Health Care for the Poor: Some Policy Alternatives

David Mechanic, PhD
New Brunswick, New Jersey

Changes in the financing and organization of medical care are most likely to affect adversely the poor who have significant needs for care, but face increasingly stringent eligibility criteria in Medicaid and other public programs. Americans estimated to have neither private nor public health insurance coverage number 33 million persons, and with increased cost pressures, voluntary and proprietary hospitals are less willing to treat such patients. One quarter of hospitals provide 60 percent of all care to the poor, and many of these nonprofit and public hospitals face economic difficulties and an erosion of public commitment. Alternative solutions include publicly subsidized premiums for the poor and near poor and assistance to financially stressed hospitals caring for large numbers of such persons. Mechanisms include all-payer systems, taxes on net hospital revenue or insurance premiums, or contributions from general tax revenues. Financing poses special problems, but it is also necessary to address the special needs of children and the elderly, the appropriate balance between technical and cognitive services, and new ways to maintain health and promote effective functioning. These issues pose challenges and opportunities for family practice.

For almost 20 years, the United States has demonstrated a strong commitment to the value that access to medical care should be available to all and should not be rationed by income, race, or region. This objective, substantially accomplished by the introduction of Medicare and Medicaid in 1966 and a variety of health programs for infants, mothers, children, and other categorical populations, dramatically improved access and modified long-established trends favoring the affluent in physician and hospital utilization.[1] In 1984, government at all levels contributed almost 42 percent of total health expenditures, $160.3 billion, of which $63.1 billion was for Medicare and $36.7 billion for Medicaid. The Medicare Hospital Trust Fund, consisting of payroll tax revenues, is expected to be depleted by the late 1990s, and Medicaid's burden on state budgets has already resulted in significant reductions in eligibility and benefits. Concern for the poor is now overshadowed by the large aggregate costs of these programs, by the growing federal deficit, and the need to restrain medical care costs more generally. In this context of conflicting needs and pressures, future access to care for the poor and near-poor populations is uncertain.

The relative disadvantages of the poor on such indicators as infant mortality, longevity, the prevalence of serious disease, and disability and incapacity have been documented repeatedly and need not be reviewed in detail. Children born in poverty are exposed to many more health risks, and throughout the life span poverty and poor health reinforce one another. Poverty has increased in recent years largely as a result of economic recession and high rates of unemployment.

From the Medical Sociology Research Unit, Rutgers University, New Brunswick, New Jersey. Requests for reprints should be addressed to Dr. David Mechanic, Medical Sociology Research Unit, 203 Murray Hall, New Brunswick, NJ 08903.

Programs to insulate those displaced by the economy and intended to provide a safety net for those most in need have eroded considerably. Between 1979 and 1983, the proportion of poor covered by the Medicaid program declined from 65 to 53 percent,[2] and Americans now estimated to have neither private nor public health insurance coverage number 33 million persons.[3]

While it is difficult to measure unreimbursed care accurately, such care seems to be declining as voluntary and proprietary hospitals show less willingness to treat uninsured patients in the face of tough cost constraints. In the early 1980s, one third of hospitals expended less than 8 percent of their revenues on charity patients, patients who never paid, and those on Medicaid.[4] In contrast, one quarter of hospitals provided 60 percent of all care to the poor. On the average, the American hospital devoted less than 5 percent of its care to charity or bad debts. The third of American hospitals that provide only 10 percent of all care for poor populations are least likely to have deficits and tend to be financially strong. The public hospital, traditionally committed to serving the most needy and poorest segments of the population, in contrast, faces economic difficulties and an erosion of public commitment. Caught in the dilemma of increasing numbers of poor patients turned away from the profit and nonpublic sectors and budgetary limitations, public hospitals are finding it difficult to maintain an adequate standard of care.

