

The Administrative Capture of American Medicine

A Clinical Assessment of Managed Care's Impact on Medical Practice, 1973–2025

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August 2026

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1. Purpose and Scope

This document serves as a clinical supplement to the campaign's existing research paper on the Health Maintenance Organization (HMO) Act of 1973 (Public Law 93-222). Where the primary paper addresses the legislative origins, structural mechanisms, and political economy of the Act, this assessment presents a quantified examination of the Act's downstream effects on clinical practice environments, professional workforce allocation, and patient access across the fifty-two years since its passage.

Every figure presented here is drawn from published, peer-reviewed literature or from official data products of the organizations cited. Where two measurement instruments produce different figures for the same metric, both are reported and the methodological distinction is noted. Where a data point reflects a survey year that differs from its publication year, the survey year governs the attribution.

2. Structural Realignment of Healthcare Delivery Infrastructure

The HMO Act of 1973 initiated a structural shift in American healthcare delivery by incentivizing the transition from inpatient to outpatient care models and replacing fee-for-service reimbursement with prepaid capitation [1], [2]. To evaluate the scale of this transformation, baseline metrics from the mid-1970s are contrasted against the most recent available survey data.

2.1 Institutional Contraction

The American Hospital Association (AHA) reports that the total number of U.S. hospitals peaked at 7,174 institutions in 1974 [3]. By fiscal year 2024, the most recent AHA Annual Survey (published as Fast Facts on U.S. Hospitals, 2026) reports 6,093 active hospitals: a net reduction of 1,081 institutions, or 15.1% [4]. Over the same period, the U.S. population expanded from approximately 213.9 million to an estimated 341.8 million, an increase of 59.8% [5]. Per capita hospital availability therefore contracted from approximately 3.35 hospitals per 100,000 population to 1.78 per 100,000: a 46.9% per capita reduction [3], [4], [5].

2.2 The Inpatient Bed Capacity Deficit

Hospital bed capacity tells a sharper and more consequential story. In the mid-1970s, the United States maintained approximately 6.8 staffed inpatient beds per 1,000 population [3]. By the decade preceding the COVID-19 pandemic, that figure had fallen to approximately 2.4 per 1,000, based on a national steady-state average of approximately 802,000 staffed beds across a population of roughly 328 million (2009–2019 mean): a decline of 64.7% in per capita capacity [6]. In the post-pandemic period, staffed bed capacity

contracted further to a new steady state of approximately 674,000 beds, or roughly 2.0 per 1,000 population: a 16.0% reduction from the pre-pandemic steady state and a total decline of 70.6% from the mid-1970s baseline [6].

Some portion of this decline was clinically appropriate. Advances in minimally invasive surgical technique, modern anesthesia protocols, and improved pharmacology have made many procedures safely performable in outpatient or same-day settings that once required multi-day inpatient stays. An honest accounting credits this progress.

But the system has now overshot what those advances justify. A 2025 UCLA health policy analysis projects that, without either a 10% increase in staffed beds or a 10% reduction in hospitalization rates, national hospital occupancy will reach the 85% threshold, which is the level that international health policy experts associate with a systemic hospital bed shortage, by 2032 [6]. A capacity crisis six years away is not a theoretical concern; it is a planning failure with a deadline. The contraction that began as appropriate modernization has become a measurable capacity deficit, and an aging population will only accelerate the timeline.

2.3 Professional Workforce Expansion

In direct contrast to the contraction of physical infrastructure, the physician workforce expanded substantially. CDC/NCHS data (Health, United States series) reports 310,845 active doctors of medicine in the United States in 1970, rising to 414,916 by 1980; a 33.5% increase in a single decade [7]. By 1975, the physician-to-population ratio stood at 153 active physicians per 100,000 civilian population [8].

By 2024, the AAMC reports 1,032,365 active physicians (both MDs and DOs), corresponding to 304 active physicians per 100,000 population; a 98.7% increase in the number of doctors per patient since the mid-1970s [9].

