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Sunday E. Ubokudom

United States Health Care Policymaking

Ideological, Social and Cultural
Differences and Major Influences

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Ideological, Social and Cultural Differences
and Major Influences

Sunday E. Ubokudom
Political Science and Public Administration
University of Toledo
Toledo, OH, USA

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Preface

I started teaching health care-related courses at the beginning of the 1993–1994 academic year. Prior to joining the academic field, I held various technical and administrative positions in Kansas in a city-county health department laboratory, a private biomedical laboratory, a section of a State health department with responsibility for water quality assessment, and a State Medicaid agency. The experience I gained in these positions, in addition to my undergraduate training in the biological sciences, was invaluable when I focused my graduate training on public administration, public policy, and health care policy and administration. After completing my graduate education, I was given the opportunity to return to the Kansas Medicaid agency as a health program analyst. I chose, instead, to change careers and seek an academic position.

Since the time I started teaching health care-related courses, I have been privileged to use a variety of very well-written textbooks. These books have served me well over the years and are referenced throughout the chapters of this book. However, after watching the debate and controversies surrounding the Obama administration's Patient Protection and Affordable Care Act (PPACA) of 2010, it became apparent to me that important new dimensions should be incorporated in the teaching of health care policy in the United States.

The controversies surrounding the PPACA are not due to the fact that most lawmakers and members of the population oppose health system reform. To the contrary, there is widespread agreement that major reforms are needed. Some of the controversies and lawsuits challenging the PPACA stem from disagreements about what types of reforms should be enacted and who should lead the reform process. Some of the controversies are due to how differently people and groups frame the problems besetting the health care system. And, some of the issues that generate controversies include federalism, the division of responsibility among the national and state governments, ideological and political differences between the two major political parties, including whether the nation should employ public or private market-based approaches to solve the problems of the health care system, etc.

The books that have been published in this subject area can be divided into two categories, health care delivery and health care policy. The books in the first category deal with clinical matters or the organization and operation of the health care system. By contrast, the books in the second category, health policy, deal with the choices that are made in the legislative, executive, and judicial branches of government in pursuit of health. Health policies are enacted by government to guide the organization, delivery, and operations of the health care system. Although there is some overlap between the two subject areas, health care delivery books are not competitive with this book. Furthermore, because the United States' health care policymaking environment is significantly more complex and different from the environments of other industrialized and nonindustrialized countries, the nation's health care policies are more complex and vastly different from those of the other countries. This book will shed more light on these complex policies.

This book is designed to achieve several goals. First, it seeks to demonstrate the role that ideology plays in problem definition and policy formulation. Second, it discusses some of the theoretical models that can be employed to study the health care policymaking process. These models are intended to provide a limited crash course on public policymaking for readers majoring in business administration, medicine, nursing, health education and administration, public health, the physical and biological sciences, and other nonpublic policy-related disciplines. Third, by exploring the history of the evolution of the health care system, the book attempts to show how past policies, actions or inactions, may have contributed to today's successes and failures. Fourth, the book analyzes some of the environmental influences on the health care policymaking process. Fifth, by presenting literature on the influences of environmental change and global factors on health and health care policymaking, the book attempts to answer the call by health policy scholars to broaden the conceptualization of health policy to include areas that are not usually considered when thinking about health. Sixth, I have tried to minimize my biases as much as possible by taking a more balanced approach and by presenting both the liberal and conservative viewpoints, in order to enable readers to better understand where different policy proposals come from and why different groups propose different solutions to the problems besetting the health care system. Seventh, I have tried to use very simple language to explain complex terms and concepts. As a result, the book is very readable and can be used by both upper-level undergraduate (juniors and seniors) and graduate students. Eight, the end-of-chapter review questions are designed to enhance both the teaching and learning processes.

Finally, the book looks at the four possible decision choices facing the Supreme Court regarding the legal challenges to the PPACA, and the likely consequences of the Court taking any of those decisions. In other words, the book presents the likely effects of the high Court taking either decision A, B, C, or D. That approach allows the book to continue to be current regardless of the decision taken by the Supreme Court.

I believe that the approach taken to develop this book will allow students and other readers to be better informed and to be able to enter into meaningful dialog

about the problems facing the nation's health care system and the need for major reforms. The intent is not to think for those who read the book. Rather, the intent is to give them the tools they need to make up their minds about the ongoing and future controversies that may arise concerning health care reform. Therefore, I invite you to read the book thoroughly and to appreciate the complexity of the United States' health care policymaking system and the policies it produces.

