



**Sociology of Health  
Care Reform: Building on  
Research and Analysis to  
Improve Health Care**

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**Abstract**

Health reform efforts in the United States have focused on resolving some of the fundamental irrationalities of the system whereby costs and services utilization are often not linked to improved patient outcomes. Sociologists have contributed to these efforts by documenting the extent of problems and by confronting central questions around issues of accountability, reimbursement, and rationing that must be addressed in order to achieve meaningful reform that controls costs, expands access, and improves quality. Major reform rarely occurs without “paying off” powerful interests, a particularly difficult challenge in the context of a large and growing deficit. Central to achieving increased coverage and access, high quality, and cost control is change in reimbursement arrangements, increased accountability for both costs and outcomes, and criteria for rationing based on the evidence and accepted as legitimate by all stakeholders. Consensus about health reform requires trust. The traditional trust patients have in physicians provides an important base on which to build.

**Keywords**

trust, illness behavior, reimbursement, physician organization, medical care utilization, managed care

From the administrations of President Truman in 1944 to the present there have been repeated efforts to bring universality and greater rationality to the American health care system. While the United States has yet to achieve universal health care coverage or a rational system that successfully links magnitude of expenditures to quality of care and improved outcomes, there have been immense changes in health policy in recent decades, from the implementation of Medicare and Medicaid, through the “rise and fall of managed care,” to the passage of significant health reform that occupied the first years of the Obama administration. These and other health reform efforts have focused on three areas: expanding access, containing costs, and improving quality (although the relative emphasis on each area has varied over time).

The American health care system is large, expensive, and complex, posing extraordinary challenges to efforts to achieve comprehensive modifications. The issues of access, cost, and quality are significantly interrelated, so that a modification of any one

aspect has implications for the others. This contributes to periods of gridlock, for example, where a vast proportion of Americans of varying political and ideological persuasions oppose excluding persons with pre-existing conditions from access to affordable insurance or from coverage continuation when their medical costs mount. Yet many of these same individuals, for political or ideological reasons, opposed an individual mandate to purchase insurance, which was required if insurance was to be made available at an acceptable and sustainable cost. Without a mandate, the healthy can remain

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uninsured until they have need for significant services, driving up the average cost for those who are insured, since risks are not being shared across a more diverse population.

Many disciplines contribute to understanding our complicated system and how it is shaped by our history, culture, ideologies, politics, economics, and social arrangements. Medical sociology has played a significant role in elucidating how economic, professional, and ideological interests influenced the way health care is organized and provided, and how major reforms have been thwarted over the years (Mechanic 2006; Quadagno 2005; Starr 1982). Over the decades, special interests have become more powerful and more sophisticated in using political donations, lobbying, and the media to curtail or shape reform efforts. At various times the United States has appeared on the threshold of major reform only to see ideological divisions, interest group politics, and a confused and fearful public disintegrate an emerging consensus (Gottschalk 2000; Mechanic 2006; Quadagno 2005; Skocpol 1997; Starr 1982). Despite significant compromises, the passage of health reform legislation in 2010 represents a major turning point in moving closer to universality and greater equity.

Typically, implementing major reform requires provision of advantageous financial arrangements for stakeholders that make it likely that costs will accelerate beyond those necessitated by expansion of eligibility and coverage, and this persists in the 2010 legislation. This pattern was evident, whether in the United States, where Medicare promised "usual and customary" reimbursement to physicians to dilute their opposition, or in England, where Aneurin Bevan, Minister of Health and an architect of the English National Health Service, co-opted the prestigious medical specialists who were opposing the plan. Bevan described: "I stuffed their mouths with gold" (Watt and Carvel 2004:1). Similar patterns have been evident in recent reform negotiations where the administration made agreements with pharmaceutical interests and other groups that facilitated their support.

The cost problem must be central in any reform debate, and this complicates the politics. Health expenditures in the United States constitute about 18 percent of gross domestic product (GDP) and are projected to reach 34 percent of GDP by 2040 in the absence of significant cost containment (Council of Economic Advisors 2009). As the largest single industry in America, health care supports the jobs, incomes, and profits of millions of

people, and those people defend their interests when health system changes threaten them. Whether considering the millions who depend on the health care system for their livelihood, or the average American who simply wants to feel confident that health care will be there for them and their families when they need it, public support for reform depends on the belief that one will not be worse off after any change. Experiences with health care reform efforts demonstrate that when people, whatever the initial support for reform, become worried that they might be worse off than before, they revert to support for the status quo. It remains to be seen how the American public eventually comes to view the reforms passed in 2010 and what changes they demand.