2.4 The Infrastructure-Workforce Divergence

The structural picture is now complete, and the paradox it presents is stark. Per capita hospital availability contracted by 46.9%, and per capita inpatient bed capacity contracted by 70.6%, past the point of adequacy toward a projected shortage [3], [4], [6]. Simultaneously, the number of doctors per patient increased by 98.7% [8], [9]. Under standard labor-market assumptions, a 98.7% increase in physician supply should have produced an environment of increasing appointment availability, longer clinical encounters, and reduced production pressure on individual providers.

As documented in the sections that follow, the opposite occurred; not because the supply of clinicians was insufficient, but because a growing share of each clinician's working day was consumed by administrative functions that did not exist in 1973.

3. The Administrative Consumption of Clinical Time

The central operational impact of the managed care era on clinical practice is not, as is sometimes claimed, a reduction in total visit duration. National Ambulatory Medical Care Survey (NAMCS) data, analyzed by Landon et al. in the Journal of General Internal Medicine (2023), shows that average U.S. primary care visit times actually increased by 33.1%, from 17.2 minutes in 2001 to 22.9 minutes in 2016 [10]. A 2024 AMA study summary found that primary care visits were typically scheduled for 30 minutes [11].

The real transformation is in what happens during and around the visit: specifically, the proportion of the physician's total workday that is consumed by electronic health record (EHR) documentation, billing compliance, and insurance administration rather than direct patient engagement.

3.1 The Sinsky Time-Motion Findings

The landmark time-motion study by Sinsky et al., published in the Annals of Internal Medicine in 2016, directly observed 57 physicians across four specialties (family medicine, internal medicine, cardiology, and orthopedics) for 430 hours [12]. The findings documented a profound misallocation of physician effort:

During the office day, physicians spent 27.0% of their total time on direct clinical face-to-face engagement with patients and 49.2% of their time on EHR and desk work [12]. Even while physically present in the examination room with a patient, physicians spent 37.0% of that room time interacting with the EHR rather than the patient [12]. The study concluded that for every one hour of direct clinical face time, physicians spent approximately two additional hours on EHR and desk work; a ratio of roughly 33% direct care to 67% administrative activity across the clinical workday [12].

A follow-up study by Arndt et al. in Annals of Family Medicine (2017), using EHR event-log data from 142 family medicine physicians, validated against direct observation, quantified the daily burden further: physicians spent an average of 5.9 hours per 11.4-hour workday in the EHR (51.8% of the workday), of which 4.5 hours (39.5%) fell during clinic hours and an additional 1.4 hours (12.3%) fell after clinic hours [13]. Clerical and administrative tasks, including documentation, order entry, billing and coding, and system security, accounted for 44.2% of total EHR usage time [13].

3.2 The Source of the Administrative Burden

This administrative architecture did not emerge solely from the HMO Act of 1973. The managed care framework that the Act established created the structural logic of utilization review, gatekeeper protocols, and capitated payment. But the specific documentation burden that dominates modern physician time allocation is the product of a sequence of subsequent federal actions:

The Employee Retirement Income Security Act of 1974 (ERISA) pre-empted state regulation of employer-sponsored health plans, effectively shielding managed care organizations from state-level tort accountability and accelerating their market penetration [14].

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and the associated Meaningful Use incentive program created federal financial incentives, and ultimately penalties, for EHR adoption, driving the transition from paper-based charting to electronic documentation systems [15]. While EHR adoption offered genuine clinical benefits in data accessibility and care coordination, the documentation requirements that Meaningful Use criteria imposed significantly expanded the volume of per-encounter clerical work.

The Merit-based Incentive Payment System (MIPS) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) layered additional quality-reporting metrics onto physician practice, further expanding the non-clinical administrative workload [16].

The HMO Act provided the structural foundation; these subsequent enactments built the administrative superstructure. A comprehensive legislative reform strategy must address the full architectural stack, not merely its 1973 cornerstone.