Toledo, OH, USA

Sunday E. Ubokudom

Acknowledgments

Several people contributed to the successful completion of this book. First and foremost, I thank the students who have taken my health care policy, delivery, and administration classes at The University of Toledo over the years. It is impossible to remember all the students I have been associated with over a period spanning more than 15 years, but a few names readily come to mind: Carolyn Guzman Fitzenreiter offered very valuable suggestions when I first discussed the idea of writing this book. Jagdish Khubchandani volunteered to help search for relevant articles for the synopsis of this book manuscript which was published in *World Medical and Health Policy* in April 2010.

The book manuscript was tested in my fall semester 2011 health care policy class. Over a period of 4 months, Patrick Jacob, Larry McCoy, Caitlyn McHugh, Benjamin Osburn, and Anne Wistow, dedicated and serious-minded students, read the manuscript thoroughly and offered constructive suggestions and criticisms. I also owe a debt of gratitude to the numerous authors and scholars whose works I have cited throughout the book.

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I also benefitted from the suggestions offered by members of the Toledo Surgical Society when I spoke to them in November 2008 about the environment of health care policymaking in the United States. At Springer, Jon Gurstelle, Nicholas Philipson, Sally Ellyson, William F. Curtis, Kevin Halligan, Rajesh Harini, Joseph Quatela, and their production and marketing personnel helped bring the project to a successful completion.

I must also thank Linda Neuhausel, our retired secretary, who promptly and accurately typed the handwritten manuscript. It would have taken me forever to type a manuscript more than 300 pages long. She did all that with a smile on her face.

That has been her demeanor since I knew her in 1995. Usoro Noah and her mother, Regina, relieved me of babysitting duties on the many weekends I had to work in the office.

I acknowledge the catalyst in everything I have done, my family. My wife, Mfon; my children, Mfon-Obong, Kenneth, Linda, and Daniel; my grandson, Alex; and my daughter-in-law, Sara, have been sources of encouragement and strength in all my endeavors. I say to them, dream, hope, persevere, maintain your positive attitudes, and never believe anybody who tells you that you cannot accomplish what you set out to accomplish. The future is yours to shape.

I must not forget my late parents, Effiong and Pehninah Ubokudom who, even though they had no formal education, paved the way for their children. Finally, after more than 35 years of leaving the shores of Nigeria for the United States, I still receive love and encouragement from my immediate and extended families over there. I hope they find peace.

Although I have received significant help from the people detailed above, I take full responsibility for the contents of this book, including errors, mistakes, and omissions.

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List of Abbreviations

AAHP	American Association of Health Plans
AALL	American Association for Labor Legislation
AARP	American Association of Retired Persons
AD	Alzheimer's Disease
ACHA	American Health Care Association
ACS	American College of Surgeons
AFDC	Aid to Families with Dependent Children
AFL	American Federation of Labor
AFL-CIO	American Federation of Labor – Congress of Industrial Organizations
AHA	American Hospital Association
AHIPs	America's Health insurance Plans
AHRQ	Agency for Health Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ALS	Amyotrophic Lateral Sclerosis or Lou Gehrig's Disease
AMA	American Medical Association
ANA	American Nurses Association
ARTs	Assisted Reproductive Technologies
BBA	Balanced Budget Amendment (Act)
CBO	Congressional Budget Office
CBS	Central Broadcasting System
CCMC	Committee on the Costs of Medical Care
CDC	Centers for Disease Control and Prevention
CDHP	Consumer-Directed Health Plan
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CON	Certificate of Need
COPD	Chronic Obstructive Pulmonary Disease

