regulation is foolish and it hurts Americans whether we trade or not, and if we do trade, foolish American regulations untimely hurt foreigners, too. Telling Americans they will fall behind foreigners if they do not maintain their ways is a good way to get their attention, thus competitiveness. To frame the issue in these terms is also misleading and a bit risky for it plays on fears that trade is a zero sum game (for example, what if Japan and Europe catch us).

Nivola would have done better to make the case for smarter regulation without playing the competitive card (Shala, 1996). Overall, as

the author of this study views it, core problems associated with healthcare on the broadest level may be seen on a micro-level. To say the United States is incapable of providing healthcare for everyone is far too simplistic a statement, nullifying the advancements made in healthcare coverage in the 1960s to the 1990s and is an exclusive statement tantamount to that administrators, those directly and indirectly associated with healthcare, were better business managers (as well as healthcare managers), then America would have no problem providing adequate healthcare for all its citizenry. It is this mindset that must be addressed in overcoming the problems and implementing the solution(s) to providing adequate healthcare for all of America's citizenry.

Inefficient Business Management

This study has identified some of the weaker aspects of the prevailing healthcare system, as well as those which portend improved aspects of America's healthcare system. The financial basis of healthcare improvement lay in improved business savvy on the part of healthcare providers and administrators. It is the lack of both business and healthcare savvy, which is impeding all Americans from receiving adequate healthcare. Throughout this study, the researcher has focused on both privatized healthcare and socialized healthcare with the belief that privatized healthcare has at least two essential benefits which can ensure

access to healthcare for everyone and can ensure that costs can be better contained. Socialize healthcare on the other hand is inefficient. However, there may also be room for some aspects of both as shall be discussed subsequently. Ultimately, it is believed there is a need to strike a financial balance to support adequate healthcare for all Americans, and herein improved business/financial management promises to advance this goal.

The need for improved business skills among healthcare providers and administrators, especially in the face of escalating costs, inadequate management, and globalization is emphasized in this study. In terms of globalization, many hospitals overseas are owned by both American as well as foreign corporations. In addition, the aforementioned problems and currency fluctuation further underscores the intense need for increased business/management savvy. Finally, it is the issue of the relationship between adequate healthcare and strong business management focused for this study.

According to Eastaugh (1992), the need for better information, active cost management and better financial management is widely accepted. Only with better financial management can we preserve the duality of our healthcare institutions as both a charity and an efficient service provider for the community. The focus will be both micro-institutional and macro which indicates better payment options for the

future. Eastaugh (1992) also focuses on the hospital economy because it is the largest segment of the healthcare sector, representing 4.7% of the Gross National Product (GNP). Before beginning a discussion of hospital cost inflation, it is essential to explain how it is known that costs are in fact increasing each year. As the previously mentioned, escalating costs is one of the singular problems contributing to America's present ability to deliver adequate healthcare to all. In other words, it is necessary to identify the indexes to cost inflation being used and to understand their implications.

One broad indicator of the relative quantity of resources devoted to healthcare is the percentage of the GNP devoted to health expenditures. National health expenditures rose from 4.5% of the GNP in 1950 to 7.2% in 1970, 10.7% in 1983, and 11.8% in 1990. An estimated 12.66% of the GNP (\$735 billion) went to healthcare expenditures in 1992. Hospital services represent 39.5% of the total, and physician services represent 20.3% (\$149 billion). Nursing home expenditures are estimated at 8.45% of the health budget (\$62 billion), finance 47% by Medicaid, 1.8% by Medicare, 1.4% by private insurance, and 49.8% by out-of-pocket spending. Prescription drug spending reached 36 billion dollars and non-prescription drugs and herb medical non-durables should cost \$19.5 billion. Commercial research expenditures exceed \$10 billion, while government-sponsored research and other non-commercial research

exceeded \$17 billion. Dental services represented \$39.5 billion, vision care products \$10.9 billion and other durable medical products \$4.4 billion in 1992.

One may assume the aforementioned figures are considerably higher. This factor serves to underscore the importance of the direct relationship between providing adequate healthcare and business management. To this extent, this study illuminates the understanding of expenditures by delineating percentages and costs, which go to various components of America as a society as well as its healthcare distributors/providers (even though the figures are somewhat less).

Although the explosion of health insurance during the past 40 years is the single most important factor in the increased demand for medical care, other factors have had an influence as well. Growth in population and increases in the average lifespan have contributed to the demand for medical care. The fastest growing age group is the 65 and older category, whose per capita expenditures on healthcare are four times those of adults 19 to 64. In addition, many innovations in medical technology are expensive and increase the demand for medical care in a multiplicative fashion.

Although the development of antibiotics and other drugs have been cost effective in saving lives, new developments in medical technology

such as chemotherapy and organ transplantation require expensive equipment and skilled personnel; that prolong life instead of curing illness, such technology can be radically cost increasing. Eastaugh (1992) elaborates on the nature of increased costs of medical technology. The most important aspect, as well as salient point proffered by Eastaugh (1992) has to do with the need for improved and active cross management, better information, and better financial management. Heirich (1998) addressed healthcare innovation in a rapidly changing world economy stating that American healthcare innovations of the 1980s grew out of an erratically altered climate. The approach of healthcare required new thinking because of the problems that were encouraged through new developments of both national and international. Older formulas for funding healthcare were no longer working well.

Meanwhile, international health crisis created a demand for new resources in the American healthcare system. Since America was the most expensive in the world they hesitated to commit. Many innovations of the 1980s moved the healthcare industry through organizational styles emphasized in the larger American economy. Hospitals, nursing homes and HMO were reorganized as mammoth healthcare chains, oriented towards cost control and bottom line, profit-oriented decision making. Physicians became less influential in day-to-day policy making and an

increasing proportion of them became employees either of the healthcare chains or of corporations not primarily concerned with healthcare.

Many healthcare systems were reorganized as explicitly for-profit-ventures. A number of healthcare facilities were closed, often for financial reasons. Meanwhile, third party payers tried to impose cost controls. Business-health coalitions organized in more than 90 metropolitan areas kept computerized records of healthcare costs and the performance of doctors, hospitals and other healthcare facilities.

Large businesses negotiated for prices with PPO and sometimes invited national healthcare chains to enter their metropolitan healthcare market. This in turn stimulated physicians to form their own HMO or PPO and to offer competitive services not previously of interest to many local doctors. Health insurance companies began to set caps on reimbursements for doctors' services and hospital charges. The government also imposed its own cost control policies on hospital reimbursements for Medicare patients. Diagnostically related groups of diseases (DRG) in terms of typical treatment cost became the new formula for hospital admissions.

These innovations had the result of injuring relations between hospitals, physicians and patients. These cost control innovations created a more adversarial relationship between the institutional funders of

healthcare (business, industries, and the federal government) and providers of healthcare services. A more adversarial relation also developed between individual patients and physicians, and between patients and hospitals, seen in the escalating numbers of malpractice suits. The net results of these changes in the organization of healthcare were discouraging. Costs continue to rise at twice the rate of general inflation. Businesses found healthcare costs now approaching the size of their after tax profits and constantly increasing healthcare costs created severe budget crisis for federal and state governments. Meanwhile, access to healthcare became increasingly difficult for many Americans (Heirich, 1998).

Rising Healthcare Costs

Rising healthcare expenses have become common knowledge and concern not only for the general public, but also for governments and employers who purchase healthcare for their employees. In 2002, the United States spent \$5,267 per person for healthcare (Bodenheimer, 2005). Switzerland, the second most expensive health system, posted a per capita figure of \$3445, two thirds of the United States amount (Bodenheimer, 2005). The third, fourth, and fifth most costly health systems, those of Norway, Canada, and Germany reported 2002 health expenditures per capita less than 60% of the United States. The United

Kingdom, a frugal system, spent \$2160 per person in 2002, 41% of the United States amount (OECD, 2004).

It has become apparent the United States outspends other nations in healthcare; this situation is worsened by the fact the United States healthcare costs are increasing rapidly. From 1988 to 1993, United States health expenditures rose by 9.7% per year, according to the researchers. Following a slowdown from 1993 to 2000, costs increased by 8.5% in 2001, 9.3% in 2002, and 7.7 in 2003 (Levit, Smith, Sensenig & Catlin, 2004; Smith, Cowan, Sensenig & Catlin, 2005). The healthcare sectors with the most rapid growth in cost are prescription drugs and administrative costs of private health insurance (each increasing at 11% to 16% over the past three years). Hospital and physicians expenditures have been increasing at annual rates closer to 7% to 8% over the past three years (Smith, Cowan, Sensenig & Catlin, 2005).

It has been asserted the federal government projected an average annual growth rate of 7.2% through 2013, with health expenditures increasing from \$1.6 trillion in 2002 (14.9% of gross domestic product, the value of all goods and services produced in a nation) to 3.6 trillion by 2013 which is 18.4% of GDP (Heffer et al., 2004). There are no doubts or disputes the United States health expenditures are high and increasing rapidly; however, the issues behind these events are relatively

controversial. There are four major actors playing a role in the healthcare stage: purchasers, insurers, providers and suppliers (Bodenheimer & Grumbach, 2005). Purchasers, employers, governments, and individuals (some of whom are patients), supply the funds. The literature suggests that insurers receive money from purchasers and reimburse providers. The government can be viewed as an insurer or a purchaser in the Medicare and Medicaid programs. In the studies, the term payer signifies both purchasers and insurers. Providers include physicians and other health professionals, hospitals, nursing homes, home care agencies and pharmacies. The suppliers, pharmaceutical and medical manufacturers, and distributors may oppose one another. If a physician group receives a capitation payment from an insurer, primary care physicians and specialists may disagree over how much of the capitation goes to each group.

High and rising healthcare expenditures present some impediments but are not a grave problem. Healthcare ameliorates health outcomes, provides employment and income, and remits services that people seek; therefore, increased health expenditures may be a positive element in lieu of a negative one. Furthermore, if the general economy is expanding, increases in health spending may not reduce spending on sectors outside the healthcare economy (Pauly, 1993; Chernew, Hirth & Cutler, 2003;

Pauly, 2003). Organizations and individuals who are affected by the harsh actuality of exorbitant costs disagree with this opinion. The vast majority of employers for whom the purchase of employee health insurance is an expense rather than revenue are very anxious to reduce insurance premiums (Bodenheimer & Sullivan, 1998; Morrison, 2000; Gabel et al., 2002). If premiums were lower, employers could augment employee wages, reduce consumer prices or increase profits (Davis, Anderson, Rowland & Steinberg, 1990; Halvorson & Isham, 2003). Expanding government health expenditures create budget deficits and crowd out spending for education, police fire, and other services (Davis, Anderson, Rowland & Steinberg, 1990).

Rising costs increase the number of uninsured individuals through three components: Employers stop offering insurance to their employees (Gabel et al., 2002; Gabel et al., 2003; Gabel et al., 2004), employers decline employer-offered health insurance because they cannot afford the employee share of the premium (Gabel, 1999), and people are eliminated from Medicaid as state governments respond to increase costs with eligibility reductions (Weil, 2003; Kaiser Commission on Medicaid and the Uninsured, 2002). For the larger percentage of the population uninsured or under insured, higher costs make physician visits, preventive services, and prescription drugs, less affordable, particularly for indigent persons,

elderly patients and those in poor health (Kaiser Commission on Medicaid and the Uninsured, 2002; Ayanian, Weissman, Schneider, Ginsburg & Zaslavsky, 2006; Lohr et al., 1986; Blustein, 2000; Federman, Adams, Ross-Degnan, Soumerai & Ayanian, 2001). When costs rise and governments reduce reimbursements, institutions serving as the safety net for the uninsured may close their doors (Institute of Medicine, 2000). Therefore, the literature indicates these effects of rising costs illustrate increased cost frequently means decreased access. It is evident that although rising costs may not be conducive to major problems for the general economy, they have a very negative impact on employers, employees, governments and patients.