Medical sociologists have extensively researched many of the micro-processes characterizing how our health care system functions, including such issues as help-seeking and access, patient and physician behavior, health and illness behavior, and functioning of health care institutions. While less engaged on a day-to-day basis than economists in health policy-making, the teaching, writing, and research of medical sociologists affects the climate of thinking and how policy makers, media, opinion leaders, and members of other disciplines frame issues and solutions. Much of sociological work, for example, has broadened interest among policy makers in such important concerns as the broad determinants of health and health disparities, patient behavior and consumerism, and the influence of social networks on health.

Here we can only explore a few areas of interest and examine how they contribute to health policy. We focus on four interrelated themes about the provision of health care, but all are conditioned by a fifth all-embracing theme of the erosion of trust in medical care and how it complicates resolving many of the difficult problems inherent to health reform. Our first theme addresses some problems that arise from patterns of care-seeking, physician decision-making, and particularly the large variations in medical interventions and costs. Theme two focuses on reimbursement and examines how methods of payment may encourage too little, too much, or the wrong kinds of care. Theme three examines efforts to reduce dysfunctions by improving accountability and how this requires building the necessary organizational and physician group cultures that achieve greater alignment between evidence of effectiveness and service provision. Theme four focuses on health care allocation and the need to recognize that we now

ration care in many ways and require a more rational and equitable way for making the necessary decisions related to the issues discussed in the first three themes. The fifth, all-encompassing theme explores how difficult it is to resolve many of the problems we face when there is so little trust in many of the organizations and actors in the health care system including government.

## THEME 1. VARIATION IN UTILIZATION AND COSTS OF HEALTH CARE: SOME SYSTEM DYSFUNCTIONS

Sociological work has shown how provision of services commonly deviates from treatment based on the best scientific evidence, and often contributes to unnecessary costs. A rational health care system is one where persons in need receive care consistent with current scientific standards of quality within permissible financial conditions. Indeed, one of the most compelling findings from the last 50 years of health research that has occupied researchers in health policy, regardless of discipline, is that of the small area variations in the use and cost of services.

John Wennberg and Allan Gittelsohn (1973) first attracted considerable attention with their research on variation in utilization of services, health care resources, and expenditures in Vermont. Most recently, health reform debates have been greatly influenced by the work produced as part of the Dartmouth Atlas Project, a research program which documents the wide variation in the distribution and use of health care resources across the United States. For example, data from the Dartmouth Atlas Project (Wennberg et al. 2008) and related studies indicate that equally outstanding hospital systems treat patients with serious chronic illness at greatly varying cost and use of resources. Comparisons of hospital referral regions in the highest and lowest quintiles of per capita Medicare spending find that high spending regions have more hospital stays, physician visits, specialist referrals, imaging, and minor tests and procedures. But these additional expenditures, on average, result in no better outcomes, functional status, or patient satisfaction, and in some cases they are associated with slightly higher mortality (Wennberg et al. 2008). Although not a sociologist Wennberg, while at Johns Hopkins, was enrolled in the sociology doctoral program, gaining from the influence of James Coleman (Wennberg 2010).

He often attributes his early curiosity about variation in the use of services to his exposure to sociology: "I had read enough sociology and was aware of the overt and covert functions within systems that I came to the RMP [Regional Medical Program at Vermont] work armed with some skepticism about human behavior" (Mullan 2004:74).

Certainly, a substantial contribution of sociology has been explaining why need for care imperfectly predicts use of services. The concept of illness behavior is key. Beliefs about sickness and the perceived value of treatment, social pressures, level of disability, costs, competing demands, and much more influence decisions to seek health care (Mechanic 1978). Patients bring to the doctor-patient encounter their own assumptions about the nature of their illnesses, what constitutes good care, and expectations about the treatment they will receive. Requests for specific services such as prescriptions, referrals, or tests are common, and physicians are more likely to recommend such services when patients make the request, independent of need (Kravitz et al. 2003). Even the earliest formulation of Andersen's (1968) model of health care use recognized that provision of services was not solely driven by need. Instead, in the original model, need is one of three categories of factors predictive of service use, others being predisposing and enabling characteristics. While critics argued that the model explained too little of the variance in utilization (Mechanic 1979), it helped motivate exploration of factors beyond health status that might explain health services use. Much of the work on illness behavior and models of utilization has focused on the characteristics of individuals that explain differences in utilization. But these matter for health policy primarily to the degree that policy changes can influence illness behavior. For example, *direct-to-consumer* advertising for pharmaceuticals has rapidly increased in recent years (Donohue, Cevasco, and Rosenthal 2007) and, to the degree it increases unnecessary demand for medications, policy to curtail such practices could reduce overutilization and associated costs.

