Question 1: Have members on the health care team experienced any role changes in the last 10 years?

Answer 1: Trends of this type are always difficult to track, but there does seem to be a shift going on at this time with a number of the roles. One role that seems to have changed the most is that of nurses who have enlarged their role into other clinical areas such as nurse anesthetists and into management positions that were previously reserved for others. An example of this trend is in the fact that more nurses are being appointed to be the administrators and chief executive officers in hospitals. Prior to about 20 years ago, such a promotion was fairly uncommon.

Another trend appears to be in the role of the physician's relationship with the health care team. The physician is not absolutely required to be present when a given procedure is conducted by one of the other health care team members. The technical skills and specialization of the members of the health care team have allowed them to perform procedures on their own within the scope of their own license or with protocols to back them.

Question 2: Why are managed care plans accused of not really caring for their members?

Answer 2: The concern of managed care plans skimming is due to some of the practices used by managed care plans. The very nature of managed care plans selling plans through employers and ERISA plans suggests that they are only providing health services to the middle and upper-middle class without regard to those not covered with health insurance. In the meantime, physicians and hospitals have continued providing health services to the indigent and patients with health insurance.

Another notion for believing managed care plans are skimming comes from the public outcries that patients are discharged prematurely from hospitals. The claim often heard, for example, is that new mothers are not getting the hospital stays they need but are getting discharged for reasons of saving the plan money.

A final reason that can help explain the argument that managed care plans are skimming is the claim that accessibility is difficult. In the past, this problem included the need for a primary care physician to make the referral before a plan member could see a specialist. Most plans have now vacated the need for such a referral, but the issue of accessibility still continues in
some managed care plans that require all doctor visits be made several weeks in advance. Again, some of these issues appear to be under control, but the concerns still appear to linger.

**Question 3:** Why has governmental and public support shifted away from managed care plans?

**Answer 3:** During and throughout the 1970s and 1980s, managed care plans were heavily subsidized by the Federal Government. Public policy in that time period was positioned to allow managed care plans to grow so they could compete with the more established health providers. Expectations of what managed care plans could deliver in terms of cost, quality, patient education, and alternative viable programs were high.

In today's competitive health care marketplace, the evaluative information reveals that managed care plans have not been able to deliver altogether on what they said they could. Different reasons exist for this occurrence, but they do include the fact that the private sector has become more competitive. Management service organizations (MSOs) have contributed significantly in making the private sector more efficient and able to compete better against managed care plans.

Managed care plans, in turn, have not been able to control costs at the level they said they could nor satisfactorily calm public outcries that they discharge patients who need longer hospital stays. At this time, public policy toward managed care plans remains skeptical and, at times, almost hostile.

**Question 4:** In terms of economies of scale, would a one-payer system for reimbursement save money?

**Answer 4:** As in many public policy issues, the old adage that the devil is in the detail applies. In theory, such a proposition makes a lot of sense. If there were one central method to coordinate reimbursement and ensure a timely response, then economies of scale could be gained.

The problem with this theory is the scale to which a single payer system would have to be to accomplish its mission. From a public policy standpoint, would such a payer system be the paying agency for all Americans who can afford health insurance or would it cover everyone? Though admirable and desirable, such a concept is not very possible.
**Question 5:** What can be done about too many "freeloaders" receiving governmental health care benefits?

**Answer 5:** This issue continues to provoke many arguments. Studies on this subject have revealed that the majority of persons receiving health care benefits from the government are not freeloding but are actually working poor. The term *working poor* is used to describe people who are below the U.S. Government's poverty guidelines, who cannot afford health care insurance, and who are actually working.

Moreover, despite the notion that most people receiving health care entitlements are racial or ethnic minorities, these same studies show the majority of persons receiving government-provided health care are Caucasian, women, or single-parent families. This argument is not well-founded and needs to be countered with facts.

**Question 6:** Why are physicians traditionally opposed to Medicare or national health insurance?

**Answer 6:** Physicians are trained to be independent decision makers and most often see government more of as an intruder rather than a payer. Although there is recognition that government does provide reimbursement for medical procedures offered, there is also an understanding that the reimbursement comes with conditions and stipulations requiring compliance.

Despite some changes in physician attitudes toward government regulations, most physicians still resist the idea of any intervention in their practice of medicine.

**Question 7:** How much competition is there between hospitals and physicians for the same patient?

**Answer 7:** To say that there is no competition between the two would be incorrect. Hospitals continue to expand their outpatient departments and advertise widely to advocate for their hospitals. The fact remains, however, that these steps do affect individual physicians in their practice.

In turn, physicians have been building facilities such as surgicenters or diagnostic clinics that clearly compete against hospitals. In many instances, these facilities are located very close to the hospital itself.
It is difficult to quantify exactly how much competition between the two affects the other. These types of competitive activities can be expected to continue for the foreseeable future on both sides.

**Question 8:** Do economic considerations rather than quality drive health care delivery?

**Answer 8:** Although it is true that economic considerations are playing an ever-increasing role in the delivery of care, quality will always have to command an important part. It is uncertain how much more the nation is willing to pay for quality.

An economic theory that is often quoted is that prices will continue to increase as long as the buyer continues to pay. The determination of when the price is too high is generally made when the demand goes down. In the case of health care, it is recognized that the ultimate user, the consumer, does not actually incur the full cost of paying for health care. Insurance reimburses the industry and therefore shields the consumer from knowing the true cost of health care.

The fact appears to be that consumers want quality and will pay the amount they believe is necessary as long as their insurance coverage continues under the present structure. At the rate of cost increases, however, a more critical decision may be necessary.

**Question 9:** Are Americans accepting preventative medicine as a way to reduce costs?

**Answer 9:** The absolute answer to this question is yes. Americans have accepted the concept of preventive medicine and have taken steps to put their beliefs into practice. Perhaps most significant is that the rate of heart disease has dropped. Studies for this decline point mostly to the fact that more people are now exercising and watching their diets more carefully.

Other indices of health status similarly show some decreases; most of these show that again individuals appear to be taking better care of themselves. Although preventive medicine has yet to be instituted by the health care industry, health promotion by individuals appears to be gaining.
Question 10: Is it likely there will be more attempts to create a national health insurance program?

Answer 10: Despite the passage of the Affordable Care Act (ACA), the debate continues in the United States as to how the health care system should or should not be reformed. Although the ACA is not a national health insurance program, its intent is to provide health insurance coverage to over 30 million Americans who previously did not have coverage. The health care system as we know it has been shaped by the values and beliefs of the American people, but many are still skeptical of government involvement in the health care system. Before the ACA, the last time major health care reform was discussed was almost 20 years earlier in 1992 by President Bill Clinton.

If the ACA is a success, it may provide an opportunity to discuss more comprehensive reform, to include a national health insurance program or even a single-payer system (although a single-payer system is unlikely in the United States). While it is not likely that comprehensive reform of the U.S. health care system will move toward a national health insurance program anytime soon, it is likely that people will see incremental changes of current programs (as the ACA did with Medicaid) to increase health insurance coverage and health care access.