LIFESTYLE IDEOLOGIES

It is now commonly suggested that health and disease are largely a product of personal lifestyles, a generalization having merit. It has also been suggested, however, that free care may contribute to less motivation to maintain health and effective functioning.[5] These arguments help justify turning attention from health needs of the poor to the pressing issues of cost and budgets. Health services research shows, however, that while marginal health benefits beyond a basic threshold may have limited value for the affluent, the poor benefit disproportionately from increased access to care[6] because they are more likely to be sick and have unmet medical care needs.

Dramatic improvements in health status coincided with the implementation of Medicare, Medicaid, and other major national programs to eliminate hunger and improve nutrition, protect the health of mothers and children, and to ensure accessibility to medical care for disadvantaged groups through neighborhood health centers and other means. Many factors were involved, but clearly these programs had an important role in improving health. In the mid 1950s length of life in the United States stabilized and changed little during the ensuing ten years. Beginning in the middle 1960s, age-specific death rates began a decline, substantially increasing expectation of life, with significant gains in life expectancy for the elderly population. Expectation of life at birth in 1983 almost reached 75 years for the entire population, and 79 years for white women.[7] Even more dramatic is that these advances do not appear to be associated with significant increases in disability.[8] Old people at all ages appear to be healthier than ever before, often advancing well into old age before experiencing significant debility. Infant mortality also declined from 20.9/1,000 live births in 1968 to 1970 to 10.9 in 1983.[7] Large improvements are evident among both whites and nonwhites, although the gap between the races has continued. Black infant mortality remains almost double that of the white rate, and blacks continue to lag well beyond the white population in longevity.

BIOTECHNOLOGY AND THE CHANGING POPULATION PROFILE

The challenges of the 1980s and beyond are made difficult not only by economic constraints but also by changing concepts of appropriate medical care made possible by technological advances. Medical care quickly incorporates the latest advances in biomedical technology, sometimes increasing new possibilities for maintaining life and preserving function, but often adding new increments of cost without discernible benefits. As the total pattern of care becomes more expensive, the costs of care for the poor escalate as well. The expansion of neonatal intensive care reflects the

impressive capacity of acute care medicine in implementing lifesaving technologies. Gains in survival of low-birth-weight infants can be attributed largely to advances in neonatal care. The United States now invests relatively large resources to save babies of increasingly lower birth weights. The Office of Technology Assessment estimated that $1.5 billion was spent on neonatal intensive care in 1978. Average cost per case was approximately $8,000. Black and low-income babies are disproportionately low in birth weight, and the continuing push to keep babies of very low birth weight alive contribute significantly to Medicaid costs. The technology has its own inherent imperative. The irony is that once having invested so heavily in saving a life, relatively little is done to promote the welfare and life chances of the infant that survives. The rate of poverty among children under 18 years of age increased from 13.8 percent in 1969 to 22.2 percent in 1983.

Similarly, the growth of the elderly population, particularly the old-old group, will require additional services and expenditures, since it is in the oldest age groups where need and consumption of care are greatest. Between 1960 and 1980 the population aged over 85 years increased by 174 percent; it is expected to increase another 110 percent by the year 2000.[9] Not only do the aged use more physician and hospital services, but also they are at increasing risk with age of requiring long-term care. Using data for 1973-74, the risk of entering a nursing home at age 85 years or over was 290/1,000 as compared with 71/1,000 among women aged 75 to 84 years.[10] Among men in these age groups the comparable rates are 180 to 41/1,000. Forty-nine percent of nursing home expenditures were paid by Medicaid in 1979,[11] such payment becoming available when the person became sufficiently destitute to meet eligibility requirements.

THE CHANGING HEALTH CARE ARENA

There is presently much ferment and innovation in health care, but very little current activity is likely to benefit the poor. There have been dramatic increases in the penetration of the health care market by proprietary interests and a rapid growth of multihospital corporations and other large hospital chains.[12] Hospitals and other traditional facilities now face competition from freestanding surgicenters, hospices, home care programs, proprietary ambulatory centers, and freestanding dialysis units. The large hospital corporations are seeking to integrate community health components under their domain so as to have control over total systems of care in preparation for a new financial environment. The health maintenance organization (HMO) sector, after sluggish growth during the 1970s, is being marketed more aggressively, now covering approximately 17 million people. Given the cost advantages of controlled systems of care, the HMO concept increasingly has attracted venture capital and is viewed as a significant profit opportunity for health corporations.