Variation in utilization of health services and cost is not driven primarily by patient demand. As long recognized, utilization is influenced by supply of professionals and resources, and by their ability to generate services. Clinical decision-making is influenced by physician characteristics such as specialty, payment, training, and practice-setting (Eisenberg 1979; McKinlay, Potter, and Feldman 1996). Indeed, Andersen's original model was modified to more explicitly include the role of

health system- and provider-level factors as predictors of health services utilization (Andersen 1995). Early work by Freidson (1970) and others called attention to the profit motive of physicians. But physicians are not the only stakeholders driving costs. Decisions by purchasers and payers shape what services are offered and the relative costs. Bradford Gray (1991) noted the ubiquitous pattern that "a service that will be paid for is a service that someone will provide" (p. 246). Variation in health care costs and utilization also is heavily driven by clinician uncertainty about diagnosis and the appropriate treatment (Wennberg, Barnes, and Zubkoff 1982). Variations in care are much larger when evidence is uncertain. The task of learning to manage uncertainty is part of the socialization of clinicians (Fox 1980); but physicians commonly deal with uncertainty through aggressive interventions and overutilization of diagnostic tests and procedures.

## THEME 2. REIMBURSEMENT IS A POWERFUL DETERMINANT OF HEALTH ORGANIZATION AND PRACTICE

Many of the recent health reform efforts focus on reimbursement because of its influence on provider behavior and the growth of health care expenditures. In the current health reform debate there has been a variety of proposals to shift from paying for number and types of services rendered to paying for episodes of care. Although new terms such as "bundling" and "paying for performance" are now popular, all involve versions of reimbursement arrangements that have existed in various forms for many decades, and in some cases for almost a century. Many of these ideas are derived from capitation or partial capitation models introduced for outpatient services provided by general practitioners under the National Insurance Act of 1911 in England (Abel-Smith 1964) and used in early industrial medical clinics and prepaid group practices in the United States (Starr 1982). There have been many instances over the years supplementing capitation in some settings to motivate provision of neglected services, a form of payment for performance.

Reimbursement arrangements are built around three core forms of payment: fee-for-service; capitation/salary; and episode payment (for example, prenatal, maternity, and postnatal care bundled together). Fee-for-service provides incentives for physicians to see more patients, work longer hours,

and make efforts to keep patients satisfied so they return, but it also encourages overutilization and the provision of unnecessary services. Capitation in many instances has had the opposite incentives, encouraging less effort, shorter work hours, and incentives for withholding some worthwhile care.

Mechanic (1974, 1975), using the same instruments in studies of primary care doctors in England and in the United States, found that general practitioners on capitation in England worked fewer hours and were less responsive to patients than fee-for-service clinicians in the United States. However, U.S. clinicians on capitation or salary behaved very much like the English general practitioners. Each form of payment may not have such perverse effects when incorporated into a well-established physician group culture with appropriate normative expectations and colleague and managerial leadership. Physicians accept whatever system they are most accustomed to if remuneration meets expectations (Glaser 1970). Payment change by itself is not a panacea for containing costs.

As the need for cost control has grown as a policy imperative there is greater attraction to capitation as an approach to moderate the aggressive interventions and high costs associated with fee-for-service. It is now understood that incentives that encourage increased volume are inefficient and do not necessarily contribute to quality. But it is essential to understand that capitation outside an organizational and cultural framework that establishes performance goals and appropriate norms can result in underuse of service and poor quality.

Health plans have long favored deductibles and co-insurance as mechanisms both to share costs and to encourage patients to consider carefully their need for care. Such cost-sharing, if significant, puts greater burden on those less affluent and inhibits worthwhile care. Research and experience indicates that while cost-sharing successfully reduces expenditures, it does not distinguish successfully between appropriate and inappropriate services (Newhouse et al. 1993). Some have advocated that especially valuable services that persons are likely to forego, such as many preventive services, should be excluded from cost-sharing, and recent health care reforms incorporate some such provisions. Clinicians make the most expensive decisions and thus addressing physician organization and accountability is the more essential focus of cost control.

