Primary care and the maelstrom of health care reform in the United States of America

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SUMMARY. Recent reform in the National Health Service has moved general practice towards a more intense market and competition structure. Meanwhile in the United States of America there has been an attempt to modify the free enterprise approach to medical care towards a more socially responsive system. This discussion paper provides a family doctor's perspective of primary care and the maelstrom of health care reform in the USA. The cultural, economic and organizational issues underlying the need for reform are considered in turn, and the current situation with regard to health care provision, medical research, medical education and primary care are outlined. General practitioners in the United Kingdom would do well to pay attention to the effects of market reform occurring in general practice among their American counterparts.

Keywords: primary health care; general practice; health service reforms; United States of America.

Introduction

IN 1993 the leading medical journals in the United States of America and elsewhere were awash with articles on reforming the American health care system[1-3] as the president's health security act[4] steered its way through congressional committees. The reform plan was finally sunk, torpedoed by determined resistance from the opposition party and a huge direct mail and media campaign funded and orchestrated by lobby groups. The complexity of the plan and its poor marketing to the public by the president's administration also contributed to its demise.[5,6]

Although the continuing problems of health care in the USA may seem distant from the medical culture and organizational structure of the National Health Service, trends in the United Kingdom suggest that there are lessons that could be learned from understanding the effects of competition, corporate control and profitability on the practice of medicine. This paper provides a family doctor's perspective of the underlying issues contributing to the need for health reform in the USA.

USA health care system

The USA health care system is expensive, consuming about 14% of the gross national product. Health care outspends other industries such as defence (13%), pharmaceuticals (8%), electronics (4%) and cars (4%).[7] The causes of this high proportion of expenditure include the rapid development and increasing use of medical technology, fee for service medicine in which doctors are rewarded for doing more, a high rate of malpractice claims stimulating the practice of defensive medicine, an ageing population needing more resources, high-risk lifestyles (such as smoking, alcoholism and sexual freedom) and the public's unrealistic expectations of the medical care system that are fuelled by the press and the research establishment.[8,9]

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Health care services are provided by a mixture of state, federal and private organizations, all with their own regulations. The services range from a single-handed general practitioner to the massive USA armed services health system run by the government.

In the UK, patients gain access to NHS health care via general practice surgeries and health centres served by the general practitioner and other members of the primary health care team. They also have direct access to hospital casualty departments. Private patients use private offices and hospitals to seek care from private general practitioners and specialists. In the USA, uninsured patients and those on federal insurance programmes such as Medicaid (for the poor) and Medicare (specifically for elderly people) can obtain health care from private practice, hospital clinics, public health clinics, community health centres, planned parenthood clinics and casualty departments. Patients with full or partial private insurance can attend private practices, urgent care centres, casualty departments, and hospital clinics. Both insured and uninsured patients often have direct access to generalists (family doctors, internists, paediatricians, obstetricians, gynaecologists and osteopaths), specialists, nurse practitioners, midwives, chiropractors, public health nurses and complementary medicine professionals. The striking difference between the two countries is the variety of pathways a patient in the USA can take to gain access to primary care. Primary care is offered by a range of health professionals, for example, specialists deliver about 20% of all primary care in the country.[10] Americans do not have universal access to care regardless of their ability to pay — a substantial number will pay directly for care.[11,12] Those who are insured have a choice of over 200 large health insurance companies.

The need for reform

Although the scale of reform is likely to be reduced by the impact of elections and according to which political party controls congress, dramatic changes are needed to prevent the current problems of health care services from getting worse.[6] These problems include lack of health insurance (16% of the population have no insurance and 25% have only partial coverage), the considerable barriers to gaining access to care, deteriorating health outcomes and spiralling costs.[13,14]

The debate on national health reform between government, powerful interest groups and the people has been intermittently active for 75 years. The main players have been the American Medical Association, the insurance industry, the labour movement, employers and the political parties. Between 1992 and 1994, three major national health models have been proposed in congress.

The president's proposal was based on competition between integrated commercial health alliances (serving about 102 million people) offering universal access to care for all. Access to care for those who were insured would be financed by savings from managed competition using techniques borrowed from industry and the power of large purchasing groups.[15,16]

According to the second proposal, the single payer system, individual states or the federal government control health insurance and guarantee universal access, financed by increased public and business taxation.[17] This system is similar to the Canadian system.

