TRENDS & Ideas

HEALTHCARE ENVIRONMENT

On the Horizon

Healthcare costs and coverage for the uninsured and underinsured will be dominant health policy issues during the next five years, with states taking the lead in experimenting with reform options, according to the Healthcare Financial Management Association's (HFMA's) 1992 environmental assessment.

HFMA noted that efforts by employers and insurers to control costs by negotiating discounted rates are making it more difficult for providers to shift costs to compensate for inadequate Medicare and Medicaid reimbursement. At the same time, growing regulatory burdens are increasing providers' "costs of compliance." Meanwhile, a smaller post–baby boom population is creating a shortage of young workers to fill entry-level jobs.

The environmental assessment predicts that in the coming years inpatient acute care expenditures will increase at a slower rate than overall healthcare costs. Meanwhile, cost-containment pressures, growing demand for services, and new technologies will lead providers to make operational changes and experiment with new treatment locations. And as outcome measurements improve, policymakers and healthcare professionals will place greater emphasis on quality measurement in planning delivery of healthcare services.

With a variety of factors curtailing their incomes and activities, physicians will practice more often in medical groups and institutional settings, according to HFMA. More doctors will become salaried employees of hospitals, but they will also demand a greater role in hospital management.

HFMA also predicts that potential financial problems will block access to reasonably priced capital for many providers, making it difficult to expand services and invest in new technologies. Meanwhile, state and local governments will continue to challenge facilities' tax-exempt status.

With such complex problems on all sides, state governments' reform approaches will take a variety of forms. The report suggests that states will experiment with "insurance reform, rate setting, budget caps, Canadian-style single-payer programs, or employer mandates to provide health insurance for employees."

Sim Gellman

HEALTH INSURANCE

State Subsidizes Coverage for Small Businesses

In an innovative experiment, Florida's state legislature is bankrolling a not-for-profit corporation, Florida HealthAccess, to help small businesses insure their employees. The company has contracted with a health maintenance organization (HMO)—at rates 25 percent to 40 percent below those of competitive HMOs—to cover about 12,700 small-business owners, employees, and their dependents.

"The reliance on state subsidies draws doubts from some small-business groups and government officials," writes Eugene Carlson in the *Wall Street Journal*. They fear future budget cuts could leave them uninsured. Nevertheless, many praise the program, now in its third year, as a step forward in efforts to cover the uninsured.

Currently, the Florida HealthAccess program is open only to companies with 2 to 19 employees who have not had company health coverage for at least six months. The program is available in only a few Florida cities, but the corporation's director hopes to win legislative approval to expand the program statewide.

Florida HealthAccess was launched with a grant from the Robert Wood Johnson Foundation but relies on hefty state subsidy—$5.5 million for the year ending June 30, 1993. Despite his reservations about the size of the subsidy, William Herrle, Florida representative for the National Federation of Independent Business, a nationwide business advocacy group, calls the program "a very effective tool in demonstrating to commercial insurers that it's possible to come into a troubled market, negotiate with hospitals and drug companies, and get a good deal."

Although Florida HealthAccess claims to exclude fewer people than most small business insurers, it does refuse to cover persons with HIV infection or active cancer, employees of healthcare providers, or those who work with explosives or asbestos.

WORKING MOTHERS

Between a Rock and a Hard Place

American mothers are in a no-win situation. In the past 30 years, motherhood in the United States has undergone some dramatic changes, with many women now facing the anxiety of juggling the demands of home and career.

"Caught between a fictional ideal, changing expectations of women's roles and the reality that many mothers now work because they must, women around the country are groping for a new definition of the good mother," writes Susan Chira in the first of a three-part series in the *New York Times.*

In 1960, 20 percent of women with children under six were in the work force; in contrast, last year 58 percent of such women were working, most of them full time. And 25 percent of children lived in households headed by a single parent (usually a mother), compared with 12 percent in 1970.

Financial need is a primary reason many women work. But many women link working with benefits such as a new sense of identity, a role in a broader community, and a temporary escape that may enable them to be better mothers when they are home.

On the other hand, many working women were raised by their own mothers and grew up with images of Donna Reed and June Cleaver. Left with no model for their new life-style, they feel guilt and anxiety—particularly if they fear the quality of care their children receive is not good.

For the most part, these women have little help from husbands, society, or their employers. Employers can make it easier for working mothers, Chira suggests, by allowing them flexible work hours, sick days when their children are sick, and time off to attend school events.

Single mothers have particularly difficult problems, but seem to agonize less about dividing their time between work and home, since their financial situation leaves them no choice, Tamar Lewin reports in the second article in the series.

The women she spoke with expressed "great pride in finding that, against all expectations—theirs and society's—they are managing reasonably well."

Unmarried mothers are more likely to be younger, poorer, less educated, and more dependent on welfare than those who were married when their children were born. "Almost half of all female-headed families with children under 18 live in poverty," Lewin notes, "and the median family income for two-parent families is about three times that of female-headed families."

Sociologists believe that poverty and disturbances preceding divorce, rather than single parenthood per se, may be to blame for the greater likelihood that children in single-parent households will have behavioral and academic problems.

Children who are cared for by someone other than their mothers also may suffer from insecurity, heightened aggressiveness, noncompliance, and withdrawal, Erik Eckholm reports in the series' final article. But the differences seem to be small and affect only a small percentage of children.

Many researchers believe the quality of care is more important than who delivers it, as long as the child is able to develop a bond with the mother. Thus most agree that having a parent at home full-time for at least the first three or four months is good for both parents and children.

TREATMENT DECISIONS

Certifying Surrogates

New state laws creating surrogate decision makers for patients who have not made advance directives promise to have a greater impact than advance directives on end-of-life treatment, Jerry A. Menikoff, Greg A. Sachs, and Mark Siegler write in the *New England Journal of Medicine.*

The authors point out that a "wide disparity" exists between those who indicate they want "to die without heroic measures" and those who have actually executed a living will or durable power of attorney. Menikoff and colleagues also doubt that the Patient Self-Determination Act, which requires hospitals to notify patients about their right to make advance directives, will have a significant impact. The period in which a patient is being admitted to a hospital, they note, "is probably the worst time anyone could choose to undertake a thoughtful discussion of advance directives."

Recent legislation, however, now makes it possible to fill the void created by the absence of advance directives. Approximately 16 states now have laws creating surrogate decision makers for various medical circumstances. One new statute in Illinois, the Health Care Surrogate Act, provides guidelines for when and how surrogate decision makers are designated for patients who have not executed a living will or durable power of attorney for healthcare.

The law stipulates the patient must be, in the physician's judgment, in a "terminal condition," a state of "permanent unconsciousness," or an "incurable or irreversible" condition that would ultimately lead to death. The statute sets a clear order of priority for persons who can act as surrogates, with the patient's guardian being the first choice.

The most important provision of the law, according to the authors, is the discretion it gives to physicians to determine whether a patient falls into any of the categories that justify selecting a surrogate. The provision removes much of the legal uncertainty that, until recently, has kept many patients alive in spite of evidence that they had no hope of recovery. Another benefit of the act, write Menikoff and colleagues, is that the law "immunizes health care professionals against liability incurred by carrying out a surrogate's decision."

The authors warn that new laws enabling surrogates to make decisions for patients may have "the unintended effect of reducing efforts to ascertain patients' wishes about end-of-life care." They suggest physicians continue to attempt "to have patients articulate their views about the issues that will need to be addressed when advance directives are completed."