HMOs and physician multi-specialty groups commonly have complex payment arrangements that build on a basic capitation or salary but adjust it

in various ways to reward productivity, seniority, quality of performance, and other group responsibilities. They may pay different professionals in varied ways depending on their capacity to handle financial risk, by the types of patients they typically serve, or by the needs for recruitment and retention of particular specialists. Risk adjustment is an essential consideration for appropriate reimbursement because providers in varying circumstances attract patients that may vary a great deal in the acuity and severity of their problems and the resources needed to treat them. Without risk adjustment, providers, as well as insurance plans, have incentives to avoid seriously sick patients. There is also little incentive without risk adjustment to be recognized as a high quality provider of services for persons with complex and serious chronic diseases because such recognition may attract more patients but without adequate and fair remuneration. Much better approaches to risk adjustment are still needed.

Efforts to reorganize services around prepaid group practice date back to the 1920s and 1930s in the United States (Starr 1982), and they continue today. There is a long history of medicine's resistance to and harassment of prepaid group practice (Starr 1982), but Kaiser-Permanente as a distinctive example evolved into an exemplary model covering some eight million members that offers enrollees an integrated system supported by a sophisticated electronic health record and team care that compares favorably on medical outcomes with competitors, and at a price that offers value for money (Enthoven and Tollen 2004; Halvorson 2007). Similar high performance, multi-specialty, integrated systems are found throughout the United States, but each evolved over many years by developing their systems of care and capacities in relation to their particular settings, and thus they can be fragile (Berkowitz and Wolff 1988; Coombs 2005). This should serve as a cautionary tale for policy makers who speak as if such high performance systems could be developed overnight and approximate comparable processes and outcomes of the most outstanding organizations (Mechanic 2010).

### **THEME 3. ACCOUNTABILITY FOR COSTS AND QUALITY REQUIRES A STRONG PROFESSIONAL CULTURE**

The Parsonsian notion of physicians having "natural" responsibility for making optimal health care decisions for their patients (Parsons 1951) contin-

ues to permeate American conceptions as well as medical culture. Much of the lobbying against health reform proposals plays to the public's worries that, with more managerial control, costs rather than patient need will primarily determine the type of health care their physicians provide. At the extreme, opponents of health reform in 2009 argued that, in the interests of cost containment, government bureaucrats operating on death panels would deny old people health care (as polls observed, more than 40% of Americans were influenced to believe the same).

The success of such fear tactics is partially attributable to wide public acceptance of physicians' professional authority over the practice of medicine. Sociologists have written eloquently of the success of physicians in maintaining such authority and the autonomy to practice medicine as they see fit, with little accountability for either costs or quality (Light 2004; Mechanic 2006; Quadagno 2005; Starr 1982). For example, as Quadagno (2005) notes, the language of the original Medicare legislation explicitly prohibited any interference by the federal government in how medicine was practiced, the compensation of providers, or the control over the administration of health care. It was not until the 1980s and 1990s, in response to rising health care costs and concerns about quality, that the control of physicians was significantly challenged.

Casalino (2004) argues that two new professional tasks emerged during the period of managed care to challenge control by physicians over the practice of medicine: constraining health care costs and ensuring quality care at the population level. Sociologists played a key role in both understanding the failure of managed care to fully accomplish either, partly a result of opposition by physicians and hospitals due to concerns about financial losses accompanying changes intended to reduce costs. Positive ways of affecting the culture and norms of medical groups, and how to use changes to support medical professionalism, are much needed (Mechanic 2008). This involves the challenging task of modifying practice cultures.

Culture represents the shared values, norms, and beliefs of a social group, as well as their emergent practices and traditions. Scott et al. (2003b) argue that the culture of an organization operates at three levels: (1) the artifacts (observable behavior); (2) beliefs and values (i.e., a belief in patient-centered care or evidence-based medicine); and (3) assumptions (for example, a medical model of illness). Much of the research attention has focused

on the first two levels, with mixed results. Part of the difficulty may be due to differences in the conceptualization and measurement of culture. Scott and colleagues (2003a) reported that in 2001 there were 13 instruments to measure the culture of health care organizations, and that number has probably continued to grow. Measures have included everything from performance under pressure to cohesiveness, making comparisons across studies difficult. Leaders of prominent medical groups emphasize four elements for an effective collaborative culture: (1) strong emphasis on mission; (2) leadership; (3) good measures of results, including clinical quality measures and appropriate feedback; and (4) tools for care coordination, operational systems support, and a strong clinical information system (Tollen 2008).