DHEW	Department of Health, Education and Welfare
DHHS	Department of Health and Human Services
DO	Doctor of Osteopathy
DOE	Department of Energy
DME	Direct Medical Education
DRA	Deficit Reduction Act
DRGs	Diagnosis-Related Groups
DSH	Disproportionate Share Hospital
DSP	Disproportionate Share Payment
EHRs	Electronic Health Records
EMTALA	Emergency Medical Treatment and Active Labor Act
ERED	Electromagnetic Radiation Emitting Devices
ERISA	Employee Retirement Income Security Act
ESI	Employer-Sponsored Insurance
ESP	Economic Stabilization Program
ESRD	End-Stage Renal Disease
FASB	Financial Accounting Standards Board
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FMGs	Foreign Medical Graduates
FPL	Federal Poverty Level
FSA	Farm Security Administration
GDP	Gross Domestic Product
GISS	Goddard Institute for Space Studies
HIPPA	Health Insurance Portability and Accountability Act
IME	Indirect Medical Education
IMF	International Monetary Fund
IOM	Institute of Medicine
IPA	Independent Practice Association
IRS	Internal Revenue Service
IVF	In Vitro Fertilization
JAMA	Journal of the American Medical Association
LCDs	Local Coverage Determinations
LTC	Long-Term Care

MA	Medicare Advantage
MAD	Mutually Assured Destruction
MCCA	Medicare Catastrophic Care Act
MCO	Managed Care Organization
MD	Doctor of Medicine
MMA 2003	Medicare Modernization Act of 2003
MS	Multiple Sclerosis
MSA	Medical Savings Account
NAFTA	North American Free Trade Agreement
NASA	National Aeronautics Space Administration
NASW	National Association of Social Workers
NCDs	National Coverage Determinations
NCSL	National Council of State Legislatures
NIH	National Institutes of Health
NLMS	National Longitudinal Mortality Study
NSF	National Science Foundation
OB-GYN	Obstetrician-Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OSRD	Office of Scientific Research and Development
OTA	Office of Technology Assessment
PAC	Political Action Committee
PBS	Public Broadcasting Service
PCBs	Polychlorinated Biphenyls
PCP	Primary Care Physician
PDPs	Prescription Drug Plans
PFF	Private Fee-for-Service
PHO	Physician-Hospital Organization
POE	Physician Order Entries
POPs	Persistent Organic Pollutants
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRO	Peer Review Organization
PSRO	Professional Standards Review Organization
PTCA	Percutaneous Transluminal Coronary Angioplasty
PVS	Persistent Vegetative State
QALY	Quality-Adjusted Life Year
QDWI	Qualified Disabled and Working Individual
QMB	Qualified Medicare Beneficiary

R&D	Research and Development
RBRVS	Resource-Based Relative Value Scale
RVS	Relative Value Scale
SAP	Structural Adjustment Program
SCHIP	State Children's Health Insurance Program; also called CHIP
SHIP	State Health Insurance Program (Hawaii)
SLMB	Specified Low-Income Medicare Beneficiary
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SSA	Social Security Act
SSI	Supplemental Security Income
STD	Sexually-Transmitted Disease
TA	Technology Assessment
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TEFRA	Tax Equity and Fiscal Responsibility Act
UR	Utilization Review
USPSTF	United States Preventive Services Task Force
WHO	World Health Organization
WTO	World Trade Organization
WWI, WWII	World War I; World War II
YRBS	Youth Risk Behavior Survey

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Chapter 1

US Health Care Policymaking: Ideological, Social and Cultural Differences and Major Influences

Systemic Problems, Definitional and Ideological Issues

In the more than 15 years that I have been teaching courses on health care policy, I have had medical doctors and students majoring in nursing, public health, business administration, health administration, and the physical and biological sciences ask me why they should study health politics and policies, given the fact that their interests are in the so-called “hard sciences.” My answer to this question has always been to paraphrase the first three axioms of government that Beard (1940, p. 232) formulated more than 7 decades ago.

Beard essentially said in his first three axioms that the “continuous and fairly efficient discharge of certain functions by government was necessary for the existence of any society; the functions of government increased in number and in their vital relationships to the fortunes of society and individuals; and that any government in a complicated society, and the society itself, was strong in proportion to its ability to perform the essential functions.” In other words, everything in a great society, as well as the great society itself, rests upon government and the effective discharge of the government’s functions.

On several occasions in the past few months while watching the national news on Cable News Network (CNN), I saw a paid television commercial urging citizens to contact their lawmakers and protest pending cuts to Medicare. At first, I thought these commercials were sponsored by the American Association of Retired Persons (AARP), one of the major interest groups representing senior citizens. But that is not the case—the commercials are sponsored by the American Medical Association (AMA). Essentially, the AMA is proactively fighting off any cuts to its members’ fees and incomes. Not surprisingly, it is not only the AMA that is concerned about cuts to Medicare expenditures; the elderly and their family members, hospitals, nurses, medical equipment manufacturers, pharmaceutical companies, and the communities where these stakeholders reside, to name just a few, are equally concerned about curtailments of the direct and indirect benefits of the Medicare program (see Chap. 9).