It is believed that factors outside the health sector may be conducive to the high healthcare costs in lieu of the characteristics of the healthcare system itself. According to some researchers, the state of the economy may possibly be the cause. They assert that international comparisons of health spending perpetually reveal the level of health expenditures per capita is closely linked with total GDP per capita. Essentially this signifies that wealthier nations spend more per capita on healthcare than more indigent nations (OECD, 2003). While no researchers disagree with this link, it is obvious that one key fact stands out: the United States is a striking outlier (Bodenheimer, 2005). A classic

example is the United States GDP per capita is 150% that of Sweden, but United States health spending per capita is 240% that of Sweden (OECD, 2003). The identical relationship is found between the United States and almost all other developed nations (Reinhardt, Hussey & Anderson, 2002).

The investigators indicate the United States outlier status suggests that high and rising costs in the United States cannot be explained merely by invoking GDP per capita. Another possible external cause for increasingly high healthcare costs is the aging of the population of developed nations. The statistics of many studies have maintained that people older than 75 years of age incur per capita health expenditures 5 times higher than those of people age 25 to 34 years (Reinhardt, 2003). Thus, it is logical to assume that nations with a higher percentage of elderly individuals would have higher per capita health expenditures than nations with younger age distributions. It is surprising to learn that research consistently indicates that this demographic trend explains only 6% to 7% of health expenditure growth (Reinhardt, 2003; Newhouse, 1999; Aaron, 1991). A cross-national regression analysis of the effects of aging on health spending found no significant relationship between the percentage of elderly persons in a nation's population and national health spending (OECD, 2003; Reinhardt, 2003; Aaron, 1991).

The literature implies there are a myriad of factors that explain this finding. The fraction of the population age 65 years and older is increasing relatively slowly (Reinhardt, 2003), and per capita health spending for the elderly is rising more slowly than per capita spending for non-elderly persons (Meara, White & Cutler, 2004), depreciating the cost impact of an aging population. Although the end-of-life costs are quite high, they are not increasing more rapidly than health expenditures as a whole (Newhouse, 1993). While life expectancy is rising, the number of years of disability is lessening, which is a cost-saving trend (Fries, 1980; Manton & Gu, 2001). One admonition is that individuals with numerous risk factors for serious illness have twice the rate of disability of those with no risk factors. The research for this study indicates the epidemic of obesity is a cloud on the cost horizon (Sturm, Ringel & Andreyeva, 2004). While most studies contend that increase in health costs are linked with an aging population. Bodenheimer (2005) suggests rising healthcare costs are not strongly associated with the aging population and are therefore not inevitable consequence of this demographic reality. Therefore, the findings suggest there are a plethora of controversies surrounding the causes of rising healthcare costs.

Large Population of Uninsured Citizens

There are a large number of individuals enrolled in HMO (79.5 million as of January 1, 2001). Despite the problems that have been associated with HMO is a result of the larger problems of healthcare in America. At present, it is very difficult to obtain reasonably price healthcare and health insurance and many individuals may feel compelled to enroll in HMO. According to one recent study, the number of uninsured Americans reached 40.3 million in 1995 and grew to nearly 44 million in 1998 (United States Census Bureau, 2000). This translates into 16% of the United States population, which is the highest proportion of uninsured Americans in five years. Some analysts suggest the number of uninsured is declining and the number could be as low as 40 million when the 2000 data is released. This represents over 15% of the United States population. As long as the economy is strong and unemployment is low, employment based health insurance coverage will expand and the uninsured will gradually decline. In contrast, if the downturn in the economy becomes severe (as it seems to be as a result of the September 11, 2001 tragedies) and the uninsured rose to 25% (63 million) Americans would be uninsured.

Minority and immigrant populations are often hit the hardest for being uninsured. Minorities comprised 46% of the uninsured, although these groups represent only 24% of the United States population. In a

recent study of urban areas, researchers of the University of California, Los Angeles (UCLA) Center for Health Policy Research found the American cities with the highest uninsured rates also had the largest minority and immigrant populations. The National Coalition on Healthcare published some revealing research on this subject in 1999. According to the study in 1997, 7.4 million African Americans (21.5%), 10.5 million Hispanics (34%) and 2.2 million Asian and Pacific Islanders (20.7%) had no health insurance. By comparison, only 15% of white Americans had no health insurance (United States Census Bureau, 2000).

Furthermore, the proportion of people aged 18 to 64 without health insurance coverage from 1987 to 1999, (those adults of working age) grew from a little more than 14% in 1987 to about 18% in 1997. In addition, during this time their employer insured only about 61% of employed people. This research emphasizes the fact there are many individuals in need of healthcare insurance (Kronick & Gilmer, 1996). It also suggests that certain members of the population may be more likely to be without health insurance and forced to resort to HMO.

Citizens with Special Healthcare Needs

At this point, the researcher has observed that much has been written regarding individuals with special healthcare needs, a segment group beyond the mainstream. Rochefort (1997) offers useful insight into

this particular population by which this study further examines in light of socialized healthcare. This group injects a greater philosophical dimension to health policy, or mental health policy. The question to be contemplated is: Should supporters of mental healthcare emphasize its uniqueness as a public policy concern? Emphasizing the factors that separate mental healthcare from other social welfare causes may heighten consciousness of the mentally ill and illicit tailor made legislative responses to their needs. Yet, the approach also runs the risk of insulating mental healthcare from broader social policy reform and alienating potential political allies.

Discussion of this strategy will arise at various points throughout this study; however healthcare reform particularly in terms of the mentally disabled is limited. Rochefort (1997) further states that social stigmatization presents the mentally ill with a major political liability, one that is easily overcome by a group whose functional impairments can inhibit effective organizational activity. AIDS too, is surrounded by terrified public fearfulness and moralistic judgment. However, the homosexual community that spearheads AIDS activism possesses a much stronger self-identity and capability for mobilization than the mentally ill. Even when compared to advocates on behalf of the mentally retarded and persons with other developmental disabilities, the mental health constituency has been decidedly weak politically.

The extent of disagreement about what mental illness is and its relationship to psychological, biological and social factors is a second striking characteristic of this policy area. Mental illness is multiform and the etiology underlying one set of symptoms may not be the same as for another. Treatment needs of different groups of mentally ill patients often differ and change over time. Lack of knowledge is a common difficulty in public policy making; action frequently must proceed without full understanding of a problem and its causes. Even so, past a certain threshold, chronic uncertainty compounded by overwhelming complexity creates disadvantages in the competitive public environment, and this remains the case with mental healthcare.

Throughout the history of mental health policy making, officials have had to struggle in making informed decisions on what level of resources to invest in rival settings of service delivery and among preventive curative and custodial care objectives. (Rochefort, 1997). Even with this singular population mental health challenges, the issue of costs and cost constraint evidences itself. It appears the Senate reform debate in 1994 was focused on money which stymied the ability of the finest minds in America to come up with a method of complete healthcare coverage for all.

A Review of the Managed Healthcare Plan and Its Role in America's

Healthcare

As this study addresses the issues associated with Managed Healthcare, in particular HMO, PPO and other forms of managed healthcare plans around which there has been a wide degree of controversy, the foremost of the inadequacy to address all of Americans' healthcare needs. At the heart of this problem is an essential financial dilemma. The individuals running the programs are simply not adequately prepared for the necessary business management. This is mandatory for the provision of healthcare for everyone, which is their stated goal.

Managed Healthcare

Managed healthcare is a concept which unites a mechanism of financing healthcare and a system of delivery under the control and direction of a system provider, which serves as the managing entity. It is designed to control escalating healthcare costs and to place the provider at financial risk (Ross, Williams & Schafer, 1991). Managed Care is any health services arrangement in which a contract for both the services and the payment is created between a provider and a purchaser (usually an employer or government agency) on behalf of a group of consumers or members (Hodge, 1996). Although the concept dates back to the beginning of the century, it gained greater acceptance within the

past 25 years as a way to curtail healthcare costs while providing quality care (Ginsburg & Ostow, 1997). As previously stated, Managed Care started as an attempt to control escalating healthcare costs in the 1980s and early 1990s. Many factors contribute to out-of-control healthcare costs:

- An aging population – Americans are living longer than ever before. Older people have more health problems, which require more services.
- Advances in medical technology – new equipment performs wonders but can be expensive to purchase and operate.
- Excess hospital capacity – Hospitals with too many empty hospital beds cannot cover fixed overhead costs.
- Labor costs for hospital, clinic, and staff – Salaries and wages consume a substantial portion of budgets.
- A disproportionate number of physician specialists – Many medical school graduates in the 1980s and early 1990s chose specialties that promised higher salaries than careers in primary care.
- Performance of unnecessary services – Physicians and hospitals make extra money when they recommend or perform

procedures that patients do not necessarily need, sometimes to satisfy patients request.

- Defensive Medicine – The tort system has proven to be inadequate in the prevention of medical malpractice (Pozgar, & Santucci, 2002). Physician’s malpractice insurance premiums have increased dramatically. Physicians sometimes recommend procedures based on their desire to avoid potential legal problems.
- Cares for Uninsured Patients – The almost 44 million uninsured Americans consume an increasing share of healthcare resources.
- The rapid spread of HIV/AIDS – HIV/AIDS patients require expensive medications and long-term care.

All of these factors drive the machine of the medical industry harder and harder, and the immense costs generated by these activities are spread out amongst those who can pay, with much of the waste first and foremost relative to social conditions. For example, even when making advanced calculations on the amount of money spent through administrative factors every year, it would be staggering to be able to estimate how much expense is caused by unpaid emergency room visits made hundreds of times every single day to remove bullets from patients. While this initially

sounds like more of a social comment than a healthcare issue, it should be mentioned as a simple illustration of the fine lines that exist everywhere throughout the medical industry and the difficulties of cost that must be factored in management.

Many of these factors will continue to place demands on healthcare delivery systems well into the twenty-first century. The delivery models that are currently referred to as managed care derived historically from two very different forms of organizations: the county medical society sponsored medical care foundations and the group and staff model prepaid group practice organizations. The origins of group and staff model came several years later. The pioneers of the group and staff HMO form include organizations such as Kaiser Permanente, the Group Health Cooperative of Puget Sound, and Health Insurance Plan (HIP) of Greater New York, Minneapolis' Group Health, Inc., and the Washington D.C. Group Health Association. HMO has been accused of sacrificing the quality of services in the name of cutting costs and in the case of for-profit HMOs boosting profits. They have also been accused of taking away the power of deciding care a patient gets from physicians and giving it to HMO administrators.

The HMO has grown to become the dominant form of Managed Care healthcare delivery. It has muscled its way into virtually every major

United States metropolitan market. Managed care has not eliminated the problem of escalating costs. It has however, helped keep annual increases to a tolerable level. Although managed care is considered the mainstream healthcare system in many markets, it still faces some hostility. Employers are battling new rounds of premium rate increases. Consumers are becoming politicized in response to the perceived abuses of managed care and state legislators are placing tighter restrictions on how Managed Care Organizations(MCO) can operate. Essentially, MCO are in a difficult situation because virtually every difficult policy decision they make (such as higher premiums, shorter hospital stays, and restrictions on specialist referrals) will anger at least one of their constituencies. The fact is, although most major markets have accepted managed care, few people are completely happy with the system.