The research on the cultural characteristics of health care organizations that engage in practices that promote quality while containing costs is still emerging. Researchers have found a modest relationship between a patient-centered culture and the likelihood of larger physician organizations adopting evidence-based medical practices; but for reasons that are unclear the findings hold only for organizations with many different types of compensation incentives. Shortell and colleagues (2005) suggest that high-performing medical groups—measured as positive financial performance, delivery of high quality care, and organizational learning—are those that have a “quality-oriented culture.” Such a culture is characterized, for example, by the presence of quality improvement initiatives or having physician compensation tied to quality measures. However, it is unclear whether “quality-oriented culture” emerged prior to the use of such quality initiatives, or after. Others have found that hospitals with a culture characterized as open to change, risk, and innovation, and that promote teamwork are more likely to have adopted quality management systems, although the findings are not consistent across studies (Wardhani et al. 2009).

Other efforts have focused on the importance of context in shaping an organization’s capacity to provide responsive and high quality care while minimizing waste. Two organizational forms gaining some traction are accountable care systems (Fisher et al. 2006) and, for primary medical care, the medical home (Rittenhouse and Shortell 2009). Key to both these ideas is the assumption of responsibility and accountability for care across providers and implementation of organized processes that improve quality of care and constrain costs

(Shortell and Casalino 2008). Organizations that appear to do this successfully are the large prepaid group practices and large multi-specialty groups that provide integrated services under a variety of financial arrangements, organizations such as Kaiser-Permanente, Mayo Clinic, Cleveland Clinic, Geisinger Health System, and many others around the country (Commonwealth Fund 2009). But most physicians continue to practice in small groups and partnerships (Hing and Burt 2008) that lack the necessary capacities to be accountable in the same ways, and these organizations are typically deficient in the development of electronic health records, use of care teams to manage chronic illness, and the ability to accurately monitor the quality and efficiency of their care (Shortell and Casalino 2008).

The dilemma is how to transition to medical settings that have the needed capacities. Shortell and Casalino (2008) suggest four additional models that potentially can integrate components of the continuum of care: hospital medical staff organizations; physician hospital organizations (PHO); interdependent physician organizations; and health plan-provider networks. These alternatives involve in some way the vast majority of the nation’s physicians, but it is less certain that they will have the necessary leadership or organizational and culture-building capacities. Managed care networks, for example, have had some success in constraining costs, but most have not developed the integrated care capacities characteristic of the model multi-specialty groups. Ultimately, success depends on the capacity to integrate services at the clinical level, a difficult challenge for these health care organizations (Shortell et al. 1996).

## THEME 4. THE RHETORIC AND REALITY OF RATIONING

As any thoughtful observer understands, medical care has been rationed in many ways (Mechanic 1997, 2006). None of the protagonists of whatever persuasion is prepared publicly to discuss rationing in a meaningful way. Americans resist direct, explicit limitations on medical care, but rationing also takes place in less obvious ways on many levels. Rationing begins with coverage decisions concerning the scope of benefits and eligibility for them. At the program level, decisions are made about reimbursable providers and institutions. Related decisions include such considerations as use of formularies and payment tiers, use of gatekeepers

to specialized services, access to primary care doctors and specialists, intensity of care, and many other such managerial choices that influence coverage, access, and treatment. Rationing also occurs at the direct service level as clinicians make decisions on patient priorities, time for each, need for referral and more or less expensive interventions (Mechanic 2006).

Klein, Day, and Redmayne (1996) described at least seven types of rationing, many of which may not be transparent to the public. These include denial of access and services (for example, among persons who lack insurance or ability to prepay); rationing by selection, as when decisions to provide a specialized service are influenced by subjective assessments of likely benefit or the patient's status and influence; rationing by deflection, as when patients are sent elsewhere to avoid responsibility for care; rationing by deterrence, as when people must confront unresponsive phone systems, rude personnel, long waiting time, and dismal surroundings; rationing by delay, making it difficult to schedule an appointment in a timely way; rationing by dilution, by offering less content in the service than is reasonable or needed; and rationing by termination, as when people in distress are told that no more can be done for them and they should not return. The inclination to think of rationing solely as distribution of an unavoidably scarce supply (for example, of an organ for transplant or a limited supply of vaccine) misses the large number of policy and service decisions that determine what care people can receive.