In the third proposal, there would be managed competition with less governmental control than described in the president's proposal. This would not guarantee universal access to care, offering little change from the present situation.

There are a number of factors, cultural, economic and organizational, that contribute to the current impasse in USA health care.

Individual choice

An important cultural factor is the uniquely American commitment to the priority of individual choice and self-reliance over the general social good of the community. In the USA, there is a tension in society between the value of self-reliance and its rewards and the egalitarian spirit of equal opportunity for all.[14,18] There is no constitutional right to access to health care services and many people believe that individuals should be able to generate the resources for their own well-being. The proponents of egalitarian values, although morally respected, are in a weak position because of the perceived high cost of implementing a basic set of health services for all, probably through taxation.[14]

The have-nots

An economic factor stimulating reform has been the growth throughout the country in the number of 'have-nots'. These people have little or no health insurance. While 39 million people lack regular health insurance, another 50 million will be without continuous insurance in 1995–96, and yet another 25 million will be underinsured. These limitations in coverage can, in the event of serious illness, lead to financial hardship or ruin.[9,19] Most workers receive a considerable proportion of health insurance coverage from their employers.[14] As health care costs rise, businesses are reducing the range of coverage for employees, or withdrawing it from employees' families. It seems as though American industry has come to understand that the rising health care premiums and costs that it pays for its workers are stifling competitiveness in home and international markets, so a universal health plan now looks more attractive. The very poor are already covered by Medicaid so it is the lower and middle classes who are being squeezed, and are suddenly feeling at great risk. This is an infinitely more vocal and politically aware group at whom the president was pitching his plan as a 'security net'.

The have-nots contribute to the country's poor morbidity and mortality statistics, as well as shorter life expectancy by being five times more likely to delay requesting and receiving care than those who are insured. They become more seriously ill, are more likely to go into hospital and are more likely to die from their illness than their insured counterparts.[20] As the middle class increasingly enters the have-not category, it is no wonder this large segment of the population is frightened.

The issue of growing poverty and social decay is also the subject of reform. There are hundreds of welfare agencies organized by different branches of federal and state government, yet recipients are frequently unaware or overwhelmed by the bureaucracy of these overlapping systems. The implementation of the family support act 1985 and the work and responsibility act 1994 shows that national leaders are fully aware that health and social welfare reform are both necessary and closely related (Southern Institute on Children and the Family, 1994).

Uneven distribution of doctors

An organizational factor is the uneven distribution of doctors. About 70% of all doctors are specialists, usually practising in urban or suburban settings because of the need to be close to hospitals, other specialists and high technology ancillary services. The remaining 30% of doctors in practice are primary care generalists.[11,19] Of all medical students in the USA graduating in 1994, 36% entered internal medicine, 13% chose family practice, and 11% went into paediatric residency programmes.[21] The remainder selected subspecialties as their career. Although many medical schools can therefore claim to have at least 50% of their students entering primary care trainee programmes, the reality is that about 75% of the internal medicine and paediatric generalist trainees subspecialize after a couple of years in practice.

The underlying causes for this workforce imbalance are clear: specialists have high prestige and incomes (sometimes several times those of family doctors). Most doctors have considerable medical training debts to pay after graduating and this factor affects career choice.[22-24] Only family doctors are fairly evenly distributed across all types of populations.[19] Internists and paediatricians tend to live and practise in urban locations and have well-defined clinical fields allowing controllable lifestyles. They have access to good schools and culture in urban settings. The market place allows any doctor to set up or join a practice in any environment in direct competition with others. Although logic dictates that competition should winnow out an overabundance of specialists, their survival and multiplication is supported by the continued introduction and overuse of new technological procedures, even greater subspecialization and the American public's known admiration of experts and gadgetry.

Medical schools add to this imbalance by being more interested in biomedical research, advancing new technologies and gaining scientific prestige than in educating doctors to deliver care to a broad spectrum of the population.[22,25] Currently, primary care research receives only 1% of the annual eight billion dollar National Institute of Health budget.[26] Despite these paltry resources, medical schools are complaining about the president's proposal to increase funding for health services research and health promotion and disease prevention.[27]

The uneven distribution of doctors and lack of medical resources in economically deprived communities has created a major problem regarding access to care. When primary care is delivered by specialists (to whom patients have open access) or by casualty departments it can be expensive. There is ample research evidence to show that family doctors deliver much more cost-effective care for the same case-mix of patients than any other discipline, with no difference in quality or outcomes.[19,24,26,28,29]

There is a traditional cultural form of Brownian motion of patients and doctors as they move around the country seeking better jobs, better climate, greater choices, increased convenience and a better health insurance programme. For example, it is estimated that on average, doctors move every seven years. This cultural pattern, though important to personal goals, inhibits the reasonable and stable planning of health care services and breaks the relationships needed to build trust and confidence at all levels of care between providers and recipients.