There is currently a movement underway to give patients more rights in the dealings with HMO. Furthermore, Congress passed legislation that stands to expand the ability of injured patients to sue managed-care plans for denying needed care and provide a host of additional protections for consumers. The bill faces stiff opposition from the Senate (McGinley, 1999). During his last year in office, President Clinton expressed support for this movement. On January 19, 1999 Senior Democratic Leader, Tom Daschle introduced Senate Bill 1890, the Patient Bill of Rights. If the bill

had passed it would have guaranteed patients greater access to information and necessary care including the following:

- access to needed specialists and emergency rooms
- guarantee of a fair appeals process when health plans deny care
- expanded choice
- protection of the doctor-patient relationship
- holding HMO accountable for decisions that end up harming patients

However, after taking office on January 1, 2001, President Bush stated he could not support the Bill of Rights legislation in its current form. Bush outlined a set of White House Principles in February 2001 that called for comprehensive patient protection (rapid review for denials, timely medical care, and so forth) employer protection, and allowing only Federal Lawsuits. The same week Senators McCain, Edwards, Specter, Graham, Chafee, and Kennedy introduced the Bipartisan Patient Protection Act of 2001 (S.283/H.R. 526). While the President's principles were general in nature, the Senators were pleased to note their bill met many of the President's stated goals. In July 2001, H.R. 2563, also known as the Bipartisan Patient Protection Act was introduced by Congressman Ganske-Dingell-Norwood-Berry. The revised bill strikes a much-needed

compromise to provide comprehensive patient protections for all Americans. This bill builds from the bipartisan Ganske-Dingell-Norwood-Berry bill (H.R. 526) and incorporates the amendments made to the McCain-Edwards bill in the Senate as well as a few technical clarifications. President Bush also has urged lawmakers to pass a patients-rights bill, though other legislators have their doubts. One thing is clear about HMOs is many consumers appear to be dissatisfied with the care that is being provided to them. Caredata, a healthcare research firm, released the results of a survey based on responses from nearly 25,000 health plan members who belong to nearly 160 managed care plans in over 25 markets. According to the survey, HMO satisfaction dropped to 55% from 58% last year alone. This survey also revealed that consumers are especially displeased with the role that HMO play in medical decisions and the difficulty they have in getting in contact with the failure of HMO to answer questions in a timely manner (“HMO satisfaction dips”, 1999). In another survey conducted by Kaiser-Harvard Health News Index in 1997, 25% of respondents said HMO had poor performance serving customers. In 2000, the percentage increased to 46%. The most common complaints were concerns over insurance bills and claims, delays and denials of coverage, and unsatisfactory access to specialists. The survey also suggested many Americans do not trust their managed care plans. For

example, 56% said they worried that if they become sick, their plans will be more concerned with saving money than providing the best treatment. The survey was released a day after Watson-Wyatt, a worldwide consulting firm, reported that 43% of workers are not satisfied with the overall performance of their health plan. Trigaux (2001) the source for all of the above data

Managed Care and Selective Contracting

According to Feldman et al. (1990) most HMO use selective contracts in order to get hospitals to care for their members. Selective contracting of HMO with particular hospitals occurs after negotiating pricing and other significant issues. The HMO then proceeds to offer its members inducements so they will only use these hospitals. This study has concluded that selective contracting has resulted in an increase in price competition among various hospitals. This, in turn has led to lower hospital price, along with slower growth in overall hospital costs. However, selective contracting has also led to a decrease in the amount of charity care that hospitals are providing (Zwanziger, Melnick, Mann & Simonson, 1997).

Selective contracting for hospital care may also mean that members of HMO may be more likely to be admitted to particular hospitals than those individuals that are not in HMO. Whether the hospitals that are

available to HMO members offer superior or inferior services remains an important and open question. According to Schulman et al. (1997), HMO considers certain hospitals to be more attractive than others based upon a variety of factors. Some of these more favorable hospitals may grant larger discounts to HMOs, offer the range of services desired by HMO or may just be supportive of managed care. In any event, these hospitals are more likely to have contracts with many HMO and to treat a high proportion of HMO patients (Schulman et al., 1997).

The fact there are some hospitals that treat a large number of HMO patients and those that treat a large number of patients not belonging to HMOs raises the questions of whether these hospitals differ in terms of the quality of care they offer to their patients. Previously, it was noted the type of HMO the patient is a member of might affect the care that a patient receives. Productivity, in this case, refers to the number of patients seen within a specified period. As a result, doctors appear to be encouraged to spend small amounts of time with each patient, rushing them in and out of their offices (Luft & Greenlick, 1996).

HMO

The healthcare crisis in America is causing more and more individuals to rely upon HMO for the provision of their healthcare, especially the American worker. Nonetheless, despite the increasing use

of HMO or perhaps because of it, such entities have also been on the receiving end of a considerable amount of criticism. There are basically five types of HMO, each of which has different impacts on patient care. Under the staff model the doctors work directly for the HMO and are eligible to receive bonuses based upon productivity.). Under the group model, the HMO contracts with a Multi-specialty group practice and pays the practice a predetermined amount per patient to provide a specified range of services. The physicians are not employees of the HMO. Instead, the group practice employs the physicians and determines physician income and profit sharing policies. A group model HMO may have its own facility or clinic and may have an on-site pharmacy or contract for pharmacy services. Some group models exist only to provide services to enrollees from a single HMO. These group models are sometimes called captive groups. The most notable example of a captive group is the Permanente Medical Group, which provides physician services to Kaiser Foundation Health Plan members only. These HMOs thus limit healthcare access only to a certain number of office locations (Luft & Greenlick, 1996).

The Network model is essentially an IPA made up of group practice physicians rather than individual physicians. Physicians in contracted groups also treat Fee for Service patients in their offices. A network may

be composed of Multi-specialty groups of groups of primary care physicians. Like the IPA network model HMO offer members a broader choice of physicians, but it is more difficult to manage member utilization of physicians' services.

Usually the HMO compensates networked groups on a capitated basis for all services, and the groups determine physician salary and bonus policies. Under the capitation arrangement, each doctor is only paid a certain sum of money per patient, regardless of whether the patient is actually seen by the doctor (Felt-Lisk, 1996). If the patient requires care that exceeds the sum, the doctor must pay for it. However, if the patient's care is less than the sum, the doctor keeps the difference. As a result, it is often in the financial interest of the doctor to actually limit the amount of care that he or she provides to the patient. The implications of this are various and even contradictory, but the bottom line is there is often a financial incentive for doctors to withhold the provision of curative care.

Under the IPA model, the health plan contracts with an association of physicians, usually a separate legal entity. The physicians maintain their own offices and practices see HMO and non-HMO patients side by side. Advantages of this type of model are that it does not require a large capital investment and individual physicians perceive they have more autonomy. Yet, they are able to compete with physicians organized under

the group and staff models. Most IPA tries to recruit physicians from all specialties, minimizing the need to refer patients to non-participating physicians.

Mixed models were born out of the need for consumers to have more choice. This led to the development of mixed (or hybrid) model HMO. These plans combine attributes of other types of MCO to offer consumers a broader selection of physicians and hospitals. In the 1990s, the fastest growth rate among HMO has occurred in the mixed model sector. A popular feature among mixed model HMO is the point-of-service (POS) option which offers consumers the choice of using either an HMO or non-HMO provider.

Consumers who choose a non-HMO provider are required to pay a higher fee.

Gatekeeper versus Open Access HMOs

HMO often relies on a gatekeeper system to control access to healthcare services. That means that plans require members to use a primary care physician (PCP) (for example, family practice physician, an internist, a pediatrician, or, in some cases, an obstetrician or gynecologist) who will either provide their care or direct them to any specialty care they need. In contrast, an individual insured under an Open Access HMO may choose to see a specialist in the network without a referral, although in

most cases, Open Access plans strongly suggest using a primary care physician. These Open Access programs designed to ease a patient's access to medical specialists were initially quite popular with health plans. Doctors and consumers often view the programs as an uncertain balance between choice and access. The primary purpose of these plans is to resolve consumer complaints about the restrictive gatekeeper systems set up by health maintenance organizations and to boost overall HMO enrollment. Many analysts see these programs have been accomplishing their goals. For example, three HMO in California that have open access plans(Blue Shield, Health Net and PacifiCare) claim that with these programs they have been able to improve consumer satisfaction and increase membership in their health plans.

Since Blue Shield launched its Access Plus HMO in September 1996, their membership has grown between 25% and 30%. Health Net, which began its Rapid Access in November 1996, saw its membership climb from 1996 to 1997 by 110,000 new enrollees. PacifiCare's Express Referrals program, which was implemented in January 1997, was so well received the plan expanded the program a year later. It is now available to more than 70% of its members in California. These testimonials show there is some good resulting from Open Access Plans. Specifically, they attempted to target the trouble spots of most HMO. The HMO set up open

access in response to overwhelming consumer complaints about the administrative problems and delays involved in getting access to specialists. Traditionally, HMO members could see specialists only after getting referrals from their primary-care physicians. That was a notable change from traditional indemnity plans and preferred provider organizations, where patients have much more access to specialists.

The open access plans now offered by many HMO allow patients, under certain conditions, to bypass the primary-care gatekeeper. However, there are still innumerable points of conflict with HMO and these plans cannot begin to solve the larger problems. Patients want the ability to self-refer, but many HMO consumers are unaware that direct and self-referrals are available and unaware of what that service entails. Blue Shield representatives underline the fact the program caters to specialists, who have been the loudest advocates for Open Access. Although many were concerned that not having patients go through their family doctors would lessen the continuity of care, the HMO claim that has not happened because the IPA works closely with the HMO to keep the primary-care physician in the loop. HMO also feared financial ramifications. Open access, they reasoned would greatly increase the use of specialists, thus the costs to health plans. Blue Shield had expected visits to specialists to increase between 10% and 15% with its Access Plus program. However,

the actual increased utilization fell short of the projection. Some of them, such as Health Net, do not track specialist use.

Each has adopted its own manner of handling the referral issues brought up by Open Access. Blue Shield, for example, was the first organization to remove the requisite clearance from a primary-care physician prior to seeing a specialist. Health Net and PacifiCare have eliminated the need for the primary-care physicians to seek authorization for referrals. There are no additional fees charged for these direct referrals within the same medical group.

Although the named HMO views open access as a success, their recent membership growth cannot be attributed solely to open access. The health plans are offering other features to enhance member satisfaction. This is the major weakness signaled by patient cared for under HMO plans. For instance, Blue Shield worked to refund an Access Plus member's co-payment if he or she claimed they were unhappy with a visit to a physician. The HMO also provides a wide range of information on health problems on its Website. Health Net has detailed how to access specialists on the Internet and tried to clarify the language used in its handbook to increase consumer understanding and awareness of health issues and the array of available choices. PacifiCare has no definite data on the membership increase that can be attributed to its Express

Referrals. This HMO doubled in size primarily because of its acquisition of Family Health Program (FHP) International in Southern California.

PacifiCare claimed that it could expect to reap long-term cost savings from the open access program because of reduced paperwork and telephone calls which has yet to be shown. Prior authorizations were removed, not only because they alienated consumers, but also because they came to be viewed by some as unnecessary red tape.

The HMO that have embarked upon open access programs maintain they are not temporary programs. New offers and expansions of service were to be amended to the open access portion of any HMO health plan. However, it was shown after some time that in the long-term development of healthcare, the open access idea generated only an initial spike in specialist activity. The idea behind requiring patients to be referred to specialists by PCP was that it would reduce unneeded visits and therefore, reduce expenses for managed care organizations. New research shows when they are relieved of the referral step, HMO patients are not entirely prone to take advantage of the nearest specialist. In fact, the rates of specialist use stay about the same over the long course of things (Federman et al., 2001). Researchers at Massachusetts General Hospital and Harvard Pilgrim Healthcare did not find a significant rise in

overall numbers of visits to specialists when they moved away from the earlier gatekeeper model.