4. Prior Authorization: The Administrative Chokepoint

No single managed care mechanism has drawn more sustained opposition from the clinical community than prior authorization (PA): the requirement that physicians obtain advance insurer approval before delivering prescribed treatments, procedures, or medications.

4.1 Scale and Burden

The AMA conducts an annual nationwide survey of practicing physicians on prior authorization. The 2024 survey, fielded in December 2024 among 1,000 practicing physicians, found that physician practices complete an average of 39 prior authorization requests per physician per week, consuming an average of 13 hours of physician and staff time weekly [17]. 40% of surveyed practices employ staff dedicated exclusively to prior authorization tasks [17].

The 2025 AMA Prior Authorization Physician Survey, fielded in December 2025 among 1,000 physicians, confirmed the persistence of these burdens: physicians completed an average of 40 prior authorizations per week, still consuming approximately 13 hours weekly [18]. 94% of physicians reported that prior authorization contributes to burnout; 74% reported that denial rates had increased over the preceding five years; and 60% expressed concern that insurer use of artificial intelligence is further increasing denial rates [18].

4.2 Patient Impact

The clinical consequences of prior authorization delays are documented across multiple surveys and specialties. In the 2024 AMA survey, 93% of physicians reported that prior authorization delays patient care at least some of the time; 82% reported that patients sometimes abandon recommended treatment due to prior authorization barriers; and 29% reported that prior authorization had led to a serious adverse event for a patient, including hospitalization (23%), life-threatening events (18%), and permanent damage, disability, or death (8%) [17], [19].

4.3 Oncology: A Case Study in Clinical Harm

The impact of prior authorization on cancer treatment has been documented by the American Society of Clinical Oncology (ASCO), the American Society for Radiation Oncology (ASTRO), and the American Cancer Society Cancer Action Network (ACS CAN).

An ASTRO survey of more than 750 radiation oncologists, conducted in September and October 2024, found that 54% of respondents reported that more than 50% of their cases require prior authorization, up from 44% in 2019 [20], [21]. 90% reported treatment delays attributable to prior authorization, with more than 50% of those delays lasting five days or longer [20]. 85% reported that their prior authorization burden had increased in the preceding three years [20]. 7% linked prior authorization directly to patient deaths, and 58% reported being forced to deviate from treatment plans that national clinical guidelines supported [20], [21]. 73% of denials were ultimately overturned on appeal [20].

An ASCO study presented at the 2025 Quality Care Symposium, which surveyed cancer patients treated between 2022 and 2024, found that 75% of patients with cancer had to undergo at least one prior authorization process [22]. In 50% of those cases, patients and their families had to personally intervene in the authorization process beyond their physicians' efforts, resulting in additional treatment delays, financial strain, and psychological distress [22].

ACS CAN survey data has shown that 34% of cancer patients and 56% of oncologists reported waiting for insurance plan approval of a cancer treatment, test, or prescription drug due to utilization management policies, resulting in delayed care [23]. 96% of oncologists surveyed had encountered prior authorization requirements [23].

5. The Failure of Cost Containment

The HMO Act of 1973 was sold to the American public on a single foundational promise: that restructuring healthcare delivery around managed care would control the nation's healthcare costs. The empirical record over the subsequent fifty-four years is unambiguous. It did not.

5.1 Healthcare Spending Outpaced Economic Growth by a Factor of Nearly Three

In 1970, U.S. nominal GDP stood at approximately \$1.07 trillion [24]. By 2024, nominal GDP had reached \$29.18 trillion; an increase of approximately 2,627% [25]. Over the same period, national health expenditure grew from approximately \$74 billion (6.9% of GDP) to \$5.3 trillion (18.0% of GDP); an increase of approximately 7,062% [26], [27].

For every dollar the American economy grew between 1970 and 2024, healthcare spending grew approximately \$2.65. Rising healthcare costs did not merely keep pace with the economy; they outran economic growth by a factor of 2.65, across a period during which managed care became the dominant payment paradigm in American medicine [24], [25], [26], [27]. Managed care did not "contain" costs; it increased them. Disastrously.