Major employers, who have faced escalating medical fringe benefit costs for some years, have reacted to mounting costs by self-insuring their employees, by establishing their own health care plans, by providing economic inducements to employees to use less medical care, and by imposing greater cost-sharing requirements on employee health insurance coverage. One study found that major employers requiring hospital deductibles increased from 30 to 63 percent between 1982 and 1984.[13] To the extent these employer efforts are successful, they affect hospital occupancy and financing and leave hospitals even less willing to provide uncompensated care. Similarly, the profit-oriented hospitals, responsible to owners, or stockholders seeking profits, have little incentive to give attention to the uninsured or underinsured. The public hospital, thus, increasingly finds itself with larger numbers of sick poor and difficult, multiproblem patients.

THE GOALS OF MEDICAL CARE

As the varying actors in the health arena position themselves for a more competitive future, major distortions in utilization patterns and the use of resources will occur. Health providers are extraordinarily astute at manipulating reimbursement. The existing modes of reimbursement favor high levels of use of laboratory tests, technical

procedures, and ancillary services, and it is in these areas that profits are typically largest. Various studies suggest that profit-oriented hospitals do not differ much from voluntary hospitals in basic bed-day rates, but earn their profits by providing more profitable ancillary services and pricing them higher.[14,15] Reimbursement incentives are very powerful, and patterns of care are not changed simply by exhortation. But if alternative use of health care resources and more equitable distribution are to be achieved, it is essential that goals and the types of care desired are articulated clearly.

Impressive progress is evident in many areas of care, and momentum will undoubtedly continue, given the vigorous state of biomedical science and technology. But the burden of illness is increasingly in the chronic diseases, where cure is illusive and the challenge is to maintain function and minimize disability. All efforts possible should be made to prevent illness and cure disease when the knowledge to do so allows, but in many areas the best efforts are in good management of irreversible illness processes. Such efforts include minimizing personal suffering and promoting the highest possible level of function consistent with the limitations imposed by disease or the individual's environment.

A lesson learned repeatedly is the impressive variation in disability and incapacity that accompanies illnesses of comparable severity. While some rally effectively and function well despite the severity and limitations imposed by their illness, others lose confidence in the ability to perform, withdraw from work and social interaction, and take on a chronic sick role. Often the magnitude of social disability is as much a result of social definitions, inadequate coping skills in dealing with the illness and the treatment regimen, and deficient problem-solving capacities as it is a result of the illness as such. Health professionals can do a great deal to facilitate coping and increased function or, in contrast, can induce dependence and contribute to a variety of secondary disabilities that are not necessarily illness dependent.[16] The challenge of chronic illness focuses the need for less emphasis on elusive cures and more on sustaining functioning and quality of life within the limitations that illness brings.

Acute medical care often fails to give function the priority it deserves, and young physicians are trained too often to prefer heroic action in search for a cure. As a consequence, they often lose interest in patients with irreversible diseases, particularly poor patients for whose life circumstances they have less empathy and with whom they communicate more poorly. Physicians perceive patients who are poor and limited in education and verbal skills as wanting less information, but studies of patients demonstrate the contrary.[17] The poor, who face more formidable problems in coping than their affluent counterparts, get even less assistance in working out an accommodation to illness that promotes function.

ALTERNATIVES TO PRESENT DILEMMAS

There are no simple answers to providing adequate medical care for the poor in a context of tough financial constraints and competing priorities. A more efficient and balanced approach to care can be achieved, but maintaining access and quality of care for the poor will require a strong professional commitment as well as public support.