Health insurance

Another organizational problem in need of reform is the complex and ever-changing system of health insurance that has grown up over the years. For example, in North Carolina, about 150 small and large insurance companies offer a variety of health care plans to individuals, businesses and institutions.[15,19] Each plan has specific benefits and limitations and can be organized in different ways in which the financial risks can be assumed by various participants, including the doctors. Patient choice may be limited, often through incentives or disincentives. Commonly, people can be refused insurance because of previous medical conditions which increase their actuarial risk. A typical plan offered to a North Carolina state employee and his or her family (spouse and children below the age of 18 years) is shown in

Figure 1. In addition to the premium, there is usually a deductible amount which is the initial amount the insured person must pay for care before insurance starts, and a co-payment (the insured person has to pay about 20% of doctors' and hospital bills). Premiums rise at a rate of between 10% and 15% annually. The limitations vary — mental health care may be excluded or restricted, and certain preventive services are not covered. Second opinions are required for certain types of surgery. Specific care standards are set by the insurance companies.

A family practitioner might have contracts with several health plans, as well as with Medicaid and Medicare. Each plan has different guidelines and protocols and uses different financial arrangements. Administering this system is a bureaucratic nightmare for administrative staff and doctors alike. It has been estimated that reducing the number of insurance companies or having a single payer system (as in Canada or the UK) would finance health care for all the uninsured people and still reduce the overall cost of national health care.[14,17] The choice of insurance plans also threatens the core of primary care: the doctor–patient relationship. For example, when a business decides to change to a lower cost health plan, employees usually have to leave their established doctor and find one who has a contract with the new insurance company. This problem seems to be increasing and causes much distress.

Health insurance plan	
Annual premium for family cover:	Employer £1157 Employee £1730
Maximum benefit:	£670 000
Annual deductible amount:	£167, £500 per family
Co-payment:	20% of first £3300 after deductible amount
Surgery visit cost:	£6 co-payment £10 after hours
Preventive care:	Cervical smear; breast, colon and prostate checks; x-ray; mammogram; blood pressure measurement; urine test; tuberculosis test. Once every 2 years for those aged 40–55 years, annually if aged 56+ years. Covered up to £100 annually.
Hospital care	
Physician fees:	Covered for surgery, anaesthetics, inpatient care, x-ray, radiation therapy, laboratory studies, immunizations and drugs.
Hospital fees:	Covered for outpatient surgery and for room and board in 2–4-bed ward. £50 deductible amount paid per admission to a specified hospital (20% co-payment of all costs if non-specified hospital).
Mental health:	Covered for all inpatient, intensive and outpatient services (approval by case manager required). £6 co-payment per outpatient treatment visit.
Chemical dependency:	Covered to £133 per day, £5300 annually, or £16 666 per lifetime. Case manager required.

Figure 1. *Typical health insurance plan offered to a North Carolina state employee 1994, converted into pounds sterling equivalent.*

The four factors that have been outlined confirm the universality of Hart's inverse care law: those most in need have least access to medical resources.[30] The national debate on health reform will continue to focus on whether there should be partial or universal coverage, who should pay for it and whether reform should be revolutionary or evolutionary. Proponents of the revolutionary approach believe that universal coverage for health care with a single payer system and regulatory control of the medical workforce is essential and urgent, particularly in light of other related social problems plaguing the country. The evolutionary proponents are concerned that revolution will push large numbers of health workers into unemployment, destroy the insurance industry, compromise the research enterprise and damage the pharmaceutical industry. With powerful lobbyists and conservative and republican forces, as well as many doctors, resisting social reform it seems as if the evolutionary approach will win the day. The gap between wealthy and poor continues to grow — 20% of the population controls 43% of the wealth while 39 million people live below the poverty line (USA census bureau 1994). There is a danger that the politicians and those with corporate interests will ignore the growing underclass who are living in social decay and who have diminishing health and support systems. A slow evolution of health care reform could be a signal to those people that their country and leaders do not care. Who knows what social unrest might ensue.