5.2 Where the Money Goes

The administrative burden, documented at the physician-practice level in Sections 3 and 4, aggregates to a staggering system-wide cost. A 2022 Health Affairs analysis reviewed published estimates and found that billing and insurance-related administrative spending accounts for between 15% and 30% of total U.S. healthcare expenditure, depending on the scope of costs included [28]. Even at the 15% lower bound, the authors noted, U.S. administrative spending annually exceeds 200% of the total spending on cardiovascular disease care and 300% of the total spending on cancer care [28].

The American Hospital Association's 2026 Costs of Caring report provides the most recent institutional-level data. Drawing on its Annual Survey, the AHA estimated that hospitals spent \$43 billion in 2025 attempting to collect payments that insurers owed for care already delivered [29]. Of that \$43 billion, \$18 billion (41.9%) was spent specifically on overturning claims that were initially denied [29]. In 2024, the average hospital employed approximately 64 administrative and billing staff dedicated to payer-related functions; approximately 6.5% of total hospital employment [29].

The system that was designed to contain costs now spends more on arguing with itself than many nations spend on healthcare in total.

6. Professional Burnout: Quantified Trajectories

The World Health Organization, in the 11th Revision of the International Classification of Diseases (ICD-11), classifies burnout as an occupational phenomenon (code QD85) resulting from chronic workplace stress that has not been successfully managed [37]. It is characterized by three recognized symptom dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's work, or feelings of negativism or cynicism related to one's work; and reduced professional efficacy, manifesting as a sense of

ineffectiveness and lack of accomplishment [37]. The WHO classification specifically designates burnout as an occupational phenomenon rather than a medical condition, placing the analytical focus on the work environment rather than the individual [37]. The AMA's vice president of professional satisfaction, Christine Sinsky (the same researcher whose time-motion study is cited in Section 3), has noted that burnout "is primarily related to the environment, such as when there is a mismatch between the workload and the resources needed to do the work in a meaningful way" [38].

The cumulative effect of administrative burden on physician well-being has been tracked through two distinct longitudinal measurement programs. These are separate instruments with different methodologies and respondent pools; both are reported here, and the distinction matters.

6.1 The Mayo Clinic/AMA/Stanford Triennial Survey

Since 2011, researchers from the AMA, Mayo Clinic, and Stanford Medicine have conducted triennial surveys of physician burnout published in peer-reviewed journals (Mayo Clinic Proceedings). The most recent study in this series reported that 45.2% of physicians experienced at least one symptom of burnout in 2023, compared to 62.8% in 2021, 38.2% in 2020, 43.9% in 2017, 54.4% in 2014, and 45.5% in 2011 [30].

6.2 The AMA Organizational Biopsy

The AMA also administers an annual survey through its Organizational Biopsy program, which collects data from participating health systems. This separate instrument reported burnout at 48.2% in 2023, 43.2% in 2024, and 41.9% in 2025, based on nearly 19,000 physician responses across 38 states and 106 health systems [31], [32].

Both instruments converge on the same directional finding: after peaking during the acute phase of the COVID-19 pandemic, burnout rates have declined but remain elevated, with approximately 42% to 45% of physicians reporting at least one symptom of burnout depending on the instrument. That approximately 42% of the most highly trained professionals in America report symptoms of systemic exhaustion, moral injury, or depersonalization is not a human resources problem; it is a structural indictment of the practice environment into which those professionals have been placed [32].

6.3 Specialty-Level Variation (2025 AMA Organizational Biopsy)

Burnout is not distributed evenly across medical specialties. The 2025 AMA data identified the highest reported burnout rates in emergency medicine (49.8%), urological surgery (49.5%), hematology/oncology (49.3%), obstetrics and gynecology (45.7%), radiology (45.2%), family medicine (45.0%), general surgery (43.8%), cardiology (43.5%), and gastroenterology (43.5%) [33].

At the other end of the spectrum, the lowest burnout rates were reported in infectious diseases (23.3%), ophthalmology (25.8%), pathology (28.3%), nephrology (29.3%), dermatology (31.5%), and psychiatry (31.6%) [33].

