Medicare, Medical Practice, and the Medical Profession

ERNEST W. SAWARD, MD

WHEN KING CANUTE stood on the beach and tested his authority by commanding the incoming tide to recede, as legend has it, the result was wet feet. When Public Law 89–97 was enacted, the first section (1801) of title XVIII disclaimed any intent to change the practice of medicine. Perhaps it was a politically essential proscription, but the result of this test of authority was much like that of King Canute's.

The Social Security Amendments of 1965 are the great watershed event of the past half century in U.S. health services. It is interesting that Medicare and Medicaid were seen as limited programs for the disadvantaged—the approximately one-fifth of the population who were dependent upon others, the aged and the impoverished. Although in no way a political expert, I doubt that such programs would be enacted today—our sense of societal priorities has changed significantly in the past decade.

Although many in the health services and particularly organized medicine saw Medicare and Medicaid as an entering wedge or foot in the door to the overall establishment of some form of national health insurance by government, there has been a paralysis of action. Moreover, the differing policy issues of parts A and B of title XVIII and title XIX are still unresolved and are being as vigorously debated as they were a decade ago. Thus, a stalemate has occurred.

☐ *Tearsheet requests to Ernest W. Saward, MD, The University of Rochester School of Medicine and Dentistry, Department of Preventive Medicine and Community Health, 260 Crittenden Blvd., Rochester, N.Y. 14642.*

The Pre-Medicare Climate

To see what changes have occurred in the practice of medicine, one must recall its early ambience. Medical care has been highly valued since the earliest recorded history. This value has had little to do with the scientific content of medicine or the statistical effects of its applications on outcomes. It should be recalled in this Bicentennial Year that Benjamin Rush, the most notable physician in the American colonies at the time of our nation's founding, a signer of the Declaration of Independence, a professor of medicine, and subsequently Director of the Philadelphia Mint, was much honored and respected. But when one reviews his management of enteric fevers in Philadelphia by purging, puking, and bleeding, one realizes that the caring function in contrast to the curing function has been and remains a vital part of the public regard.

The scientific content of medicine evolved almost entirely in this century, and the most important advance-

ment—the conquest of infectious diseases—came about during the lifetime of most of the physicians in practice when Medicare and Medicaid were enacted. Scientific advances in this century gave the profession great new powers. The "miracle" drugs and "miracle" cures were widely publicized and lauded. Thus, the medical profession came to believe that it was not only socially relevant but also perhaps the leading contributor to human welfare. Attitudinally, the profession was riding high in the saddle.

Because of the greatly increased values of medical care, particularly as it was practiced in hospitals, the number of people having voluntary health insurance grew rapidly in the 20 years before the Social Security Amendments—from less than 10 percent of the population before World War II to approximately 75 percent of the population by 1960. Again, the ambience was one of success, and despite the ability of critics to point out significant groups in the population who were not covered and the lack of comprehensiveness in the existing coverage, there was more of a feeling of accomplishment by health providers than of failure.

Of course, health providers in the early 1960s were aware of many problems. However, the general feeling was that significant and rapid progress had been made since the 1950s and that such progress would continue. There were basic scientific problems. Despite heavily funded research, no breakthroughs occurred in the degenerative diseases and cancer that were in any way comparable to the earlier conquest of infectious diseases. Health services were poorly distributed—many populations suffered from lack of availability or lack of access. And, the costs of health services were rising. The right to health care was a semantic having an entirely different meaning to the profession than it had to leaders in socio-political thought.

The private practitioner had no concept of responsibility to underserved populations per se, except in a most primitive public health sense. His sole concern was for those persons who sought his services. The physician from time immemorial has believed that anyone coming to him in suffering had a right to his services. The societal responsibility of the rights of populations to health care often proved an abstraction that was difficult for the physician to grasp. The precedent was that even the great religious healers of antiquity never ministered to the poor and leprous as a class, but only to the person prostrating himself before them.