About 50% of all Americans are currently in healthcare plans with gatekeeping requirements. In addition, eliminating gatekeeper plans may not necessarily raise costs for HMO as suggested by new study findings (Escarce, 2001). Escarce's (2001) study provides an initial look at how point-of-service HMO which is increasing throughout the United States and affect patient demand for primary and specialty medical care. The study was funded as part of an Agency for Healthcare Research and Quality (AHRQ) program to examine the impact of managed care plans' specialist referral policies on patient health, access to services, and costs.

To determine the role of gatekeepers in cost reduction, Escarce (2001) found no evidence that medical care expenditures were higher in POS plans. When the researchers examined claims for patients with no co-payment requirement for either primary care physician visits or PCP-referred visits to specialists, they found the overall cost of physician services was 4% higher in the gatekeeper HMO than in the POS plan. However, when co-payments were \$10, overall physician expenditures varied from being roughly equal for both plans to being 7% higher in the gatekeeper HMO, depending on the amount of the co-payments the self-

referred POS plan patients had to make when visiting specialists (Larkin, 1998).

Members of the gatekeeper HMO had to obtain both their routine healthcare and referrals to medical specialists through a primary care physician they selected from among 1,152 generalists in a physician network shared by both plans. The POS plan's members also had to select a primary care physician from the network and were encouraged to use that doctor for their routine care and for obtaining referrals. However, the POS plan also provided generous coverage for self-referrals to the 1,692 medical specialists in the shared physician network. All the physicians in the network were independent contractors (Larkin, 1998).

Anecdotal and empirical research have both suggested the quality of healthcare and patient satisfaction in Gatekeeper HMO compared to those in enrolled in Open Access HMO comes under considerable scrutiny in terms of the quality and accessibility of the care in question. This concern is further elaborated through variegated situations of the elderly and the poor and other groups, which shall be discussed. The Federal Government neither requires nor forbids Gatekeeper systems, as long as they do not conflict with the applicable provisions in Title XIII; applicable parts of the Social Security Laws; applicable portions of volume 42 of the Code of

Federal Regulations; and the HMO manual subject to the following considerations (Department of Health and Human Services [DHHS], 1999):

- a. The provision of basic health services is on a basis that is available and accessible with reasonable promptness with respect to geographic location, hours of operation and provision of after hour's service depending upon the nature of care needed. Medically necessary emergency services must be available twenty-four hours a day, seven days a week. In addition, the contracting managed care organization must provide its services on a basis that ensures continuity in compliance with the provisions in 42CFR 417.106.
- b. The managed care organization does not relinquish the requirement that it provide or arrange for all basic healthcare services with the exception of medical emergencies.
- c. The managed care organization uses the same or a subset of its non-Medicare panel to provide Medicare covered benefits.
- d. The provision of healthcare by a non-physician must be supervised by a physician except for the services of physician assistants, nurse practitioners and clinical psychologists.

- e. The contracting managed care organization ultimately does not relinquish its authority to select a practitioner among those able to provide a given service. We interpret this requirement to mean, in this instance, the managed care organization would nominate a suitable practitioner for its members who have no preference of the plan's panel of physicians they would see.
- f. The managed care organization must furnish the required services to its Medicare enrollees through providers and suppliers that meet applicable Medicare statutory definitions.
- g. The managed care organization must have an ongoing quality assurance program for its health services that stresses health outcomes and provides review by physicians and other health professionals of the provision of health services. It must be supported by an adequate system of health and medical records which accumulate performance and patient results, and which are adequately reviewed, interpreted and acted upon. Pertinent medical information relating to the healthcare of Medicare enrollees must be readily available to plan-contracted medical professionals.

- h. The managed care organization may not impose additional charges for open access or self-referral arrangements such as higher premiums or co-pays.

The Preferred Provider Organization

Another type of managed care plan, which was engineered to make amends where HMO were known to have certain shortcomings, was the PPO. With PPO patients are free to select any provider, but if they select from the list of preferred providers, they pay less. For example, if a patient selects a PPO physician, many plans covers 100% of the cost of an office visit. If a patient selects a non-PPO physician, the plan might cover only 80% or 90% of the cost and require the patient to pay the difference. A PPO is a variation of traditional indemnity insurance plans and is a network of designated providers who accept discounted fees and agree to abide by certain utilization guidelines. In PPO contracts, providers agree to deliver services to plan members for discounted fees. This cost benefit encourages members to use the preferred providers. Providers anticipate increased patient volume in return for reduced fees. A PPO may consist of thousands of physicians throughout a state or region and a physician may belong to several PPO. Because providers retain their independence, a PPO resembles a network rather than a tightly structured organization.

Enrollment in the classic closed-panel HMO had been flat at 30% for two years while enrollment in the open-ended HMO or POS plan actually declined from 20% to 16%. Enrollment in PPO rose from 35% to 43% during this period. Further, when asked to predict the direction of their HMO enrollment over the next three years, the majority of employers offering HMOs stated they believed it would stay the same or decrease; only about a third (36%) predicted an increase.

Once considered a vehicle for obtaining provider discounts, PPO are adopting the elements of managed care that effectively control cost while avoiding those that drive participants away. One of the facets involved in this development is sharing risk with hospitals by paying a set amount per day or per diagnosis, regardless of the number of services provided. This tactic, a cornerstone of HMO cost management strategy, has been shown to be effective in reducing inpatient costs. PPO have also borrowed a popular cost-sharing strategy from HMO which is the fixed-dollar employee co-payment (generally about \$10), as a way to encourage participants to use doctors within a given network. In 1999, 83% of PPO plans required an in-network co-payment, something that was all but unheard of 10 years earlier.

In addition, in 1999 there was a big jump (from 47% to 58%) in PPO plans providing one or more disease management programs for

conditions such as heart disease, diabetes, asthma, back pain, and depression. Disease management programs reach out to participants with chronic conditions to educate them about their disease, actively monitor the progress of their condition, and assist in behavioral change. Such programs, an example of the softer side of managed care, ideally work to reduce health plan costs by improving the health of the plan participants most in need of care.

As other strategies mentioned, PPO does not require participants to get referrals to specialists from primary care physician gatekeepers. In addition, they do not conduct prospective review (requiring doctors to get the plan's approval before beginning a specific treatment) to the same extent, as do HMO, although many PPO do require pre-certification of elective surgery. PPO are more likely to monitor physician performance after the fact, avoiding the risk of denying care that should have been given. PPO also avoid the administrative expense of extensive prospective review and gatekeeper referrals. In 1999, the average administrative cost of a PPO was \$17 per employee per month, while in an open-ended HMO it was \$25. At the time of the mentioned analysis, the average per-employee cost of PPOs and open-ended HMOs was virtually identical in 1999, at \$3,742 and \$3,732, respectively. Given the negative publicity surrounding the HMO gatekeeper function, in many

markets there's not a lot of financial incentive for employers to offer an open-ended HMO over a PPO or for an employee to enroll in one, given a choice. In this manner, the PPO works as another alternative to the bad reputation of gatekeeper programs.

Faced with mounting consumer dissatisfaction and legislative interference, some HMO is beginning to shed the same managed care features that PPO can simply avoid. The introduction of the open-ended HMO in the early 1990s was a first step in that direction. Now a growing number of HMO is offering open-access products, which do away with the gatekeeper provision. In 1999, 16% of employers with HMO offer an open-access plan, up from 13% last year. Others are permitting year long specialist referrals or self-referral to OB/GYN providers. Recently, a major healthcare company announced the discontinuation of prospective medical necessity review in its HMO plans because they had determined the return on investment was not justified.

It is easy to see why employers like PPO. Because they do not limit coverage to a closed panel of providers, they are less likely than HMO to face legal intervention. Survey results show a notable increase in the percentage of large employers who claim they are concerned about the threat of litigation by plan participants from 48% in 1998 to 70% in 1999. For the very largest employers, this concern is justified: 20% of those with

20,000 or more employees have been named in one or more legal actions related to medical care provided through one of the health plans with which they contract. Large employers also have come to prefer the flexibility of the PPO. Leading-edge employers are using a modular approach to building PPO plans, contracting with a number of best in class providers of disease management, alternative medicine therapies, and utilization management and overlaying them on a PPO network.

What the PPO Does Not Accomplish

The researcher of this study has previously discussed the advantages of PPO over HMO. It is essential to present other aspects of this issue. Hurley, Strunk & White (2004) have asserted that one of the most salient trends is the decreased price spread on premiums in the Community Tracking Study (CTS), markets between fully insured HMO and PPO offering with comparable benefits. It was revealed that in seven of the 12 markets, HMO has little or no remaining price advantage. This is indicative in part of the now-failed strategies of new HMO entrants to under price products to gain market share, which erroneously implied the HMO product could be delivered at a substantial price advantage over other offerings, according to the researchers. However, the eagerness of some provider organizations to accept substantial financial risk fostered

an illusion in other markets the HMO could be less costly despite it's having more comprehensive benefits (Hurley et al., 2002).

Only in Miami, Boston, and Orange County does there appear to be a considerable price advantage for the HMO owing to either competitive dynamics, culture differences or some combination (Hurley et al., 2004). The researchers contend that while numerous companies that offer HMOs have made significant modifications to make them more appealing or less unattractive, benefit mandates, consumer-protection impositions, and solvency requirements have restricted their adaptability compared with PPO. The literature suggests that disillusionment with HMO inability to sustain apparent cost savings of five years ago had caused many employers to doubt whether HMO adds value commensurate with their higher administrative expenses, narrower networks, and more aggressive medical management techniques. Based on the research in this study the more modest practices found in PPO are more transparent to purchasers and frequently cost less than half of what might be paid to an HMO in administrative costs. It has been suggested by some researchers that purchasers can also directly influence the amount they are obligated to pay by adding or deleting features such as utilization review, disease management, or case management that are priced and sold separately.

In some instances, the investigators contend that employers in an array of markets complain that HMO failed to provide them with adequately detailed utilization and cost information to permit them to sufficiently evaluate the value of what they are purchasing or even to investigate if they should consider changing to other products and vendors. As the demand for increased consumer responsibility builds with increased cost sharing, more benefit buy-down opportunities, multi-tier provider networks and diverse consumer driven health plan designs, PPO arrangements seem well positioned to respond to their preferences (Lesser & Ginsburg, 2003). The positioning to offer one or more of these options is apparent in every market, as employers become more unsettled about what existing product designs can deliver by way of cost containment and interest transforms from supply side to demand side interventions. The coinsurance feature of PPO options is particularly valued as a method to cultivate price sensitivity as consumers begin to spend more of their own money for their medical care.

It appears the public sector summons as a possible market for PPO promoters. Medicare instituted a PPO demonstration at the beginning of the Round Four site visits and demonstration programs were being implemented in Cleveland, Indianapolis, northern New Jersey, Orange County, and Phoenix (Gold, Achman & Vedier, 2003). Medicare appeared

to be attempting to capitalize on the increasing popularity of the PPO product in the commercial sector by adding a PPO option under Medicare+Choice (M+C), which has undergone a multitude of failures by participating HMO in recent years. Nevertheless, the demonstration was created to mandate PPO network sponsors to sustain some financial risk. The literature maintains that this made it unappealing to many PPO network developers, which have disparaged the initiative.

Although the PPO have matured in popularity at the same time that overall health benefit costs have acutely increased, this does not confirm they should be endorsed; nor are the trends reported for PPO premiums different from HMO premium trends (Kaiser Family Foundation Health Research and Educational Trust, 2003). Therefore the investigators maintain that it does not appear that PPO arrangements have played a significant part in cost containment despite the fact that more than half of all commercially covered lives are in PPO. They do seem to deliver cost displacement by moving costs from employer sponsors to individuals, which nonetheless, has the real effect of moderating the rate of increase in employers' contributions for benefits (Hurley et al., 2004). The flexible PPO design allows employers to buy down benefits by requiring more cost participation for existing benefits or to lower their premium contributions by transforming more expenses to consumers in the form of user fees,

according to the investigators. It has been indicated that organizations that offer HMO products are using the same method, such as adding or expanding deductibles, however HMOs' flexibility is more restricted by regulatory compulsions.