If the above story does not convince you that government matters, look around your communities and neighborhoods, drive on the interstate highway system, take a flight from your local airport, visit the welfare office, talk to any foster parent you know, or visit your child's school. In all of these places, the reach and scope of government will be evident. The ongoing paralysis of our government is due to the unwillingness, not inability, of the two major parties to come together and forge the type of compromises necessary to move the country and the economy forward. But if you are still not convinced and would like an example from the international arena, look at Somalia and see for yourself how the failure of government has led to the failure of every other thing in that country. Government and the functions it performs matter. Health care is one of those functions.

Health care is one of those vital functions that government performs, which is essential for the existence of our society or country. How well this function is carried out has serious implications for the well-being of the country and its citizens. Therefore, this book is about health care policymaking. Its main focus is on the policies that are made in the executive, legislative, and judicial branches of government to address the costs, access, quality, and other problems the health care system experiences, and to guide the organization, delivery, and operation of the system. Accordingly, we begin the discussion by looking at some of the health system's problems that policies seek to mitigate.

Health care is a very important component of the American economy. The total direct health care expenditures of \$2.34 trillion in 2008 accounted for about 16.2% of the nation's gross domestic product (GDP), or an average of \$7,681 spent for every man, woman, and child in the country. By contrast, the total 1970 direct and per capita expenditures were \$75 billion and \$356, respectively (United States Centers for Medicare & Medicaid Services (CMS) 2009).

Health care cost increases have caused serious problems that threaten to bankrupt the system, providers, employers, and families that pay the costs that their health insurance plans do not cover. Similarly, cost increases have reduced access to health care services, adversely affected the quality of care, and resulted in avoidable illnesses, premature deaths, and health disparities based on race, ethnicity, and income (Frist 2005, p. 268; American Medical Association 2008). Simply put, the health care system has been facing a crisis of immense proportions (Cutler 2004; AFL-CIO 2009, p. 1; Kendall 2005, p. 1). As a result, health care reform has continually been on the public and governmental agendas. The 1994 Clinton and the 2009–2010 Obama administrations' reform plans grew out of this environment.

The passage of the *Patient Protection and Affordable Care Act* (PPACA) by a Democratic Congress in March 2010 was an important step toward solving some of the problems discussed above and in greater detail below. But passage of the legislation has not allayed fears about escalating costs, uninsurance, and underinsurance for several reasons. First, most of the important aspects of the law will not go into effect for several years. Second, due to interest groups' opposition and declining public interest shortly before passage of the law, the cost containment measures included in the legislation appear to have been watered down. Third, it will take many years after the law goes into effect to evaluate most of its consequences,

positive and negative. And fourth, Republican lawmakers have openly stated their desire to repeal the entire law or some aspects of it whenever they are able to do so.

Furthermore, as things stand, the fate of the Obama administration's reform measure will be decided by the Supreme Court. As is reported in Chap. 9, on September 28, 2011, the US Justice Department and the 26 states that filed a lawsuit challenging the constitutionality of the law petitioned the Supreme Court to take up the case during the Court's current term, October 2011 to June 2012. The High Court announced its decision to take up the case on November 14, 2011. A ruling is expected in the summer of 2012.

Even if the Supreme Court rules in favor of the legislation, Republican lawmakers may try to frustrate its implementation by withholding the necessary funds. Therefore, the legislation resembles a moving target. Its future is uncertain. But this uncertainty notwithstanding, passage of the legislation remains a major milestone in the history of the evolution of the US health care system.

But even if the Supreme Court nullifies the PPACA or Republican lawmakers succeed in frustrating its implementation, the legislation and the controversies it has generated will remain in history and health policy books, similar to the *Medicare Catastrophic Care Act* (MCCA) of 1988, which was repealed by the Congress a year after its passage. For this reason, it is worthwhile for health policy scholars to study and fully understand the provisions of the law.

The Health Care System's Problems

One impetus for the PPACA and previous reforms efforts has always been the recognition or perception of serious systemic problems with the health care delivery system. As was discussed above, these include high costs, inaccessibility, poor quality, and disparities based on race and ethnicity. We briefly elaborate on these problems below in order to lay the groundwork for the topics that are presented in subsequent chapters of the book. We begin by discussing high health care costs.