The poor and near-poor population includes a number of subsets who fail to receive services for varying reasons. A majority of the core poor are covered by Medicaid, although eligibility and administration vary so much from one state to another that inclusion, scope of coverage, and access to care may be an accident of residence. In 1982, more than one third of the uninsured—11.6 million people—were below the poverty line but did not have Medicaid.[3] As noted earlier, eligibility has been tightened and cost sharing has also been increased among those in the program. Two thirds of the uninsured population in 1982 had incomes below 200 percent of the poverty level, and their low incomes make it difficult to purchase individual health insurance policies when group insurance is not available through their employment. A third category consists of uninsured workers and their families who lost their health insurance when the primary wage earner lost employment. Many states now require that employers provide continuation of benefits for a short time—usually 60 to 90 days—and allow for conversion to individual

policies, but the expense is often more than the unemployed can manage. Also among the 33 million uninsured are some whose medical illness requires sophisticated care but whose medical histories make it impossible to purchase individual insurance at an affordable rate.

Not all of the groups described above pose issues of the same magnitude. Some uninsured have the ability to purchase insurance but, because of the cost and alternative spending preferences, chose to play the odds that given their age and health status, they are unlikely to have large medical expenses. In contrast, three groups should be of special concern: those who are below the poverty level, those workers near the poverty level whose employers offer no group health insurance but who face prohibitive costs in purchasing an individual policy, and those who by virtue of illness and disability cannot obtain health insurance at an affordable cost.

There are basically two approaches to the uninsured population at risk. A desirable alternative would be to assist this population in acquiring a reasonable insurance program on a group basis, with government facilitating the establishment of groups that pool the risks of varying uninsured populations. These persons could then acquire insurance through the pool at subsidized premiums dependent on income. The governmental unit subsidizing the premium would establish eligibility and co-payment criteria, and may require that care be organized through preferred providers who would deliver the insured services at negotiated rates. However organized, a meaningful program of this type would require many billions of dollars. If one half of the uninsured population received an average insurance subsidy as small as $200 per year, the aggregate additional cost would exceed $3 billion. In the context of the national deficit and cutbacks in Medicare and other popular social programs, it is difficult to anticipate the political consensus that would encourage this result.

An alternative approach is to have government make provision for special assistance to financially stressed hospitals that give large amounts of unreimbursed care to the poor. Such assistance could be direct through grants to financially stressed hospitals because of their heavy burden of care for the poor. Many of these institutions are urban hospitals in poverty areas that are unable to shift costs to nonpublicly insured patients or public hospitals that are underfinanced for the populations they serve.

There are alternative ways of sharing the costs of indigent care among a large population. One possibility is an all-payer system as in New Jersey, where the individual rates established for hospitals take into account unreimbursed care for the poor and require all insurers to share in such costs. Some states, in contrast, have established funds for indigent care by taxing net hospital revenues, as in Florida, or insurance premiums, as in New York.[2] These approaches to raising funds for indigent care may introduce distortions by the way they shift costs. Paying for indigent care by an add-on to hospital rates may affect the competitiveness of hospitals in attracting patients. Taxing insurance premiums levies a higher tax on less affluent individuals who pay part of their insurance premiums in contrast to those more affluent whose employers more typically pay the entire premium. Further, these approaches in treating varying income groups equally are all relatively regressive forms of taxation in contrast to the use of income tax revenue.

These various ingenious devices to shift costs among payers contribute to solving the problem of uncompensated care, but they are complex and indirect forms of taxation. Advocates of taxing premiums point to the massive government subsidy of private health insurance through the tax system. It would, however, be more logical to reduce these subsidies to the private sector to offset needed revenues applied to cover medical care for the poor more directly. What is logical may not be strategic, however, and the indirect approaches despite their imperfections may be perceived as politically more acceptable and can be implemented more easily.

While there is strong resistance to raising further general revenues for health care programs, a conscious effort to maintain an accessible and equitable system of care has implications of importance. There is a broad consensus that all people ought to have an equal opportunity in pursuit of their personal and social goals, and poor health inhibits opportunity. Equality of health depends on many factors and cannot ever be guaranteed, but equality of access is a feasible goal that binds together an increasingly divided society.