It is difficult to determine how effective the discounts are that preferred provider network developers transact with providers. The researchers contend they found that most employers using these networks see discounts as partially real and partially illusory. The literature suggests the reality appears in the fact that transacting with a preferred provider network that has negotiated discounts is better than paying providers full billed charges, which purchasers would do unless they negotiated their own discounts. However the illusion, according to the investigators, appears to be the meaningfulness of discounts off charges for physician and hospital services disappears rapidly, if network developer is unable to restrict the charge increases that hospitals can impose by increasing their overall charges.

The more current controversies about the pricing practices of investor-owned hospital chains emphasize this point (Institute for Health and Socio-Economic Policy, 2003). A multitude of network providers noted they were compelled to recede from the case rates to per diem rates and in some instances back to percentage of charge payments. Preferred

provider networks generally make fewer demands on providers and strive less to revising clinical practice patterns than HMO (Hurley et al., 2003).

However, networks charge employers lower administrative fees that are comparable with their modest efforts to manage care. Despite their positive qualities, the researchers indicate that many preferred provider networks do not have the power to advocate behavior transformation, such as in the case of drug prescribing practices. Most have abstained risk based payment methods or use of incentives or sanctions. A neutral approach has removed providers' opposition to negotiating but presents less than a minimal promise of influencing care delivery or advancing quality amelioration.

Greenberg (2001) asserts that some PPO planners have claimed their ability to induce care delivery is exceedingly restricted because they do not have enrolled populations to the degree of HMO. Although they collect data on services delivered by network providers, the ability to convene utilization profiles is deterred because PPO participants are free to use out-of-network providers and no specific physician is responsible for all of their care (Hurley et al., 2003). It is maintained by the researchers that this makes systematic reporting of members' experiences and providers' performance indistinct. Nevertheless, it is not surprising to learn that some of the Blues plans that have invested significantly in developing

PPO options that are very similar to the HMO products and that include the ability to create comparable performance indicators, according to the researchers. It is apparent that within the PPO business widely conflicting views about how much accountability a PPO benefit option should and can realistically accept ameliorating the quality of care delivered by network providers and received by participating consumers (Smith & Scanlon, 2001).

The PPO value to purchasers appears in what it delivers relative to its cost. This includes a contracted network with some level of discounts off of full charges and some provider credentialing, possibly with some medical management features, for an additional fee. This fee can be as little as \$3-\$5 per member per month, although broader networks with better discounts like those offered by Blues plans may have much higher fees. However, it is less than the 10-12% of premium (\$15-\$25 based on a typical premium) that HMO spend for administration. It is maintained by the investigators that many purchasers of PPO products assert they are getting just what they are paying for.

One of the flaws of PPO is its reduced accountability. Preferred provider network developers are not doing much to hold providers more accountable or position themselves to systematically ameliorate care (Hurley et al., 2003). In fact, many of these networks view this as being

beyond the scope of their responsibility. Some are satisfied their limited field of vision in care delivery exonerates them from the need for a stronger sense of responsibility.

PPO growth signifies a retreat from the era of benefit expansion of the 1990s because financing these benefits, especially via provider discounts has demonstrated unsustainable. The researchers indicate the PPO option is an instrument for private purchasers to realign what they desire to pay for health benefits with what they believe they can afford to pay. The perpetual success in PPO growth appears to suggest, for consumers paying more to attempt to hold onto what they have. This implies that PPO represents a decrease in benefits for consumers, which is not beneficial.

Regardless of the small innovations of the PPO and the corrections it can bring about over the standard HMO, there is a lingering doubt about whether or not this is only a temporary solution. There is no way to tell currently whether the care and cost management tactics adopted by the PPO can prevent a return of the double-digit cost inflation that plagued employers in the eighties. This pattern can easily be repeated. PPO cost rose 7.1% in 1999; an increase that employers may feel is acceptable – but just barely. While even its critics acknowledge that managed care has eliminated some of the waste in the healthcare delivery system and

reduced the incidence of unnecessary or ineffective treatments, the fundamental forces pushing up medical costs remain. Chief among these is the aging of the American population and the rapid introduction of expensive drugs and treatments in addition to the lingering problem of social security exhaustion the coming age of elderly people might bring about. Some have proposed that ultimately, the success of PPO may hinge on yet-to-be-developed applications of information technology that make healthcare delivery more efficient even as new medical technologies increase cost. An example of such an application is the recently introduced hand-held electronic prescription pad for doctors who can check a patient's records for allergies or adverse drug interactions, indicate whether a drug is covered by insurance, and e-mail the prescription directly to the pharmacy.

This sort of hopeful technology is never a good foundation upon which to plan for the long-term development of a healthcare strategy. Technology often finds its niche in a tangential manner, coming into an unexpected use when the original goal of an application is missed. These types of care management tools could be both more effective and less obtrusive than a physician gatekeeper. Applications that give doctors and patients the information they need, when they need it, may make heavy-handed managed care obsolete.

Medicare HMOs

An interesting developing phenomenon is the availability of forms of managed care to supplement areas of care that are not available under federal and state Medicare and Medicaid programs. Goldman and Zissimopoulos (2003) conducted a study to determine if Medicare HMOs, employer supplements and Medicaid effectively insulate against the high risk of high expenditures. The researcher of this study contends the majority of elderly people are insured against healthcare expenses through Medicare, but Medicare does not provide complete insurance and some beneficiaries may be compelled to confront enormous out-of-pocket expenses. The existing research used with this study places emphasis on average expenditures or expenditures as a percentage of income, but these measures overlook the fact that a few individuals may represent a huge portion of out of pocket spending. It is believed that supplemental insurance can alleviate this peril by restricting out-of-pocket expenses, lowering co-payments, and covering more services.

Supplemental options accessible to an elderly Medicare beneficiary vary with individual circumstances. It is a known fact that Medicaid provides such coverage for elderly people with low incomes and little wealth. Private coverage is accessible to some beneficiaries through a current or former employer. Medicare beneficiaries can also purchase

Medigap insurance on their own, although the premiums are very expensive and coverage of prescription drugs and other health services is limited (Rogowski, Lillard & Kingston, 1997).

Medicare (HMO) may provide a financially suitable alternative. In return for beneficiaries' agreement to adhere to administrative constraints on healthcare delivery, Medicare HMO offer benefits that are more comprehensive than those of traditional Medicare Parts A and B and less expensive than additional insurance through a Medigap policy (Goldman & Zissimopoulos, 2003). The consequence is that Medicare HMO beneficiaries have lower average out-of-pocket spending than Medicare beneficiaries overall have (Kasten, Moon & Segal, 2000). Nevertheless, the investigators indicate the primary question is how well these insurance alternatives protect the elderly against high (and perhaps catastrophic) expenses, which is a story about the tail of the distribution.

In their study, Goldman & Zissimopoulos (2003) used the Health and Retirement Study (HRS), a biennial survey of the elderly and near-elderly. In this study data is used from the fourth survey wave folded in 1998 for respondents age 65 and older. The HRS is exceptionally valuable because of its high-quality data on affluence and income. Bias in these measures can be conducive to overestimates of the true burden of out-of-pocket spending (Goldman & Smith, 2001). Respondents were assigned

to one of the five insurance categories to obtain the most notable arrangements. They are:

1. Medicare Parts A and B only
2. Medicare managed care
3. Medicare and Medigap
4. Medicare and employer-sponsored insurance
5. Medicare and Medicaid

The researchers indicate the HRS has information eight types of health services grouped into categories for reporting out-of-pocket spending as follows:

1. nursing home
2. hospital
3. doctor
4. outpatient surgery
5. dental
6. prescription drugs
7. in-home medical care
8. special care center

Out-of-pocket medical expenditures (except for prescription drugs) are reported for the time period since the last interview (two years on average or two years exactly for those responding for the last time).

Spending on prescription drugs is reported as average monthly spending since the last interview. If a respondent did not provide a precise estimate, he or she was asked a series of questions to bracket the expenditure. The researchers imputed the amount of out-of-pocket spending using a nearest neighbor, within-bracket approach. The data on out-of-pocket spending compared favorably with those from other surveys.

In this study, the investigators estimated a quintile regression model to determine the effect of supplemental insurance on out-of-pocket spending for people with median and higher spending levels. They also examined the effect of supplemental health insurance on the probability of service use to distinguish the impact of benefit design from supply-side effects. The results of this study indicated that a majority (64%) of Medicare beneficiaries in 1998 had additional coverage either through an employer or through a Medigap plan. Another 15% were insured with an HMO, which provided coverage for benefits not covered by Medicare at a premium lower than if they had purchased a Medigap plan.

In contrast to high drug coverage rates among the beneficiaries with Medicaid and Medicare managed care, only 27% of seniors in Medigap plans and 71% with employer plans had drug coverage. While 24% of low-wealth elderly were covered by Medicaid, 22% had no supplemental coverage. Low-wealth elderly had low rates of supplemental

coverage, and the likelihood of having supplemental insurance increased with wealth. In contrast, insurance coverage through managed care was generally unchanged across the wealth distribution.

It was revealed in this study that mean-out of-pocket spending in the HRS over two-year periods was \$2,022 and median spending was \$920. This indicates the nature of the out-of-pocket spending: 10% spend \$4,800 or more over two years, and the top 1% spent \$15,248 or more. The literature concurs that elderly people in poor health are vulnerable to high out-of-pocket spending. Those in very good or excellent self-reported health spend approximately 50% less than did those in poor health, at both the mean and the upper tail of the distribution.

In order to evaluate the effect of out-of-pocket healthcare spending on the welfare of the elderly, Goldman & Zissimopoulous (2003) reported spending levels by two measures of economic status: income and wealth. The researchers contend that income is frequently used as a measure of economic status for the elderly; wealth measures spending opportunities better than income does. Out-of-pocket spending was just slightly higher for people with high wealth or income than for those with low wealth or income in 1998. Therefore, it is apparent the financial burden is much greater for the elderly with low economic status.

In this study it was revealed the elderly in the bottom quartile of the wealth distribution spent on average 17% of their annual wealth on healthcare over two years, those in the top quartile spent 43% or more of their annual wealth on healthcare in two years. It has been concurred by the investigators the high level of variation results from the highly inclined nature of out-of-pocket healthcare spending. The findings of the study maintain that people with Medicaid spent the least out-of-pocket at all reported percentiles of the distribution. It was indicated the managed care beneficiaries at 75 percentile spend \$1,300 less than traditional fee-for-service beneficiaries spent (46% lower). Employer coverage is also linked with lower out-of-pocket spending, and the distribution is quite similar to that for beneficiaries in managed care. It was maintained that for people in poor health, Medicare managed care provided greater protection against loss than employer-sponsored insurance provides. In contrast, the elderly with Medigap plans spent as much as or more out of pocket than did the elderly with no supplemental insurance.

The research findings of this study asserted that among low-wealth elderly, the ration of out-of-pocket spending to mean wealth was the largest for those without supplemental insurance. Both employer sponsored supplements and HMO protect those elderly against high expenditures. Two-year average out-of-pocket expenditure for an HMO

enrollee was \$1,549 (10% of mean wealth) and for a person with employer-sponsored insurance, \$1,658 (11% of mean wealth). The findings also indicated that in contrast, the two-year average out-of-pocket expenditure for a person without supplemental coverage (Medicare A and B only) was \$ 2,627 (25% of mean wealth). At the 19th percentile of the healthcare distribution, an elderly HMO enrollee spent 26% of his or her annual wealth out of pocket for a two-year period, compared with 56% spent by an elderly person with no supplemental coverage.