The concomitant of this philosophy in the United States was a wide division between the practitioners of what we call public health and the so-called private practitioners of medicine. Their philosophies were so different that remarkably little interchange took place between the two. Although the role of government in health was substantial in this period, apart from aid to medical research and education it was limited to public health in its most narrow definition. The provision of direct services was categorical and only to populations hopelessly out of the mainstream of American society. The mainstream was defined by the medical profession to be those who were self-sustaining in the private sector. Persons in the Armed Forces, veterans with service-connected disabilities, Indians, merchant seamen, and the permanently disabled were perceived as government wards. Until shortly before the passage of Medicare and Medicaid, the medical profession had even resisted aid to physician training and support of medical schools, except through the device of research grants.

Government's role in the private sector was not only small, but it was also regarded with what might be called organized apprehension. For many years organized medicine had impressed upon physicians that they would lose their freedom and that their vital patient-physician relationship would in some way be destroyed if government became involved in any way with their services. With the Cold War and McCarthyism, county medical societies came to believe that any action of government to increase its role in health services was either Socialism or Communism; ergo, any member of a county medical society who vocally favored an expanded role of government was a Communist. This attitude was clearly evident during the debate over the King-Anderson bill that led to the Medicare and Medicaid legislation. Although many physicians may have privately favored this proposal to have the hospital bills of the elderly paid for by the social security system, very few expressed their favor publicly. The organized profession vehemently opposed the proposal.

As they evolved, the health professions and health institutions created many standards. When examined historically, most of these standards can be seen as responses to abuse. Licensure by State examination in the post Civil War period is a clear example. The 1910 Flexner reforms of medical education and the subsequent accreditation of medical schools by the American Medical Association were likewise responses to abuse. The American College of Surgeons' review of hospital standards during World War I was a response to the incredible findings of its investigatory commission, and the evolution of that body into the Joint Council on Accreditation of Hospitals was a natural result. As medicine developed technologically, it became necessary to certify who in fact was a "specialist." Thus, each field of practice so qualified itself seriatim, ending with the field of family practice, so that each could be called a "specialty."

Government in general, particularly the Federal Government, had little to do with the preceding events. Although State health departments did inspect hospitals, their criteria were usually significantly lower than those of the Joint Commission on Accreditation of Hospitals. The States that regulated voluntary health insurance had little regard for the health implications of the coverage provided or the consequences for health services—their primary concern was the fiscal soundness of the insurers. Public accountability was only for dollars. This was the

medical practice environment before the great compromise of Medicare and Medicaid, arranged by Congressman Wilbur Mills.

Less than a year elapsed between President Johnson's signing of the Social Security Amendments and the implementation of the provisions, an extremely short time to implement such a fundamental change. Concomitantly, the Community Action Programs of the Office of Economic Opportunity, the Comprehensive Health Planning legislation, and the Regional Medical Programs came into being—all at the time that health manpower funding had begun to flow and at the peak of the Federal funding of medical research through the National Institutes of Health. In no other period in U.S. health affairs has such profound change occurred in so short a time.

Medicare's Effects on Medical Practice

As I mentioned earlier, parts A and B of title XVIII and title XIX do not create any semblance of either conceptual or program unity. Although there are overarching Federal requirements for the Medicaid program, its implementation by the 50 States is so diverse in its effects on medical practice that it requires endless qualification. Therefore, my primary focus here is on Medicare. When I describe the effects of Medicaid, my frame of reference is the larger and more expansive State programs, such as those in California and New York.

In implementing the program for Medicare, the Social Security Administration not only had to organize a whole new Bureau, but also a vast and detailed set of rules and regulations that required continuous elaboration. Suddenly the providers of health services were confronted with the new tasks of compliance and accountability. For the institutional providers, Medicare related to every aspect of their function. They soon realized that what they saw originally as a simple means of paying the hospital bills of the aged actually entailed compliance with codes of nondiscrimination (for employees as well as patients), fire safety codes, laboratory standards, conceptually new accounting procedures, personnel standards, recordkeeping, the Joint Commission on Accreditation's ever-expanding review of technical processes in the hospital (with considerable involvement of medical staff), and a review of the appropriateness of hospital care in its most fundamental sense. The Medicare program also created a new class of institution—the extended care facility—and greatly expanded the role of home health services.