The pattern is instructive. Hospital-based specialties, including emergency medicine, radiology, and anesthesiology, performed worse than the overall benchmark on 60% of well-being indicators (three of five measured), pointing to persistent operational workflow and staffing challenges in acute care settings [32], [33]. The specialties with the lowest burnout rates tend to be those with the least interference from healthcare "managers" and insurance companies; where the insurance bureaucracy's reach is shortest, physicians report the least exhaustion.

7. Major Medical Organization Positions

7.1 The American Medical Association

The AMA has maintained active policy opposition to the harms of managed care utilization management since the Act's passage. AMA Directive H-285.998 ("Managed Care") establishes that all health plans that utilize managed care techniques should be subject to legal action for any harm to patients resulting from the application of such techniques [34]. The policy requires that public and private payers disclose their screening and review criteria, weighting elements, and computer algorithms to physicians on request [34]. It mandates that a physician of the same specialty must be involved in any utilization management decision to deny or reduce coverage for services based on questions of medical necessity [34].

A separate policy, H-285.939 ("Managed Care Medical Director Liability"), seeks to subject medical directors of managed care organizations to state medical licensing requirements and disciplinary review, and to hold them accountable and liable for medical decisions regarding contractually covered services [35].

7.2 The American Society of Clinical Oncology and ASTRO

ASCO has issued formal position statements that characterize prior authorization as a threat to timely cancer treatment [36]. Its 2022 survey data found that nearly 100% of oncology providers reported prior authorization causing delayed care, and the organization has advocated for the Improving Seniors' Timely Access to Care Act to reform prior authorization processes in Medicare Advantage [36].

ASTRO's data demonstrates that radiation oncology faces the greatest prior authorization burden of any medical specialty, with 54% of radiation oncologists reporting that more than 50% of their caseload requires prior authorization [20]. The finding that 73% of denials are overturned on appeal is particularly significant for policy argumentation: the majority of

prior authorization denials do not reflect legitimate clinical disagreements [20]. They are administrative friction, pure and simple; friction that delays care without improving outcomes.

7.3 The American Hospital Association

The AHA's 2026 Costs of Caring report provides system-level quantification of the administrative burden [29]. The finding that hospitals employed an average of 64 administrative and billing staff per institution (approximately 6.5% of total hospital employment) dedicated to payer-related functions, and that the system collectively spent \$43 billion in a single year chasing insurer payments, proves that the "business" of medicine has grown far beyond any plausible cost-containment justification, and has itself become the core of our current problems [29].

8. What Managed Care Got Right; and Where It Crossed the Line

A rigorous assessment requires acknowledging the problems that the HMO Act was designed to address. Prior to the managed care era, the fee-for-service system created well-documented incentives toward over-utilization: unnecessary surgical procedures, excessive diagnostic testing, and extended inpatient stays that served provider revenue rather than patient outcomes [1], [2]. The managed care model's emphasis on evidence-based protocols, preventive care coverage, and utilization review did produce measurable reductions in medically unnecessary interventions in certain clinical domains. That was the legitimate purpose, and where the system accomplished it, the accomplishment deserves acknowledgment.

The critical distinction, for policy purposes, is between utilization review that prevents genuinely unnecessary procedures and utilization management that delays or denies medically necessary care. The clinical evidence assembled in this assessment documents that the system has crossed decisively from the former into the latter. When \$43 billion per year is spent on administrative collection activities in a single sector [29]; when 73% of prior authorization denials in radiation oncology are overturned on appeal [20]; when 93% of physicians report that prior authorization delays patient care [17]; when 58% of oncologists report being forced to deviate from national clinical guidelines [20]; when the administrative apparatus consumes 49.2% of a physician's office day for every 27.0% spent with a patient [12]: the cost-containment rationale no longer justifies the operational reality.

The system was built to stop waste. It has become the waste.