The findings of this study seem to confirm that Medicare HMOs, employer supplements and Medicaid are very effective in insulating elderly people against high expenditures. The investigators concurred that Medicaid is only available for the very indigent elderly, and only a small fraction of the near-poor elderly have employer-sponsored insurance. It was found in this study that even with adjustment for numerous characteristics, ordinary least squares regression results indicated that elderly people enrolled in HMO spent \$809 (31%) less out of pocket than did people with traditional only. Medigap coverage resulted in slightly lower out-of-pocket spending than among people with traditional Medicare only (reference group), although the effect is not statistically different from zero at the 5% level. The results of this study indicated that individuals with employer insurance spent \$837 less than did people in the reference

group and Medicaid enrollees spent \$1,754 less. The socioeconomic status, as evaluated by income and wealth, has an independent effect on out-of-pocket spending for those in the highest income and wealth quartiles. It was maintained by the literature the most indigent elderly used less health-related services, although the effect is not statistically different from that of the middle-income elderly.

The regression results for this study indicated that at each percentile, Medicare HMO enrollees had significantly lower expenses than did those in traditional Medicare reference group (28%, 37%, and 29%). Generally, the findings implied that HMO enrollees are protected from high expenditures at various points in the distribution compared with people with only traditional Medicare. It was revealed that at the 50th and 75th percentiles, people with Medigap plans had out-of-pocket expenditures that were 35% and 10%, respectively, higher than those of the reference group. At the 90th percentile, those with Medigap plans had expenditures that were 10% lower than the reference group. It was suggested by the results that Medigap plans might protect against high-out-of-pocket spending only at the upper tail of the spending distribution.

According to the findings as with Medicare managed care, employer sponsored insurance reduces out-of-pocket spending compared with the reference group. At the 50th, 75th and 90th percentiles, elderly

people with employer supplements had significantly lower expenses than did those in traditional Medicare (22%, 31%, and 29%, respectively). It was not surprising to find that those with Medicaid experienced the largest reduction in out-of-pocket spending relative to the reference group. The findings asserted the most indigent elderly used fewer healthcare services and the wealthiest, more healthcare services, than do the elderly with middle income and wealth.

The researcher of this study suggested HMO enrollees were more likely to have a doctor visit and outpatient surgery and to use prescription drugs but less likely to have a hospital admission than were elderly people with only Medicare Parts A and B. It was found the reduction in out-of-pocket spending for HMO enrollees was not primarily attributable to lower hospital admissions. The findings in the regression of expenditures less hospital expenditures indicated that at each point in the distribution, HMO enrollees had significantly lower non-drug related medical expenditures at all points in the distribution.

Goldman and Zissimopoulous (2003) also attempted to determine if their results reflect preferential selection into Medicare HMO by the healthiest elderly and adverse selection into Medigap. However, this was not observed after controlling for detailed socioeconomic and health status measures, or has been found to be of a small magnitude (Hurd &

McGarry, 1997). Additionally, the researcher did not observe any evidence for selection using a bivariate probity model relating Medicare HMO choice to the likelihood of high (above \$3,000) out of pocket spending. The literature maintains that in technical terms, there is no significant correlation between these outcomes after controlling for the observed health status. Nevertheless, there is a significant correlation when health status and wealth are not included. The findings imply that any bias attributable to selection is small.

The findings of this study show that controlling for confounding factors known to influence out-of-pocket spending such as health status, income and wealth are at the upper tail of the distribution (90th percentile). The elderly with employer supplements or Medicare managed care spent approximately \$1,600 less over two years than did those with traditional Medicare. It was also found the elderly in the lowest wealth quartile were the most at risk of incurring a large financial loss due to the high expenditures, but the burden was lowest in this group for those in managed care.

The findings of this study also maintained that Medicare HMO, employer supplements and Medicaid effectively protected the elderly against the risk of high expenditures. However, for the near indigent who depends primarily on Medicare HMO benefits have probably declined

since the inauguration of Medicare+Choice (M+C) in 1997 (Goldman & Zissimopoulos, 2003). Medicare HMO provided increasingly generous benefits throughout the 1990s, but by 2000 this trend acutely reversed, according to the researchers. Co-payments for primary and specialty physician visits have increased and some plans have begun charging co-payments for inpatient and outpatient hospital services. The proportion of plans offering supplemental benefits such as dental or vision services has also decreased. In all, there have been many proposed addition, modifications, and replacements to the managed care/HMO categories. As will be noted in the following studies, the real problem is fundamentally one that exists as a direct link between patient and doctor. Nothing can circumvent this basic fact and as will be implied later in this study. The ultimate development of the complicated and seemingly endless train of changes and alterations that managed healthcare undergoes might be a total breakdown of the entire system in such a way that in the end the system as a whole will end up resembling something more akin to a European healthcare system could be imagined. This shall be discussed more at the end of the study. The main study will seek to understand how families feel about the services provided by these type HMO. In studying the family's reactions to HMO services, emphasis will also be placed upon information pertaining to the patients' state of health

and other factors relevant to this study. Following the discussion of the main study, there will be a profile of a second parallel study in order to underline some of the basic differences in approach that various groups have taken. Furthermore to voice the fact that difference in findings can itself be considered a finding of the state of not only the research being conducted, but also of the vast area of discrepancy and the tangled lines of the system as a whole.

Two Families' Experiences with HMOs

The researcher seeks to determine whether the family members of patients in gatekeeper HMO reported lower satisfaction and the receipt of a poorer quality of care than the family members in Open Access HMO, based upon at-length interviews with groups of such family members.

Twenty-seven family members of patients enrolled in a Gatekeeper HMO and 25 family members of patients enrolled in a Gatekeeper HMO were recruited to participate. The interviews were conducted with the participants' informed consent and with the understanding their identities would be protected. The principal investigator facilitated the groups using procedures recommended by focus group experts (Krueger, 1994).

It was anticipated that such interviews could help to lead to information regarding the general satisfaction with such different forms of healthcare associated with different types of HMO. At the same time, it

was anticipated the interviews could help to lead to information concerning the qualities that are most significant when evaluating the quality of healthcare and individuals' satisfaction with the provision of healthcare services. The results were largely consistent with the expectations in general. For the most part, the family members of the patients in Open Access HMO reported a higher level of satisfaction with their healthcare services than did those enrolled in Gatekeeper HMO. However, the margin or differences were considerably less than originally anticipated.

The interviews also generated useful information concerning the desired characteristics of health plans. However, for purposes of this study, the researcher will not scrutinize these (interviews) in any kind of detail regarding specific plan provision per se. This study is being done in effort to gain an in-depth understanding of how HMO decisions can affect a family. This implies the use of a particular qualitative design called the case study design. The needs of healthcare consumers can be considered subjective. Thus, what one person considers being their own healthcare need may not be considered a need by others. At this point in the study, healthcare needs will be tentatively defined as those services necessary in order to sustain the level of health desired by the family's members. These needs are to be uncovered during the course of the study.

The pertinence of this study is related to the fact that HMO are currently being criticized as being insensitive to patients and for failing to meet the needs of patients. Polls have been conducted that indicate the American people are increasingly dissatisfied with managed care. By examining a particular family's experiences with managed care up close, it is expected that insights may be yielded that simple surveys are unable to glean. It is further anticipated that such insights might help to contribute to the debate regarding healthcare reform. Moreover, as shall be put forth numerous times, the inclusion of a second study profile demonstrates there is an overall lack in the diagnostic ability to point at explicit points of weakness in the HMO system in a manner, which would directly suggest ways these weaknesses can be rectified.

The factors, which might be improved in these studies and in the plans they focus, are as numerous as the health concerns. For example, it might be noted that regional differences are likely to account for not only the difference in the reported quality of the care given at a certain location, but for the nature of the dissatisfaction. For example it could be taken up as a point of research that HMO in New England are much more likely to allow access to unconventional medicines. This difference must be identified as a concern and as a determining factor in the reports given. The type of treatment in question should not be divorced from the study at

large. The fact that it has been shown in the study, while finding a generally positive picture of HMO, does not dig deep enough into the individual details of managed care choices that can support one or the other outcome. The study consists of a literature review regarding the experiences that Americans have had with HMO, the feelings regarding those experiences, and the nature of HMO in general.

CHAPTER 3

METHODOLOGY

In accordance with the (universities') proposal guidelines, the methodology does reflect what the researcher construes as a quantitative study. However, for purposes of this dissertation, the researcher has opted for what is defined as the historical case study method.

Approach

The approaches used throughout this dissertation include an assessment of HMO scrutinized in as much detail as is deemed appropriate by the researcher, as well as other case studies. As cited, one thing is clear about HMO. Many consumers appear to be dissatisfied with the care that is being provided to them. Caredata, a healthcare research firm, released the result of a survey based on responses from nearly 25,000 health plan members who belong to nearly 160 managed care plans in over 25 markets. According to the survey, HMO satisfaction dropped to 50% from 58% last year alone. This survey also revealed that consumers are especially displeased with the role the HMO has in medical decisions. This is especially true because of the difficulty they have contacting the HMO to answer questions in a timely manner. Similarly, in another survey conducted by Kaiser-Harvard in 1997, 25% of respondents

stated HMO inadequately served customers. Essentially this study concerns itself with the reaction of family members of sick individuals to experiences with Gatekeeper model HMO versus open access model HMO.

This study will use a qualitative methodology. Essentially, there are two research paradigms discussed by Creswell (1994): the qualitative and quantitative. Quantitative researchers assert that both the natural and social sciences strive for testable and confirmable theories that explain phenomena. Qualitative researchers reject the idea that social life can be studied with the same methods as the natural physical sciences and they feel that human behavior is always bound to the context in which it occurs. Accordingly, they believe that behavior should be studied in a manner that could be classified as being subjective. Research design and methodology are fundamentally important because they can affect the validity of a study. Creswell (1994) notes qualitative and quantitative designs are based upon different assumptions. Creswell (1994) also notes that when it comes to qualitative designs, there is little agreement regarding methodology. Indeed, Creswell (1994) points out the fact “those who conduct qualitative research are faced with many possibilities of design drawn from disciplinary field of anthropology, psychology, social psychology, sociology and education” (Creswell, 1994, 194).

Creswell (1994) outlines qualitative data collection and recording procedures which include setting the parameters of data collection, the types of data to be collected, protocols for recording data, and the issues of internal and external validity and reliability. Qualitative methods and designs have several strengths. For one, qualitative designs and methods allow acts or events to be observed that may have been previously overlooked by other researchers. They also try to represent people so that others may see and appreciate their perspectives. Qualitative research approaches look at experiences as a whole and they analyze the data they obtain from their studies inductively although Creswell (1994) emphasizes the deductive. These approaches are interested in understanding behavior from the frame of reference or point of view of the participant and they operate from the assumption that events can be understood within the contexts in which they occur. Thus, the setting in which a study takes place plays an important role in qualitative research. Qualitative interviews may be utilized as the primary strategy for data collection, or in conjunction with observation, document analysis, or other techniques (Bogdan & Bilken, 1982).

A quantitative study is an inquiry into a social or human problem based on testing a theory composed of hypothesis. This hypothesis is composed of variables that are measured with numbers and analyzed with

statistical procedures in order to determine whether the predictive generalizations of the theory are true (Creswell, 1994). Creswell (1994) asserts the question can be examined with a prospective study. He recommends that researchers ask no more than two grand questions followed by several sub-questions.