Health care cost increases are of two dimensions, direct and indirect. The direct costs are the actual dollars spent for health care from all sources in a given period. These include the costs of biomedical research, funding for medical schools, hospitals, and other delivery systems, health insurance premiums, payments for medical services, and the costs of operating the numerous public, private, and nonprofit agencies administering the many health care programs in the country.

The indirect costs of government and private expenditures for health are the opportunity costs or what also could have been funded if the money was not spent on health care. Opportunity costs rest on the premise that resources are finite and that money spent for one purpose cannot be spent for another purpose (Anderson 2006, p. 259). Therefore, high health care expenditures may limit spending for other domestic discretionary programs such as law enforcement, education, social welfare, housing, regulatory programs, and so on; may make it difficult to extend health insurance coverage to the millions of Americans without coverage; may reduce

workers' wages and corporate profits; may adversely affect the ability of American companies to compete with their foreign counterparts; may lead to the outsourcing of jobs to the less developed countries where costs are lower; and may raise concerns about the relationship between costs and quality of care (Frist 2005, p. 267; Levit et al. 2004, p. 147; Reinhardt et al. 2004, p. 10; DeNavas-Walt et al. 2004; Kendall 2005, p. 3; AFL-CIO 2009, p. 1).

Concerning the quality of care in the United States, there is evidence from a few studies that as many as 20–30% of American patients receive contraindicated care (Starfield 2000, p. 483). In addition, studies show that Americans, even in the best of circumstances, receive only about 55% of the recommended care for many common conditions; as many as 44,000–98,000 Americans die each year as a result of medical errors or the so-called iatrogenic illnesses; prescriptions are not routinely checked for dangerous interactions or whether patients even picked them up at the pharmacy; health disparities exist based on race, gender, ethnicity, geography, and class; and the health care system is said to experience chronic waste and high inefficiency.

It is also argued that while we have made massive investments in medical research, we have invested poorly in the infrastructure and research necessary to utilize the results of the massive investments in basic biomedical research. For example, the health care sector is said to invest close to 50% less in information technology than any other major sector of the economy. The result is that medical records are often kept in bulky paper files and archived in distant storage centers. Similarly, doctors and nurses contact patients by phone instead of email to deliver test results and arrange follow-up care (Kendall 2005, p. 4; McGlynn et al. 2003, p. 2635; Schroeder 2007, p. 1221; AFL-CIO 2009, p. 2; Kohn et al. 2000, p. 26; Starfield 2000, p. 484; Frist 2005, p. 267; Bates 2002, p. 7).

According to Starfield (2000, p. 483), the data regarding the poor position of the United States in health worldwide are robust and not dependent on the particular measure of health used, thereby prompting the questions: What has gone wrong with the health care system? Why is it that the population that spends the most for health care does not have anywhere near the best health indicators in the world? Why has the health care system been so resilient and resistant to change? What factors impede changes in the system?

The above questions are not new to the American people, health policy analysts, health providers, and public policy-makers. While the policymaking system is designed to resist change, there are equally strong disagreements as to what should be the appropriate answers to the above questions. First, there are those who believe that the problems of the health care system stated above are not public problems and, therefore, do not merit government action. Second, while the majority of Americans seem to agree that the problems listed are, indeed, public problems, there is no agreement as to causality. People's perceptions of the problems afflicting the health care system are influenced by their values, the information at their disposal, and by their personal experiences (Anderson 2006, p. 83). For example, conservatives are likely to view inflationary health care costs as due to government regulations, the excesses of the welfare state, malpractice awards and high malpractice insurance premiums, and defensive medicine, to name but a few.

Liberals, by contrast, are likely to blame excessive utilization and prescription of health services by consumers and providers, respectively, the costs of high-technology equipment, the aging of the population, the behavior of health care interest groups and insurance companies, and the lack of progressive financing of health benefits as being responsible for health care inflation. The question that arises is why are the above explanations for high health care costs so far apart? We can find the answer to this question by looking at the ways public problems are defined.

Problem Definition

A problem is a situation that is different from the ideal—the gap between the preferred and the prevailing state of affairs. Here is a simple illustration: If the goal of policy-makers is to insure all Americans, yet only about 70% of them are actually insured, the 30% that is uninsured would constitute the problem—the difference between the preferred situation and the prevailing situation.