Because of the method of paying hospitals for services—cost reimbursement—profound changes occurred in the kinds of services provided. Cost reimbursement coincided with the introduction of intensive care services—coronary care units and surgical and respiratory intensive care units. The quality-cost equation was reduced to quality, because any cost would be reimbursed. Part of the charitable nature of hospitals, beginning with the first such Christian institution—Rome's Fabiola—stemmed from the philosophy that people worked in them not for earthly reward but for "gaining grace." Before Medicare, the wages for hospital workers somewhat reflected this philosophy, although perhaps poorly realized by the recipients. Under Medicare, however, hospitals suddenly had the financial mechanism to pay wages comparable to those of community workers in other fields.

The method of remunerating physicians their usual, customary, and prevailing fees produced the truly "golden age" of American medical practice, despite the earlier apprehension of organized medicine. Because of Medicare and Medicaid, it was no longer necessary to treat the indigent without reimbursement. The Medicare formula tended to provide the fee for any item of service equal to the highest fee usually charged; thereby, the entire fee structure was elevated. As for the wealthy, nothing in the Act precludes charging them more than the usual, customary, and prevailing fees when it is not necessary to take payment on assignment. Assignment applies largely to fees of such magnitude that payment may be in doubt without this device, or to fees of any amount for the truly destitute. The net result, after years of such interactions, has been that less than half of the Medicare fees are collected by assignment.

Thus, the profession has been experiencing a new affluence and a new attitude. The long tradition of personal charity has been abrogated, and the usual and customary fees are expected of all patients. For the Medicaid program, which in most jurisdictions has fee schedules that are lower than the usual ones, statistics indicate that fewer than one-third of the physicians will see Medicaid patients customarily; in this respect, the Medicaid patient was, and is, a second-class citizen. The result is the anomaly of the now more prosperous physician (because of Medicare) being unable to attend the charity patient because that patient cannot under Medicaid pay a fee equal to one covered by Medicare.

Controls and regulations. Early in the Medicare program and despite the vigorous opposition before its enactment, the only complaints voiced by physicians concerned bureaucracy and paperwork. The controls and accountability had fallen heavily on the hospital provider; initially, they fell lightly on the practitioner. Eventually it came to light that physicians were abusing the program in many ways. A small amount of fraud, which on revelation produced considerable emotion, doubtless was not a statistically significant cause of the rising costs of the program.

The areas of presumed abuse differed, and by no means were they readily agreed upon. Overutilization and inappropriate utilization are not absolutes; they must be judged by some standard. The lack of a clear national standard for such utilization is evidenced by the data from the Blue Cross programs for the 20 years preceding Medicare. Many specific morbidities—standardized for patients' age and sex—had produced annually,

for example, 40 to 50 percent longer hospital stays in the New England States than they did in the Pacific Coast States. Therefore, one can ask: Which is the correct use and which is the abuse? It is not surprising that Medicare utilization varied at least as much as that of Blue Cross by geographic location, as well as by various demographic factors.

When the Bureau of Health Insurance began to look at the utilization review function in hospitals, it found that this condition of participation was either poorly implemented or in many instances essentially disregarded. Of course, the members of the medical profession were seen to be at fault. By the third year of the program, the cost overruns compared with the original estimates were out of control. This situation engendered public and congressional concern. By July 1969, after reviewing the costs of medical care and their rate of rise, President Nixon proclaimed a "health crisis" and stated that if health services were not reorganized, chaos would ensue. Naturally, these strong remarks produced an attitudinal reaction in the organized profession.