Efforts at reform involving allocation decisions have often seen the rational discussion of alternatives sidetracked by misrepresentation and fear-mongering. This is not unexpected given the stakes for competing economic and ideological interest groups. Increasingly, we will require more sober evidence-based processes to make the many difficult decisions about what interventions are worthwhile and what their implications are for benefit design, coverage, payment policies, and the like. Given the realities of interest group activity, political campaign financing, and the disproportionate influence of many interested parties, there is need to separate many of these deliberations from usual politics.

A core issue is the role of clinical effectiveness research in making many contested determinations of what should be covered and on what basis, and how payment might vary for essential as compared with more discretionary or unproven aspects of care. While support for clinical effectiveness research is widely shared, there is disagreement on

whether cost should be considered in decision-making, and how much power should be embedded in an agency outside the usual political process. Interest groups such as health plans, pharmaceutical companies, and medical device manufacturers have good access to the political process and typically oppose delegating these powers or insulating them from political influence.

Doctors and patients also resist cost considerations in making health decisions. It is not clear how well the public understands cost-effectiveness (Beach et al. 2003), although some studies suggest that patients may be receptive to such information (Gold, Sofaer, and Siegelberg 2007). However, patients appear more willing to accept cost-effectiveness as a consideration in treatment planning when that information comes from physicians rather than the insurance company or government (Ginsburg 2004). Thus, it is likely that recommendations from any oversight agency about the comparative cost-effectiveness of treatment alternatives are likely to be greeted with skepticism or mistrust unless accepted by physicians. So far, physicians have not accepted cost containment as part of their responsibility in making medical decisions. In a recent national survey, more than half of physicians had a moral objection to using cost-effectiveness data when deciding what treatment alternatives to offer patients (Antiel et al. 2009). Further, when given cost-effectiveness information, many do not change their treatment decisions (Asch, Hershey, and Ubel 2003). Without some consensus about who has jurisdiction for making claims about what is quality medical care, or cost-effective care, it will continue to be difficult to change physicians' behaviors or gain broad public acceptance.

There are, of course, difficult dilemmas in implementing evidence-based recommendations based largely on results from controlled clinical trials. As practitioners commonly note, the eligibility criteria for controlled clinical trials often exclude patients commonly seen in community practice who may be more likely to have additional illnesses and complications, different cultural preferences, or very different life circumstances. Moreover, as Eliot Freidson (1970) so effectively described in his classic work, physicians continue to feel strongly about their clinical autonomy, responsibility, and judgment in relation to the individuality of each patient. What may be optimal for the *average* patient may not be appropriate for a *specific* patient with unique circumstances. Thus, it is important to protect physician discretion while also holding doctors accountable for the

appropriateness of their decisions, as judged by their peers and physician management of large medical groups (Daniels and Sabin 2002; Freidson 1975).

## THEME 5. HOW LACK OF TRUST MAKES REFORMS DIFFICULT

Medical theory and practice has been built around the idea of a continuing personal relationship with a physician or medical team who take holistic responsibility for coordinating the patient's needs, a concept that primary care struggles to maintain and which policy makers seek to reestablish through medical homes and other enhanced supports. The glue maintaining cohesion in primary networks and small groups is the continuing associations and reciprocity that contribute to interpersonal trust. Such primary relationships are the building blocks of cooperation and loyalty. Complex societies, however, require participation in large and more impersonal organizations where one's fate is less dependent on a history of personal associations with known persons and where maintaining impersonal trust is more problematic (Shapiro 1987).

Medical care has changed in many ways, and it is not atypical for a seriously ill patient to deal with many unfamiliar doctors and medical institutions. For example, a recent study found that a primary care doctor treating Medicare patients typically has to coordinate with 229 other physicians in 117 practices who are involved in the care of their patients (Pham et al. 2009). Surveys in recent decades document a large erosion in confidence in medical leaders and institutions, but trust in one's personal physician, for those who have one, although suffering some erosion, has remained impressively high. Patients continue to trust their personal physicians more than any other authority, including governmental expert panels, performance ratings, employer human resource divisions, and media. But as third parties have become more prevalent in medical determinations, and particularly managed care, patients are more uncertain about how much they can trust even their personal physicians. This is illustrated in a survey by the National Opinion Research Center in which respondents were given a detailed vignette of a patient reporting headaches. After a complete examination, the doctor in the vignette tells the patient that the headaches were probably due to stress, and subsequently the patient requests an

MRI. In the vignette the physician acknowledges the patient's worries and the fact that some patients are unsure about cost affecting such decisions, and explains why an MRI is not needed. When asked if they would trust the doctor to put their health above costs, 30 percent expressed little or no trust, but only 13 percent said they would trust completely; 26 percent responded mostly, and 29 percent responded somewhat (Mechanic 2006).