THE CONTEXT OF FUTURE HEALTH CARE: RATIONING, HMOs, AND THE POOR

There seems little doubt that the social, demographic, and technological forces at work will in the future result in more conscious rationing of medical care for all population groups. Rationing by fee and the ability to pay has been a traditional mode of limiting services. In the modern context, where much of the population is insured against medical care costs, co-insurance and deductibles play a similar role as disincentives to utilization. Such cost-sharing mechanisms affect use of ambulatory and other services initiated by consumers but have little impact on hospital utilization, which is largely determined by physician decision.[18] Advocates hope that cost sharing will primarily deter trivial forms of utilization, but the imposition of fee barriers seems to have broad influence affecting utilization of both trivial and serious illness. Cost sharing as a rationing approach is more likely to deter from necessary care those who are poor rather than those who are more affluent.

An alternative to cost sharing is the limitation of available services, either through the establishment of fixed budgets as an overall constraint on decisions by health care providers, or through explicit regulatory entitlements and exclusions.[19] Both approaches will be utilized in the future. On balance, setting general budgetary constraints, as in health maintenance organizations, but allowing professionals who face the responsibilities of caring for the sick and managing the complex contingencies of illness to establish priorities and allocations, is the preferable approach.[20]

Studies of HMOs, including the Rand Health Experiment, which randomized patients into an HMO in Seattle,[21] demonstrate significant savings in hospital cost in the vicinity of 30 to 40 percent.[22] Persons having more comprehensive coverage for health care costs, as is typical within HMOs, also use more preventive care, which is important for the poor, who are often deterred in other contexts because of out-of-pocket costs. Despite these advantages, as more of the population are covered by capitated plans, careful checks and balances will be necessary to protect fair access.

Health maintenance organizations and preferred provider organizations are more complex and bureaucratic than office-based physician groups. Negotiating these organizations, getting into the system, and having one's expectations and needs met depend on skills and sophistication more often found in those who are educated and affluent. In competing for access and attention, there is the danger that the less needy but more affluent learn to manipulate the system for what they want, while those less sophisticated make do with what they get.[23] Even within the British National Health Service, a highly rationed system of care, a sophisticated patient simply by persistence can obtain services denied to others.[24] Physician-patient interactions in all systems are complex negotiations, and as in other interactions physicians often succumb to requests and pressures, particularly when skillfully communicated. Poor patients and those with less education are more diffident, feel more threatened, and are more likely to acquiesce to initial physician decisions.

An important feature of HMOs and preferred provider organizations is that they lock patients into the provider organization and maintain internal control over more expensive forms of utilization. Not only will it be important to monitor access to services among the poor, but also it will be essential to develop easily used mechanisms for patients to make complaints and have them expeditiously negotiated. Many patients are fearful about complaining, believing that physicians and staff will retaliate at some future time when the patient needs them. Thus, it is essential that health care plans impress patients that it is legitimate and constructive to communicate concerns about poor service and that health professionals view such feedback less as a threat and more as a way of improving the provision of care. As patients more commonly receive care within systems that have incentives for efficiency, and as some services are withheld, trust will become more strained. An openness to feedback and appropriate education of patients when they are misguided will contribute to trust. While organizational and financial changes that constrain options are needed, it would be well to ensure that trust-enhancing mechanisms are developed and put in place.

Family practice already has played an important role in residency training and practice in promoting a broad view of health and a strong focus on improving the quality of individual and family functioning. It also has encouraged a more appro-

priate balance between technical and cognitive services and between health maintenance and cure. Recognition of the impact of change on the most needy and vulnerable segments of the population should encourage family physicians, both as individuals and as a key specialty group, to participate actively in policy discussions in their own communities and in the nation to insure that the poor receive adequate and appropriate medical care.