Many options were explored, and about 1½ years later in his health message to the Congress, the President enunciated what is called the HMO (health maintenance organization) policy. Again, the medical profession reacted negatively; it had always regarded organizations that provided highly organized health services for defined populations as un-American, despite the fact that such organizations had existed only in the United States. Five years have passed since the enunciation of the HMO policy. Although Congress passed an awkward and difficult law to aid the development of HMOs, the policy would not have been adopted had it not been for the responsibilities that Medicare and Medicaid placed on government.

Concomitant with the HMO policy, another major change was proposed—local peer review bodies were to examine by a specific methodology the quality and appropriateness of health services under Medicare and Medicaid. This proposal was debated for 2 years before it was passed. It became part of the Social Security Amendments of 1972, known by its acronym as PSRO (professional standards review organization), and it generated substantial controversy. The gradual implementation of PSROs across the country has further polarized the interrelationships between medicine and the Federal Government. In fact, the first law suit that the American Medical Association ever instituted against the Federal Government related to proposed rules for utilization review, and other organized groups of physicians have sued as to the basic unconstitutionality of the PSRO amendments.

When a third legislative act was passed as an amendment to the Public Health Service Law in 1974, the National Health Planning and Resources Development Act, the prompt reaction of the leaders of the organized profession was to consider a lawsuit to declare it unconstitutional. It seems that the new mode is for various bodies of the organized profession to litigate any new legislation that they see as infringing upon their independence. Even the normally aloof Association of American Medical Colleges has sued the Federal Government over those portions of the Medicare Act that relate to the reimbursement of teaching hospitals. The trend of health legislation is a rapidly rising curve, with hundreds of bills introduced each year in Federal and State legislative bodies. Medicare, and its resultant cost, has precipitated a relationship of legislating and litigating between government and the medical profession.

Costs. The progressive control and regulation of professional and institutional providers of health services by Medicare and Medicaid has led to a new attitude among State officials toward controlling voluntary health insurance. No longer are Blue Cross rates automatically adjusted upward by State insurance commissioners upon request. Public hearings are held to produce an adversary process between consumers and providers, and Blue Cross and others are charged with the control of the costs of medical care. A pioneering example of this was the actions of Pennsylvania State Insurance Commissioner Walter Dennenberg. More recently, even more Draconian measures were proposed by Governor Hugh Carey of New York. The States, of course, are as anxious as is the Federal Government to control Medicaid expenditures, and Medicaid has become progressively restrictive in almost all jurisdictions.

Despite the much-resented controls and regulations, the costs of medical care continue to rise at a rate faster than the productivity of the economy in general, so that health care takes an ever-larger percentage of the gross national product. Blame is assessed in various directions, and whatever goodwill there may have been between government and medicine appears to have evaporated in embittered controversy.

There appears to be little awareness among members of the medical profession, the Congress, or the public that the sophisticated medical technologies developed in the past 20 years make the high costs inevitable. Moreover, more and more marginal technological innovations are being developed, particularly in the degenerative and neoplastic diseases, which Dr. Lewis Thomas, president of the Sloan-Kettering Institute and Memorial Hospital, refers to as "half-way" technologies. These technologies are not curative, at best they are ameliorative, and they have little effect on health status. But it would be monstrous for the individual physician, when confronted with the choice of a technology that might help a patient, to start allocating the health care resources on a cost-effective basis. His ethical duty is to give any possible aid to his patient, and therefore he can only commit resources to every circumstance in which there is a possibility of gain. The rise of malpractice concern and the practice of "defensive" medicine only exacerbate this tendency.