In the above example, the task of the concerned policy-makers would be to convince fellow lawmakers and the general public that the 30% of uninsured Americans constitute a public problem that government should do something about. They would attempt to show that the uninsurance problem affects a large number of people, cannot be resolved by individual action, imposes costs on both society and other individuals that are not directly involved with the problem, and that there is a possible governmental solution for the problem. Once that is done, they would then set out to define the problem or identify its cause or causes. According to Stone (1988, p. 106), “a problem definition is never simply a matter of defining goals and measuring our distance from them. It is rather a strategic representation of situations.”

The reason why Stone argues that problem definition is strategic is because individuals, groups, politicians, and public agencies purposefully use symbols, numbers, and stories to portray problems in ways that promote their favored courses of action. In other words, strategic problem definition usually implies portraying or framing a problem in such a way as to make the proponents’ favorite courses of action appear to be in the public interest, necessary, and the right thing to do. It also means attempting to manipulate the scope of a conflict by making some people seem to be affected by it while others are not so affected (Stone 1988, p. 122).

Based on the above discussion of problem definition, the answer to the question I posed about why the definitions of high health care costs are so far apart is that the definitions are carefully crafted and presented to the public in an attempt to convince them that the proposed solutions are the right courses of action that can be pursued to solve the problem. They might blame health care consumers or health care providers and equipment manufacturers; they might blame policy-makers for failing to take steps to curtail high health care costs; or they might use a carefully crafted terminology, such as “socialized medicine,” “government takeover of the health care system,” or “Obamacare,” to mock the solutions proposed by the opposition.

The different causal explanations compete for acceptance primarily because each causal explanation implies a different approach to solve the problem. For example, if the accepted causal explanation is that health care consumers cause inflationary health care expenditures, a likely approach to solve the problem would be to curtail their consumption of medical services. If, on the other hand, providers are blamed for excessive costs, attempts would be made to curtail their prescription patterns and, by extension, their incomes. According to Stone (1988, p. 164), causal stories are mechanisms for linking a desired policy or program to a problem that happens to be high on the policy agenda.

For the same reasons there are strong disagreements about the causes of high health care costs, there are equally strong disagreements about the causes of the dismal health indicators in the United States relative to other industrialized countries. The explanations differ depending on who is doing the explaining. The explanations that have been offered for the relatively poor health in the United States are complex and multifactorial and include the historic failure to build a strong primary care infrastructure and the resulting lack of access to primary care for a great number of citizens; medical malpractice and defensive medicine; behavioral and social factors, such as smoking, drinking, and the perpetration of violence; pollution and other environmental damages; a high degree of education and income inequality in the country; low physician-to-population ratios in some areas of the country; genetics and obesity, etc. (Schroeder 2007, p. 1221).

Other factors that are blamed for the poor health indicators in the United States are the prevalence of uninsurance and underinsurance. For example, the Institute of Medicine (IOM) reported in 2002 that about 18,314 Americans aged between 25 and 64 years die annually due to lack of insurance. Other researchers argue that the IOM statistics are outdated. Wilper et al. (2009, p. 2292) estimate that 27,424 deaths occurred among Americans 25–64 years in 2000 due to lack of insurance. The 2005 estimated deaths among Americans 18–64 years of age due to lack of insurance were 35,327 (with age stratification) or 44,789 (without age stratification).

Deaths attributable to lack of insurance can be expected to increase further during difficult economic times, and as employers drop health insurance benefits for their employees because of high costs, increased foreign competition, and dwindling profits. Declining business profitability and stagnant or declining wages have eroded the previously strong association between employment and possession of health insurance coverage.

To sum up, the competition among different causal explanations for problems creates problems of its own (Anderson 2006, p. 85). The lack of agreement as to what causes the problems is likely to result in disagreements as to the appropriate solutions to the problems. The contrasting definitions of the problems generate different proposals for solving them; both the definitions and the possible solutions are unlikely to meet with everyone's approval, thereby reducing the likelihood of action (Johnson 1996, p. 296; Ubokudom and Khubchandani 2010, p. 11). For a long time this has been the experience of health care reformers in the United States.