It seems clear that the United States will continue to maintain a generous health sector and will continue to take advantage of newly emerging biomedical science and technology. It is inevitable that everything people might demand or science will make possible will not be provided, but there is public support for maintaining a vigorous and dynamic medical care system that incorporates all clearly effective technologies. It is not so clear, in contrast, in the face of economic and social forces and a growing deficit, that the nation's commitment to the poor and the institutions which primarily serve them will not be compromised. There is already disconcerting evidence of an erosion in access to care and the health status of the poor.[25] The nation's willingness to continue its commitment to equity in health, despite current economic difficulties, will speak loudly about its priorities and the strength of commitment to equal opportunity.

References

1. Lewis CE, Fein R, Mechanic D: A Right to Health: The Problem of Access to Primary Medical Care. New York, Wiley-Interscience, 1976
2. Lewin ME, Lewin LS: Health care for the uninsured. Bus Health 1984; 1:9-14
3. Swartz K: The changing face of the uninsured. Presented at the Annual Meeting of the Association for Health Service Researchers, Chicago, June 11, 1984
4. Hadley J, Feder J: Troubled hospitals: Poor patients or management? Bus Health 1984; 1:15-19
5. Murray C: Losing Ground: American Social Policy 1950-1980. New York, Basic Books, 1984
6. Brook RB, Ware JE, Rogers WH, et al: Does free care improve adults' health? Results from a randomized controlled trial. N Engl J Med 1983; 309:1426-1432
7. Annual summary of births, deaths, marriages, and divorces: United States, 1983. In National Center for Health Statistics: Monthly Vital Statistics Report, Provisional Data, vol 32, No. 13. DHHS publication No. (PHS) 84-1120, Sept 21, 1984
8. Fuchs V: Though much is taken: Reflections on aging, health and medical care. Health Soc 1984; 62:143-166
9. Rice D, Feldman J: Living longer in the United States: Demographic changes and health needs of the elderly. Health Soc 1983; 61:362-396
10. Russell LB: An aging population and the use of medical care. Med Care 1981; 19:633-643
11. Rango N: Nursing-home care in the United States. N Engl J Med 1982; 307:883-889
12. Starr P: The Social Transformation of American Medicine. New York, Basic Books, 1982
13. Company Practices in Health Care Management. Lincolnshire, Ill, Hewitt Assoc, 1984
14. Pattison RV, Katz H: Investor-owned and not-for-profit hospitals. N Engl J Med 1983; 309:347-353
15. Relman A: Investor-owned hospitals and health care costs. N Engl J Med 1983; 309:370-372
16. Mechanic D: Illness behavior, social adaptation, and the management of illness: A comparison of educational and medical models. J Nerv Ment Dis 1977; 165:79-87
17. Waitzkin H: Doctor-patient communication: Clinical implications of social science research. JAMA 1984; 252:2441-2446
18. Newhouse JP, Manning WG, Morris CN, et al: Some interim results from a controlled trial of cost sharing in health insurance. N Engl J Med 1981; 305:1501-1507
19. Mechanic D: Approaches to controlling the costs of medical care: Short-range and long-range alternatives. N Engl J Med 1978; 298:249-254
20. Mechanic D: Rationing of medical care and the preservation of clinical judgment. J Fam Pract 1980; 11:431-433
21. Manning WG, Leibowitz A, Goldberg GA, et al: A controlled trial of the effect of a prepaid group practice on use of services. N Engl J Med 1984; 310:1505-1510
22. Luft H: Health Maintenance Organizations: Dimensions of Performance. New York, Wiley-Interscience, 1981
23. Mechanic D: Future Issues in Health Care: Social Policy and the Rationing of Medical Services. New York, The Free Press, 1979
24. Aaron JH, Schwartz WB: The Painful Prescription: Rationing Health Care. Washington DC, Brookings Institution, 1984
25. Lurie N, Ward NB, Shapiro MF, Brook RH: Termination from Medi-Cal—Does it affect health? N Engl J Med 1984; 311:480-484