Hospital administrators generally have responded by creating every conceivable technology and facility that their physicians request. We have such egregious examples as open heart surgery units that are used but once a month, as well as considerably underused high-energy radiation therapy units. But far more commonplace and much more costly is the uncontrolled growth of the multiplicity of more ordinary laboratory and X-ray procedures. The hospital world is accustomed to having the number of laboratory procedures used on a fixed-bed capacity increase at the rate of 20 percent or more a year and, under the rules of cost reimbursement, with neither the pathologists nor the hospital administrators having cause for concern. When Congress asks for meticulous examination of appropriateness in order to control costs and to create at least a uniform standard of quality, but at the same time and in the same piece of legislation it adds universal coverage for end-stage renal disease—an exceedingly costly and sophisticated technology for relatively few people—the message of a limited resource allocation becomes blurred in the eyes of the profession.

Conclusions

In most areas of the United States, health planning has been a faltering instrument. The inclusion of certification of need for creation or modification of facilities in the 1972 Social Security Amendments does not begin to deal with the technological imperative I have described. If society in general or the Congress in particular believe that physicians have been made aware of proper priorities in the allocation of health resources by the measures adopted to date, they surely will be disappointed.

A major problem in standard setting for Medicare is the diversity of the United States. The attempt to make uniform rules and regulations that apply to all, the urban teaching center as well as the small community hospital with less than a half-dozen physicians, has proved almost impossible—even by the exception process. For this reason, Public Law 93–641, the National Health Planning and Resources Development Act of 1974, which creates a national network of health agencies and gives them responsibility for appropriateness, if properly funded may produce more rational and relevant use of the resources. However, many other changes must occur before such reordering can take place. The nature of the payment mechanism of part B of title XVIII—an item by item payment system for morbidity only, rather than for comprehensive responsibility for defined populations—merely invites the technological imperative to drive the costs ever higher.

The political atmosphere of 1965 did not hold the possibility of enacting Medicare and simultaneously making an orderly organization of comprehensive services. It is doubtful that government and the organized profession have yet attained the relationship necessary to make this possible. The present debate on national health insurance goes over and over the same sets of policy decisions that resulted in the three-layer cake of 1965. (The "three-layer cake" was the term applied at the time to the three different funding and eligibility concepts of part A and part B of title XVIII and title XIX of the 1965 modifications of the Social Security Act.) Perhaps the lack of resolution of any of these policy matters can be attributed to the nation's recent affluence. If, however, the country is no longer so affluent and is not likely to be in the decades ahead, then with the costs of health services escalating faster than our productivity, steps may finally be taken to resolve our extravagant indecision.

Although the medical profession still lags considerably behind many other groups in its public stance on such matters, the decade since the enactment of Medicare and Medicaid has seen a vast awakening and an ever-increasing apprehension by the profession as to the role of government in health services. Work action by physicians, unheard of a decade ago, is now commonplace. We will see much more of it, and by all other health workers as well. It is likely that policies will be made and issues joined, not in a single grand legislative program, but piece by piece with slow progress, controversy, and confrontation.

The medical profession, although still held in high esteem, no longer has the credibility or stature that it had before Medicare. The rise in malpractice suits is but one reflection of this. Proposed legislation to allocate medical specialties in a quota system, to allocate medical manpower geographically in return for payment of educational costs, and other similar manipulative schemes being discussed within the Administration and the Congress were unthinkable a decade ago. Now, however, it is almost unthinkable that some such denouement will not occur.

Medicine is still a privileged profession and will remain so, but the profession and the ambience of medical practice have changed. And, the rate of change is constantly accelerating. We are nearing a period when health spending will no longer be open ended, growing faster than the economy. It is possible that a multiplicity of controls will arrive at a closed ended resource allocation, which must then face political and societal decision making as to the priorities for health spending.

In view of the present consumerist nature of society and our historically ever-increasing interest in equity, it appears that the fixed allocation of resources will significantly reorder the priorities from heavy spending on complex tertiary care to spending on more accessible and available primary and secondary services. The professional already senses this, although the tide toward tertiary care has not yet turned. That it must turn is inevitable. The reordering of priorities will be the ultimate effect of Medicare and Medicaid and the inherent cost overruns that result when the technological quality imperative and open-ended reimbursement are combined.