However, Creswell (1994) also notes that “one typically finds research questions, not objectives or hypotheses, written into qualitative studies” (p. 70). Creswell (1994) also notes that research questions, hypotheses, and objectives serve the same purpose in different contexts in which all three function in effect are specific restatements. However, Creswell (1994) also notes that hypotheses are often used in studies that utilize experiments. This does not mean that a study that uses a case study design cannot use hypotheses to clarify. However, given the nature of the qualitative study, such research is normally used to gather general information about a particular issue, rather than to attempt to obtain a narrowly defined answer to a singular problem. The central concept of this study revolves around patient needs. Creswell (1994) notes the general definition of the central concept in a qualitative study “is not rigid and set, but rather is tentative and evolving throughout a study based upon information from informants” (Creswell, 1994, p. 58). Accordingly, what the families under investigation considers necessary for its well-being will be

revealed and further clarified as the study proceeds. As noted for the purpose of this study, a tentative definition for patient needs is the services that are required to maintain the level of healthcare as needed by family members.

Data Gathering Method

The initial component of this research focuses upon classifying the types of individuals that will participate in the study. The typical participant, in the previous study, was female and in their mid-forties to mid-fifties. There were also men included in the study, but they were in the minority. The interviews conducted with both groups will be helpful in revealing useful information concerning the kinds of services that are important to individuals when evaluating satisfaction with healthcare services. By analyzing the interviews from the sessions with the family members of patients enrolled in gatekeeper HMO and individuals who are enrolled in open access HMO, it will be possible to identify those areas of healthcare service that are considered as important by family members when evaluating the quality and effectiveness of healthcare services. In undertaking the research, it is anticipated that both groups would tend to identify more or less the same characteristics as being important when considering the effectiveness of healthcare plans. This conclusion is

based upon the assumption that individuals tend to share the same ideas about what constitutes a quality healthcare plan.

The results of the interviews will be transcribed and names of the participants changed to protect their anonymity. The researcher will review the data for themes that applied to the two different groups, as well as those specific to each group and question. The researcher then will develop a consensus on the findings by identifying common themes as well as differences among the three groups. Data from the questionnaires will be analyzed using descriptive statistics.

Database of the Study

This research will focus on two groups of family members enrolled in two HMO in South Carolina; a Gatekeeper Model and an Open Access Model. One of the groups will be comprised of the family members of individuals in a Gatekeeper HMO and the other group will be comprised of the family members of individuals in an Open Access HMO. Once recruited, the subjects for each of these groups will be asked to provide detailed information about their family members' experiences while receiving healthcare services. In this study, the emphasis will be placed on understanding whether the family members of ill individuals enrolled in an Open Access HMO will report a higher level of satisfaction with their family member's healthcare services than the family member's of individuals

enrolled in a Gatekeeper HMO. The dependent variable in this study will be the level of satisfaction of the family member of the patient enrolled in an HMO. The independent variable of this study will be the membership in the MCO the participant is enrolled in.

Validity of Data

One form of validity refers to the factual accuracy of the account as reported by the researchers. Questions to be considered to validate the data include the following:

1. Did what was reported as having occurred actually happen?
2. Did the researchers accurately report what they saw and heard?

In other words, was descriptive information (for example description of events, objects, behaviors, people, settings, times and places) reported accurately?

This form of validity is important because description is a major objective in nearly all-qualitative research. Another form of validity refers to accurately portraying the meaning attached by participants to what is being studied by the researcher. A third type of validity is qualitative research. This refers to the extent to which the conclusion of the study fits the data, and therefore is credible and defensible.

Originality and Limitations of Data

The researcher will attempt to delineate the many dynamics associated with the ongoing and ever popular HMO and Insurer relationship. The researcher has scrutinized the different types of managed care, such as Gatekeeper and Open Access HMO fully aware of the underlying and ongoing patient dissatisfaction with the quality of healthcare provided by HMO for either type. The Federal government is visible and instrumental in terms of how HMO are run and unfortunately, they are not in step with the necessary financial management which is required to pay for the level of treatment when sophisticated healthcare treatment is needed. This is better explained through the reality of prevailing inadequate management as well as escalating costs.

In making the comparisons, effort will be directed at obtaining a general understanding of the factors that are important in achieving a positive ranking by family members. It was determined this would be an important factor in understanding the factors that may be lacking in HMO. This is also something that appeared to be missing from the available research. According to Creswell (1994) there are two types of questions: the grand tour question and the guiding hypothesis. The former is typical of qualitative studies and the latter is typical of quantitative studies. A qualitative study is defined as an inquiry process of understanding a social

or human problem, based on building a complex, holistic picture formed with words, reporting detailed views (Creswell, 1994).

Qualitative research methodology has its weaknesses as well as its strengths. Its strengths are research involving qualitative methodology tends to involve fewer subjects than quantitative research. The results of research involving qualitative methodology are usually less easily generalized. Moreover, qualitative research does not comfortably lend itself to the aggregation of data and systematic comparisons. According to Creswell (1994), “qualitative researchers have no single stance or consensus on addressing traditional topics such as validity and reliability in quantitative studies” (p. 157). Nevertheless, there are specific issues of validity that emerge when it comes to qualitative studies.

However, the researcher of this study did not attempt to differentiate the different factors that led them to voice the opinions they did indeed express during the survey. For example, there was comparatively little background investigation into the conditions existent in particular cases, which would lead the patient to find a particular fault with the services they were receiving. Similarly, family members were not interviewed in parallel with the patients themselves and this is something that would provide material for a crucially important component to the study. The lucidity of a patient may determine the report they give on the quality of the care they

receive as could the patient's medical condition itself. For example, someone who is being treated for heart problems but who is simultaneously suffering from depressive illnesses might be led to report poor service in connection with cardiology treatments when in fact the services were properly administered.

A patient who is poorly informed about the conditions and extenuating circumstances of his or her illness might believe the care being delivered is adequate when in fact they are receiving inferior treatment. The absence of a globalizing benchmark will be discussed again later in the study. While these issues are not directly figured as an error margin into the existing data, they do draw up questions about the application and standing value of the data that was collected. It is in itself intact but recognizes a large gulf of absence.

The data in this study is limited to literature reviews, statistical analyses and case studies. The principal data in this study will be obtained from two groups of 25 family members enrolled in two HMO in South Carolina. One set is a Gatekeeper Model and another is an Open Access Model. As in the previous study, one of the groups will be comprised of family members of individuals in a Gatekeeper HMO and the other group will be comprised of family members of individuals in an Open Access HMO. It will be limited to interviews conducted with both groups.

Summary

The results from the interview sessions will reveal whether both groups are somewhat satisfied with the medical services being provided to their family member. At the same time, they will also demonstrate whether there are certain criticisms about the services being provided to their family members and how they are being provided. It is apparent the available literature paints an interesting and somewhat disconcerting view of the functions and role of HMO in modern society. While the literature tends to demonstrate that HMO are being relied upon more and more frequently as a means of providing medical care, it also shows there are reasons to be concerned about their ability to meet the needs of all the population in an adequate manner. The research for this study aims to establish a clear understanding of whether gatekeeper HMO are less effective at providing adequate medical care than Open Access HMO. It does so by examining the experiences of family members of individuals enrolled in gatekeeper and Open Access HMO and comparing those experiences.

CHAPTER 4

DATA ANALYSIS

In the mainstream, this researcher is largely concerned with the academic ideology that is qualitative in nature. The statistics is found to be useful. It is possible to revert to the administration of President Truman. As previously indicated, in the late 1940s, socialized medicine was used to confuse government financing of health insurance as total government control of medical care and the prospect of Stalinist minions getting between patient and doctor. In fact, Truman's idea was to do for the entire population what Medicare has since done for the elderly. In traditional social science usage, socialism means government ownership of the means of production. If we think of hospitals and doctors as the healthcare system's means of production the Truman plan or any other in which the government's role is to pay private-sector providers on behalf of patients is not socialized medicine.

The data in this study is limited to literature reviews, statistical analyses and case studies. The principal data in this study is limited to two groups of 25 family members enrolled in two types of HMO in South Carolina (Gatekeeper Model and an Open Access Model). One of the groups was comprised of family members of individuals in a

Gatekeeper HMO and the other group was comprised of family members of individuals in an Open Access HMO. It is also limited to interviews conducted with both groups; the participants were primarily high school and college graduates. Only a small number of participants had advanced degrees. Primarily, the participants were women in their mid-forties to mid-fifties. There were fewer men in the study than women.

CHAPTER 5

SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

This researcher is of the belief, based upon historical case study methodology, that healthcare for all citizens should be run by the government. This is seen in other countries that may be regarded as somewhat socialist yet; both the United Kingdom and Canada have had sterling successes wherein America has not. Canada maintains a publicly funded healthcare system. It has been the view of this researcher the government should pay for Americans' healthcare. While it has worked in the United Kingdom, it is not the view of this researcher that we should model ourselves precisely in accordance with their system. Although there are elements, which we will inevitably encounter and should embrace. There are other countries where the government assumes the healthcare responsibility for all its citizenry, including Singapore. Ultimately, as is in the case of other more socialistic oriented healthcare countries and those which maintain programs analogous to Medicaid and Medicare, there also exist extraneous or adjunct programs which serve to solidify or ensure all those benefits as are necessary to provide adequate healthcare for all of American citizens.

REFERENCES

- Aaron, H. J. (1991). *Serious and unstable condition*. Washington, DC: The Brookings Institution.
- Aday, L. (1993). *At risk in America: The health and healthcare needs of vulnerable population in the United States*. San Francisco, CA: Jossey-Bass.
- Amin, S. G., Hagen, A. F. & Sterret, C. R. (1995). Cooperating to achieve competitive advantages in a global economy: Review on trends. *SAM Advanced Management Journal*, 60, 37-41.
- Austin, R. J. (1997). Disability and healthcare reform: Principles, practices and politics. *The Journal of Rehabilitation*, 1-9.
- Ayanian, J. Z., Weissman, J. S., Schneider, E. C., Ginsburg, J. A., Zaslavsky, A. M. (2000). Unmet health need of uninsured adults in the United States. *JAMA*, 284, 2061-2069.
- Blustein, J. (2000). Drug coverage and drug purchases by medicare beneficiaries with hypertension. *Health Affairs*, 19, 219-230.
- Bodenheimer, T. (2005). High and rising health costs: Seeking an explanation. *Annals of Internal Medicine*, 142, 847-854.
- Bodenheimer, T. & Grumbach, K. (2005). *Understanding health policy: A Clinical approach*. New York: McGraw Hill.

- Bodenheimer, T. & Sullivan, K. (1998). How large employers are shaping the healthcare marketplace. *New England Journal of Medicine*, 338, 1084-1087.
- Bogdan, A. C. & Bilkin, S. N. (1982). *Qualitative research in education: An introduction to theory and methods*. Needham Heights, MA: Allyn & Bacon.
- Cavalier, I. (1995). Psychologists may benefit from changes in Medicaid. *American Psychological Association Monitor*.
- Caredata. (1999) Commercial Health Plan. *Member Survey*.
- Chernew, M. E., Hirth, R. A., & Cutler, D. M. (2003). Increased spending on healthcare: How much can the United States afford? *Health Affairs*, 22, 15-25.
- Cherwitz, R. A. & Zagachi, K. S. (1996). Consummatory versus justificatory crisis rhetoric. *Western Journal of Speech Communication*, 50, 307-324.
- Crabtree, P. (2001) Rights to sue HMOs. *San Diego Tribune*.
- Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publishing.
- Culyer, A. J. (1989). Cost containment in Europe: International comparison of healthcare financing and delivery: Data and perspectives. *Healthcare Financing Review*.