Research across sectors finds many factors have contributed to an erosion of trust in social institutions, including the vast availability of conflicting information, evidence of institutional malfeasance, and erosion of confidence in expert authority more generally (Inglehart 1997; Mechanic 1996, 1998). Given the low prevalence of impersonal trust in medical institutions and authorities, and ideological and political polarization around trust in government and many entities in the private and nonprofit sectors, forging consensus on the range and limits of publicly financed health care will remain difficult. The firestorm in 2009 following recommendations of a nonpolitical preventive task force on mammograms is indicative of the challenges we face. As a general principle, success will have to build on the reservoir of interpersonal trust in physicians (Roter and Hall 2006) and the kind of person-centered care, effective communication, and patient participation in decision-making that builds trust.

No single intervention can build the type of trust needed to set fair limits. However, various elements that contribute to effective care and accountability—such as good access, continuity of care, effective use of electronic health records, transparency of decision-making with involvement of patients, improved management of chronic disease, and elimination of conflicts of interest—provide the context for building trust consistent with credible and just decisions (Daniels and Sabin 2002). This, like many of the other challenges we have reviewed, is a continuing agenda.

## THE POLICY PATH FORWARD AND NEEDED FUTURE RESEARCH

Considering the challenges of health reform may lead to the inescapable and perhaps pessimistic conclusion that there is little prospect of solving the health care cost problem without significantly transforming our health care system and public viewpoints. Some believe that money spent on medical care is money well spent, even with all of its inefficiencies,



and accept having considerably more of GNP and government budgets allocated to our health care. Others see health care costs constraining development of other valued goals and services in education, culture, infrastructure, public transportation, and environmental remediation, and they look with great concern on uncontrolled medical care growth and the fact that we spend so much more than other developed countries where there is reasonably comprehensive health coverage. We appear to get little value for these added expenditures.

Greater alignment between evidence of what works and the provision of services is key to serious health reform. Achieving this will require much greater trust than is presently apparent. There is growing consensus among experts that such a process, protected from everyday politics, is needed to receive input from interested parties, to objectively review the evidence, and to provide guidance at least to government health programs. To succeed, the process chosen must have legitimacy with the public. It must be open and adaptive to new evidence, perceived as politically neutral and fair, and committed to revised judgments and recommendations in a timely way when the facts warrant. With sufficient credibility, it is likely that many private health plans would follow the federal lead. This mechanism could serve as a source of guidance about the comparative cost-effectiveness of alternative treatments, although at present there is significant resistance to considering cost as part of the effectiveness evaluation, and much rhetoric about government restrictions on care.

New reimbursement structures are needed to achieve greater parity among essential components of health care services, particularly primary and specialist care. This is needed in order to discourage misuse of technology to generate income, to promote chronic care management, and to generally improve the quality of care and reduce medical and hospital error. Some of the "pay-for-performance" ideas now being launched have potential. But if pay-for-performance is to be a serious inducement, it must reflect agreement among a number of payers on goals and incentives, so as to have a large enough impact on professional and hospital reimbursement to change behavior. Moreover, the measures must be sufficiently broad and diverse to discourage neglect of aspects of care not measured.

Successfully carrying out many desired objectives to improve quality and manage illness effectively will require expeditious adoption of appropriate information technology (IT) and electronic health records. Realistically implementing a national IT system requires a large commitment over many

years (Hillestad et al. 2005), but the Obama Administration is already aggressively pursuing this goal.

Reforming health care is an iterative process involving hundreds if not thousands of issues that need attention. No single group, however expert, can design or anticipate all of these complexities. Health reform is primarily a framework for coverage, financing, and regulation, but a great deal of detail must follow, involving many participants and much additional research. The most effective way to control costs is to have a budgetary commitment to maintaining a particular level of growth, but this is obviously politically difficult. Restraining increases that have continued to exceed growth in the economy overall will require strong efforts and political discipline in balancing many competing desires, needs, and priorities. It is no easy task to achieve budgetary discipline while improving access and quality of care.