9. Strategic Synthesis for Legislative Reform

The clinical evidence assembled in this assessment supports four principal lines of argument for comprehensive legislative reform of the managed care architecture.

First, the administrative burden must be addressed as a clinical safety issue, not merely a cost issue. When 29% of physicians report serious adverse events, including patient deaths, attributable to prior authorization [17], [19], and when 58% of oncologists report being forced to deviate from evidence-based treatment guidelines [20], the system is producing measurable patient harm. Reform legislation should establish binding timelines for authorization decisions, require same-specialty clinical review of all denials, and impose liability on payers for documented harms resulting from administrative delays.

Second, the multi-causal legislative architecture requires comprehensive reform, not single-statute repeal. The HMO Act of 1973 created the structural incentives [1]; ERISA shielded managed care from accountability [14]; HITECH and Meaningful Use imposed the documentation burden [15]; MIPS/MACRA layered additional reporting requirements [16]. An effective reform package must address the full stack: restoring state-level regulatory authority over health plans (ERISA reform), rationalizing EHR documentation requirements to clinical necessity rather than billing compliance, and restructuring quality reporting to reduce the administrative tax on clinical practice.

Third, the cost-containment argument for managed care has been empirically falsified. For every dollar the American economy grew between 1970 and 2024, healthcare spending grew \$2.65 [24], [25], [26], [27]. The system that was designed to control costs now spends \$43 billion per year in hospitals alone on administrative collection activities; of that \$43 billion, \$18 billion per year goes to overturning its own denials [29]. Reform is not a return to uncontrolled spending; it is the elimination of a cost-containment mechanism that manifestly failed to contain costs while imposing substantial clinical harm.

Fourth, the physician workforce expansion has been administratively captured. The number of doctors per patient increased by 98.7% between the mid-1970s and 2024, from 153 to 304 physicians per 100,000 population [8], [9]. That expansion should have produced substantial gains in clinical capacity and access. Instead, time-motion data documents that 49.2% of the physician office day is consumed by EHR and desk work, while only 27.0% is spent in direct patient contact [12]. The legislative strategy can frame reform as an act of liberation: freeing the clinical capacity that already exists but is currently locked inside an administrative apparatus.

Glossary

Capitation. A payment model in which a healthcare provider receives a fixed amount per enrolled patient per month (Per Member Per Month, or PMPM), regardless of the volume or cost of services actually delivered.

Electronic Health Record (EHR). A digital system for recording, storing, and retrieving patient medical information, mandated for widespread adoption by the HITECH Act of 2009.

ERISA Pre-emption. The doctrine under the Employee Retirement Income Security Act of 1974 by which federal law overrides state regulation of employer-sponsored health plans, effectively shielding managed care organizations from state-level tort liability.

Fee-for-Service. The traditional payment model in which providers bill separately for each service, procedure, or encounter delivered.

Managed Care. A system of healthcare delivery that integrates financing and clinical services under corporate management, using utilization controls, network restrictions, and capitated payment to constrain costs.

Meaningful Use. A set of federal standards under the HITECH Act defining the minimum requirements for EHR adoption, compliance with which determined eligibility for financial incentives or penalties.

Medical Loss Ratio (MLR). The percentage of health insurance premium revenue that an insurer spends on actual medical care, as opposed to administration, marketing, and profit.

MIPS (Merit-based Incentive Payment System). A quality-reporting program under MACRA (2015) that adjusts Medicare physician payments based on performance across quality, cost, improvement activities, and promoting interoperability measures.

Prior Authorization. A utilization management requirement under which a physician must obtain advance approval from an insurer before delivering a prescribed treatment, procedure, or medication.

Professional Burnout. An occupational phenomenon classified by the WHO under ICD-11 (code QD85), characterized by energy depletion or exhaustion, increased mental distance or cynicism toward work, and reduced professional efficacy.

Utilization Review / Utilization Management. The process by which insurers evaluate the medical necessity, appropriateness, and efficiency of healthcare services, including prospective review (prior authorization), concurrent review, and retrospective review.

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