- Davis, K., Anderson, G. F., Rowland, D., & Steinberg, G. P. (2003). *Health care cost containment*. Baltimore: John Hopkins University Press.
- Department of Health and Human Services. [DHHS]. (1999). Report of new system. *Federal Register*, 64(117).
- Drummond, M. F., O'Brien, B. O., Stoddart, G. L. & Torrance, G. W. (1997). *Methods for the economic evaluation of healthcare*. New York: Oxford University.
- Eastaugh, S. R. (1992). *Healthcare finance: Economic incentives and productivity enhancement*. Auburn House.
- Edelman, M. & Fleming, R. W. (1965). *The Politics of wage-price decisions: A four-county analysis*. University of Illinois.
- Errunza, V. R. & Senbet, L.W. (1981). The effects of international operation on the market value of the firm: theory and evidence. *The Journal of Finance*, 36(2), 401-417.
- Escarce, J. J. (2001) Medical care expenditures under gatekeeper. *Health Services Research*.
- Farrel, C. (2006). Health care reform, now. *NPR lecture series*.
- Federman, A. D., Adams, A. S., Ross-Degnan, D. Soumerai, S. B. & Ayanian, J.Z. (2001). Supplemental insurance and use of effective cardiovascular drugs among elderly medicare beneficiaries with coronary heart disease. *JAMA*, 286, 1752-1759.

- Feldman, R. D., Chen, H. C., Kralewski, J., Dowd, B., & Shipro, J. (1990). Effects of HMOs on the creation of competitive markets for hospital services. *Journal of Health Economics*, 9, 207-222.
- Felt-Lisk, S. (1996). How HMOs structure primary care delivery. *Managed Care Quarterly*, 4(4), 96-105.
- Fries, J. F. (1980). Aging, natural death and the compression of morbidity. *New England Journal of Medicine*, 303, 130-135.
- Gabel, J. R. (1999). Job-based insurance, 1977-1998: The accidental system under scrutiny. *Health Affairs*, 18, 62-74.
- Gabel, J. R., Claxton, G., Gil, F., Pickreign, J., Whitmore, H., Holve, E., et al. (2004). Health benefits in 2004: Four years of double-digit premium increases take their toll on coverage: Five million fewer jobs provided health insurance in 2004 than in 2001, this new analysis finds. *Health Affairs*, 23, 200-209.
- Gabel, J. R., Levitt, L., Holve, E., Pickreign, J., Whitmore, H., Dhont, K., et al. (2002). Job-based benefits in 2002: Some important trends. *Health Affairs*, 21, 143-151.
- Ginsberg, E. & Ostow, M. (1997). Managed care - A look back and a look ahead. *New England Journal of Medicine*, 336, 1018-1020.

- Gold, M., Achman, I., & Verdier, J. (2003). *The medicare preferred provider organization demonstration*. Washington, DC: AARP Public Policy Institute.
- Goldman, D. H. & Smith, J. (2001). Methodological biases in estimating the burden of out-of-pocket expenses. *Health Services Research*, 35(6), 1337-1365.
- Goldman, D. P. & Zissimopoulos, J. M. (2003). High out-of-pocket spending by the elderly. *Health Affairs*, 22(3), 194-202.
- Goodman, R. W. (2003). Healthcare industry market update. *Managed Care*, 14-16.
- Greenberg, L. (2001). PPO performance measurement agenda for the future. *Medical Care Research and Review*, 58, (1), 8-15.
- Grossman, J. H. (1992)). The future of health care. *AJHP*, (Vol. 49, 2451-2456).
- Halvorson, G. C. & Islam, G. J. (2003). *Epidemic of care*. San Francisco: Jossey-Bass.
- Harris, G. E. (2000). Wall street comes to Washington. *Center for Studying Health System Change*, 31, 2.
- Heffer, S., Smith, S., Keehan, S., Clemens, M. K., Zeeza, M., & Truffer, C. (2004). Health spending projections through 2013. *Health Affairs*.

Retrieved April 13, 2008, from

<http://content.healthaffairs.org/cgi/contents/full/hlthaff.w4.791/DC>

Heirich, M. (1998). *Rethinking healthcare: Innovation and change in America*. Westview Press/Harper Collins.

HMO satisfaction dips, POS up. (1999). *Healthcare PR Marketing News*.

Hodge, M. H. (1996). Healthcare and America's rolling depression.

Healthcare Management Review, 21(3), 7-12.

Hurd, M., & McGarry, K. (1997). Medical insurance and use of healthcare services by the elderly. *Journal of Health Economics*, 16(2), 129-

154. Hurley, R., Grosman, J., Lake, T., & Casalino, L. (2002). A

longitudinal

perspective on health plan and physician risk contracting. *Health*

Affairs, 21(4), 144-153.

Hurley, R. E., Strunk, B. C. & White, J. S. (2004). The puzzling popularity of the PPO. *Health Affairs*, 23(2), 56-68.

Institute for Health and Socio-economic Policy. (2003). *Tenet healthcare corporation, drug and hospital charges: Impact on healthcare costs in California and nationwide*. Orlando, CA: IHSP.

Institute of Medicine. (2000). *America's healthcare safety net intact but endangered*. Washington, DC: National Academies.

- Kaiser Commission on Medicaid and the Uninsured. (2002). *Medicaid enrollment in 50 states*. Menlo Park, CA: Kaiser Family Foundation.
- Kaiser Family Foundation Health Research and Education. (2003). Employee health benefits 2002 survey.
- Kasten, J., Moon, M. & Segal, M. (2000). *What do medicare HMO enrollees spend out-of-pocket*. Washington, DC: Urban Institute.
- Kongsvedt, P. R. (1995). *Essentials of managed care*. Greensburg, MD: Aspen.
- Kronick, R. & Gilmer, T. (1996). Explaining the decline in health insurance coverage: 1979-1995. *Health Affairs*, 18, 30-47.
- Krueger, R. A. (1994). *Focus groups: A practical guide for applied research*,h (2nd ed.). London: Sage.
- Larkin, H. (1998). Bypassing the gatekeeper. *Between Rounds*.
- Lesser, C. & Ginsburg, P. (2003). *Healthcare cost and access problems intensify*. Washington, DC: Center for Studying System for Change.
- Levit, K., Smith, C., Cowan, C., Sensenig, A., & Carlin, A. (2004). Health spending rebound continues in 2002. *Health Affairs*, 23, 147-159.
- Lohr, K. N., Brook, R. H., Kamberg, C. J., Goldberg, G. A., Lebowitz, A., & Keeseey, J., et al. (1986). Use of medical care in the rand health insurance experiment: Diagnosis and service-specific analyses in a randomized controlled trial. *Medical Care*, 24, 51-87.

- Low, L. (1998). Healthcare in the context of social security in Singapore, Sojourn. *Journal of Social Issues in Southeast Asia*
- Manton, K. G. & Gu, X. (2001). Changes in the prevalence chronic disability in the United States black and non-black population above the age 65 from 1982 to 1999. *Proceedings of the National Academy of Science*, 98, 6345-6359.
- McGinley, L. (1999, October 8). House passes broad patient rights bill-plan backed by GOP chiefs gets sound rejection, HMO suits expanded. *Wall Street Journal*.
- Meara, E., White, C., & Cutler, D. M. (2004). Trends in medical spending by age, 1963-2000. *Health Affairs*, 23, 176-183.
- Morrison, I. (2000). *Healthcare in the new Millennium*. San Francisco: Josey-Bass.
- Murphy, S. W. (2000, September 15). Market analysts' round table. *Capitation and Contracting*, 5(9).
- Luft, H. S. & Greenlick, M. R. (1996). The contribution of group and staff model HMO to American medicine. *Millbank Quarterly*, 74, 445-461.
- National Committee for Quality Assurance [NCQA]. (1999). Compass Data Base. Washington, DC. *JAMA*, 288(12), 1484-1490.
- Newhouse, J. P. (1977). Medical care expenditure. *Journal of Human*

- Resources*, 12, 115-125.
- Newhouse, J. P. (1993). An iconoclastic view of health cost containment. *Health Affairs*, 12, 152-171.
- Nivola, P. S. (1991). *Georgetown Law Journal*. 1253-1255
- Organization for Economic Cooperation and Development [OECD]. (1987). A future in question. *OECD Observer*.
- Organization for Economic Cooperation and Development [OECD]. (2003). Operational policy letter # 50. *A disease-based comparison of health systems: What is best and what cost?* Paris: OECD.
- Organization for Economic Cooperation and Development [OECD]. (2004). *Health Data*. Retrieved April 13, 2008, from www.oecd.org
- Pauly, M. V. (1993). U. S. healthcare costs: The untold true story. *Health Affairs*, 12, 152-159.
- Pauly, M. V. (2003). Should we be worried about real medical spending growth in the United States? *Health Affairs*. Retrieved April 13, 2008, from <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.15v1/DC1>.
- Porter, M. P. (1985). *Comparative advantage*. New York: Advantage Fress Press.
- Pozgar, G. & Santucci, N. M. (2002). *Legal aspects of healthcare administration*. Gathersburg, MD: Aspen.

- Reagan, M. G. (1992). *Curing the crisis: Options for America's healthcare*. Boulder, CO: Westview Press.
- Reinhardt, U. E. (2003). Does the aging of the population really drive the demand for healthcare? *Health Affairs*, 22, 27-39.
- Reinhardt, U. E., Hussey, B. S. & Anderson, G. F. (1999). Cross-national comparisons of health systems using OECD data. *Health Affairs*, 21, 169-181.
- Reng, P. S. & Van de Ven, A. H. (1992). Structuring cooperative relationships between organizations. *Strategic Management Journal* 13(7), 483-498.
- Rochefort, D. A. (1997). *From poor houses to homelessness: Policy analysis and mental healthcare*. Westport, CT: Auburn House.
- Rogowski, J., Lillard, L., & Kingston, R. (1997). The financial burden of prescription drug use among elderly persons. *Gerontologist*, 37(4), 475-482.
- Ross, A., Williams, S.J. & Schaefer, E.L. (1991). *Ambulatory care management*. USA: Delmar Publication.
- Schulman, K.A., Rubenstein, D.M., Seils, M., Harris, J., Hadley, J. & Escare, J. (1997). Quality Assessment in Contracting for tertiary care services by HMOs: A Case of Three Markets. *Joint Commission Journal on Quality Improvement*, 23(2), 117-127.

- Shala, D. E. (1996). Healthcare financing: What next? *Brookings Review*.
- Smith, C., Cowan, C., Sensenig, A., & Catlin, A. (2005). Health spending growth slows in 2003. *Health Affairs*, 24, 185-194.
- Smith, D. & Scanlon, D. (2001). Covered lives in PPOs. *Medical Care Research and Review*, 58(1), 16-33.
- Sturm, R. J., Ringel, J. & Andreyeva, T. I. (2004). Increasing obesity rates and disability trends. *Health Affairs*, Vol. 23(2), 1-7.
- Thomas, J. (2005, February 15). University of Colorado looking to revamp healthcare on campus. *University Wire*.
- Trigaux, R. September 5, 2001. St. Petersburg Times. *Healthy Disrespect For Managed Care*.
- Tuohy, C. J. (1999). *Accidental logics: The dynamics of change in the healthcare arena of the United States, Britain and Canada*. London: Oxford University Press.
- United States Census Bureau. (2000). Health Insurance Data. *Health Insurance Report Catalog*. Vita, A. J., Terry, R. B., Hubert, H. B., Fries, J. F. (1998) Aging, health risks, and cumulative disability. *NEJM*.
- Wall Street Comes to Washington: Analysts' perspectives on the changing healthcare system. (1999). *Center for studying healthcare change*.

Weil, A. (2003). There's something about Medicaid. *Health Affairs*, 22, 13-30.

Wolf, S. M. (2002). Low quality of care and HMOs. *The Journal of the American Medical Association*.

Zwanziger, J., Melnick, G. A., Mann, J. & Simonson, L. (1997). How hospitals practice cost containment with selective contracting and the medicare prospective payment system. *Medical Care*, 32, 320-333.