Sociological conceptualizations and research will continue to contribute in each of these areas in cooperation with other disciplines. A major research challenge that is distinctly sociological is advancing understanding on how to build accountable care organizations within reasonable economic constraints with strong structures and norms that facilitate high quality care and a high level of professionalism. Such organizations will need to be adaptive, open to new knowledge and innovations and our growing cultural diversity. Physicians and nurses presently report great dissatisfaction with the chaotic organizations and care environments where they work (Linzer et al. 2009; Pellico, Brewer, and Kovner 2009). It is difficult to meet our aspirations if those who provide the bulk of care are dispirited, resentful, and disengaged. Much careful study is needed on how to appropriately prepare health professionals for future medical care, how to structure work and teams that are efficient and effective but also professionally gratifying, and how to develop organizational cultures that function well for both patients and clinicians.

A major difficulty in each of the areas we have reviewed is the abundance of claims for which there is much uncertainty and little evidence. The American health system is fertile with innovative ideas about successful medical organization, better reimbursement arrangements, effective incentives for improving clinician performance and institutional safety, and approaches to accountability and more equitable allocation determinations. However, the research by medical sociologists and others typically fails to support the glowing presentations of advocates. The reality is that these innovations often fail, typically have only small or

uneven effects, often are not sustained over time when found promising, and are difficult to translate or replicate. Usually, as we have noted, the literature provides a complex and mixed picture.

The fact is that we are studying complex systems and interventions and our usual methodologies are often inadequate to the task of capturing or controlling the many contingencies. For example, while there have been many studies of managed care organizations, they yield disparate results depending on unmeasured but crucial organizational variations. It is common in the industry to assert that, "if you know one managed care organization, you know one managed care organization." Similarly, in studying the culture of medical groups and hospitals, or what makes particular organizations exemplary, we often fail to capture key variables and processes that might explain large variations. We need better understanding, for example, of why medical organizations such as Kaiser-Permanente, whose culture and management processes have had such success in California and the Pacific coast, have been so difficult to transplant in the Northeast.

This problem is quite typical of much health policy research. Perhaps the most important and the largest health policy study ever done, the RAND Health Insurance Experiment (Newhouse and the Insurance Experiment Group 1993), with a cost exceeding \$100 million, was an invaluable study of co-insurance, but it was promoted by policy makers and others as a test of national health insurance. The randomized study design, however, made it impossible to understand what would happen to community delivery systems if everyone had comparable insurance coverage, a key policy question. Even the massive literature of micro studies of insurance and medical care utilization typically provides only a crude and incomplete understanding because most studies fail to specify the co-insurance arrangements that greatly affect how people make decisions to seek care. This has especially been a problem with mental health because a measure of whether individuals had private, public, or no insurance conveys too little information about mental health coverage and financial barriers to seeking care.

We need to develop better approaches and methodologies for studying and understanding complex systems and processes because the key components are highly sensitive to changes in other parts of the system. This is particularly the case in studying health care organizations and associated professional culture and norms, all of which are impacted not only by internal leadership and

managerial capacities but by external incentives and regulations such as reimbursement arrangements, legal requirements, the ability to attract high quality personnel, and competition in its market areas. Such studies require multiple methods and careful triangulation of varying kinds of data.

As we have suggested, trust is the glue necessary for well-functioning systems, and many of the problems and failures in health care both contribute to and result from its erosion. When trust fails, greater regulation, a substitute for trust, becomes essential, but too much regulation is inefficient and dampens morale and motivation. While trust should be thoughtfully given, and is commonly abused, the bedrock of medical care for decades has been the high opinion most patients have of their personal physicians. It is important to understand how the residue of physician trust can be mobilized to address many of the problems we have considered. Physicians resent what they fear as a loss of autonomy and clinical discretion. When resentful and dispirited they have the ability to undermine reform efforts and agitate the public, as they did in leading the backlash against managed care. Physician discretion has much value and should be protected, but it must be embedded within organizational culture and structures that are transparent and accountable. How this will be achieved remains an important research challenge.

The high level of trust the public has for their individual physicians and the concomitant power physicians have in shaping health reform debates is fragile and not inevitable. Medicare passed, despite the opposition of the American Medical Association, and it eventually gained wide acceptance even from groups that were once its most vocal critics. Competing interests, such as health plans, hospitals, employers, and health technology and pharmaceutical companies, must also be appeased in the current climate. There are many thoughtful proposals for a more rational health care system, but the challenge is in our politics, not in our imagination. The health reform legislation passed in 2010 is a massive change with many important advances and opportunities. These modifications are not fully comprehensive or efficient, but we will have to muddle through as we go and iteratively build coalitions to implement further needed changes in covering the uninsured, cost control, reimbursement, and regulatory processes (Mechanic 2006). While at this time polarization and distrust are at high levels, building the needed organizational structures and norms will require renewal of more trustful and cooperative efforts.

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