Current situation

The current winners of the health reform debate are the insurance companies and large managed care corporations (health maintenance organizations), who are moving rapidly towards dominating the organization of health care through purchasing a variety of private practices, private ancillary health groups and hospitals. This is the fruition of strategies developed by the Jackson Hole Group headed by Paul Ellwood and Alan Enthoven (a past consultant to the NHS) in which patients and doctors will become units in an industrial process.[31] The underlying principle is profitability, not the common good or the doctor–patient relationship. For example, there is now a trend for previous not-for-profit health insurance organizations to change to for-profit status. Important clues to the trend to an industrial, profit-driven model are the salaries paid to chief executive officers of the health care corporations, the mean salary being $2.9 million and the highest being $127 million.[32] The immediate losers are health care professionals and those people who cannot afford health insurance, such as elderly people and people living in rural areas. Doctors who remain in private practice are already losing patients (and thereby income) to the more efficient corporate groups. Those practitioners already working for the corporations are highly regulated case managers with questionable job security.[33]

Medical education and primary care

In contrast to the slowed pace of health care reform, there are considerable changes occurring in medical education.[34] After 25 years of battling its way into the medical school, often as a result of state government mandates, the discipline of family medicine is increasingly recognized as having a vital role to play in changing the emphasis from specialization to generalist medical education.[35,36] Family practice offers the only community based vocational training system tested for effectiveness over many years. General internal medicine and paediatrics training is mainly hospital based with little emphasis on preparation for practice, which may be why graduates from these disciplines only remain in practice for a short time before subspecializing.

Why are the medical schools welcoming family practice? First, the practice environment is changing rapidly, from private

or fee for service work to managed care systems. These systems are networks of practices, home health agencies, nursing homes and hospitals managed by health corporations — mini-NHS groups.[16] These corporations, while trying to maintain clinical standards, have understood how cost-effective family doctors are. The result is a high demand for family doctors (with substantial increases in salaries) and fewer openings for specialists. This high demand has resulted in managed care organizations looking abroad for doctors to help build their programmes.[37] Medical students have quickly perceived the changing climate and more are moving to choose generalist careers.[36]

At the same time, federal and state government, increasingly aware of the deplorable access to care for patients and the uneven distribution of doctors, are disenchanted with their investment in medical schools when there is little evidence of overall improvement in the population's health. For example, although the discovery of the poliomyelitis vaccine has saved $30 billion dollars in health care costs, a large number of children in the country are not being immunized because of poor access or inability to pay for care.[8] This legislative frustration has led to specific plans to change the way money is paid to medical schools and teaching hospitals for education, and to the passage of laws mandating the percentage of generalist physicians leaving trainee programmes. These mandates require an increase from the current 30% to a target of at least 50% of generalists (family practitioners, paediatricians and doctors in internal medicine), being established in practice within the next seven years.[34,35] The task seems impossible despite more nurse practitioners and newly 'retrained' specialists being proposed as a solution to providing primary care.[38,39] It could take 30 to 40 years to achieve the desired workforce balance.

Some medical schools are responding by changing student admission policies and decentralizing educational experiences to community practice. They are also changing curricula to include more primary care. In addition, there are strong recommendations at the federal level to improve funding for generalist trainees and to develop a national physician workforce commission to advise congress and the government.[34,36,40,41] Another medical school strategy is to develop its own local or regional integrated health care system by purchasing, often in partnership with health insurance companies, local practices, nursing homes, rehabilitation centres and small hospitals. This will ensure feeder systems from primary to tertiary care specialists, thus maintaining the stability of inpatient services and technology centres, while retaining the loyalty of local practitioners who teach medical students. It is exciting for family medicine to participate as an equal agent in the education of doctors, although the resources for this remain slim. Because of the market demand for primary care practitioners and the shortage of educators in primary care, this challenge could in fact overwhelm the remaining teachers in training programmes.[42] For example, there will be 249 junior, 125 mid-level and 407 senior unfilled academic positions in family medicine in the next two years (faculty recruitment survey results, 1994).

Conclusion

As British general practitioners ponder over the effects of NHS reform that have moved them towards a more intense market and competition structure, the USA is still considering whether to risk a turn from free enterprise towards a more socially responsive, but regulatory approach. The results of the 1994 mid-term elections which have put the republican party at the helm of national policy indicate that the next few years promise to be challenging, risky and exacting for primary care in the maelstrom of health care reform in the USA.

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