As we shall discuss in greater detail in Chap. 2, efforts to achieve major reforms of the health care system failed from 1920 to 1994 when the Clinton administration's

Health Security Act was defeated (Hacker 2009, p. 11). Each time reform was attempted during the period, opponents, arguing in ideological terms, expended tremendous resources and energy to convince Americans and their elected representatives that the nation would be better off maintaining the status quo. Therefore, even though the advocates of reform were able to call attention to their perceived problems, they were not able to move them through the policy window to the policy formulation phase of the policy cycle. This was so either because the perceived problems were not sufficiently appealing, did not garner enough political support, or the alternatives for solving them were deemed inadequate or not viable. Put differently, the perceived problems, the potential solutions, and the existing political circumstances did not flow together in a favorable alignment to move the process to the legislation development phase (Paul-Shaheen 1990, p. 833; Kingdon 1995, p. 18; Longest 1994, p. 58).

Surprisingly and defying all past precedents and experiences, a massive reform plan was enacted in March 2010 by a Democratic Congress. Significantly, not even a single Republican legislator in either the House of Representatives or the Senate voted for the reform plan (Jacobs and Skocpol 2010, p. 119). The politics that played out in 2010 may lead us to conclude, albeit erroneously, that the unified Congress President Obama and his cabinet enjoyed was the sole factor that paved the way for passage of his reform plan. But, partisanship is not and has not always been the only factor that drives the nation's health care policymaking process. Some of the other factors at work include the legal system, citizens' opinions, economic conditions, interest group pressures, federalism, technological growth, physical environmental factors, global influences, population demographics, social and cultural factors, and health providers' influences. This book is an attempt to study all these factors, including partisanship.

In order to fully understand the factors that influence health care policymaking in the United States, we will review some relevant models that have been developed and used to analyze the policy process. There are several of these models but the discussion below will only focus on a select number of them that we consider relevant for our analysis. For example, we have not included several popular models that seek to explain policy stability or change, such as punctuated equilibrium or social movement theories, because those issues are not the primary focus of this study. Put differently, the models presented below are not exhaustive, and others might be equally relevant. They are intended to provide a limited crash course on public policymaking for readers who major in business administration, medicine, nursing, health education and administration, public health, the physical and biological sciences, and other disciplines outside of public policy and administration.

Some Models of Policymaking

Models can be employed to study policymaking in general, and health policymaking in particular, in the United States. Although some of these models are very similar

in their descriptions and functions and appear to be combinations of some of the individual models, they are given different names. They include the political systems or institutional model, the process model, the rational model, the institutional rational model, the public choice model, the incremental model, the group model and advocacy coalitions, the elite model, the garbage can model, game theory, and the structural choice model. We shall discuss these models and their limitations before we focus on the approach taken for this book. Where possible, we shall identify the similarities between the models. We begin with the political systems or institutional model.

Institutional or Political Systems Model

The institutional or political systems model, also called open systems theory (Haberstroh 1965; Katz and Kahn 1966), views public policy as the government's response to environmental or public demands and expectations. Public policymaking generally takes place in particular government institutions such as the Congress, the presidency, courts, bureaucracies, independent regulatory agencies, states, counties, municipalities, etc. The policymaking processes in some of these institutions are discussed in greater detail in Chap. 3.

Political institutions respond to demands and supports or inputs from the environment. For example, demands for accessibility of health services to inner city residents may result in the funding of health departments to provide primary care services for this population group. The funding of health departments to provide medical services to inner city residents would be the output or the immediate service or good provided by the program to increase the accessibility of health care services in the inner city.

Support is given to government institutions when people pay taxes, obey laws, accept the decisions that are made in the government agencies, etc. Because the policies that are pursued in response to citizens' demands and expectations may affect the environment positively or negatively, feedback, which also arises from the environment, is used to gauge the acceptability of the policies (Anderson 2006, p. 18; Dye 2008, p. 11). If the feedback shows that the public is dissatisfied with the policy or some aspects of it, changes may be made to the original policy in order to address the negative feedback.

Rational Model

The rational model, derived from the subfield of microeconomics, advocates policies that are efficient, or that maximize output for a given input, or that minimize input for a given output. For example, most of the cost containment strategies and policies discussed at length in Chap. 4 are due to the desire to achieve some level of efficiency in the health care system. The rational model advocates policies that confer more benefits on society than they cost. It essentially rests on the systems

approach discussed earlier, and goes a bit further by demanding an efficient outcome (Kettl and Fesler 2005, p. 286).

The process of making a rational policy choice requires that policy-makers specify the goals of the policy, consider all evidence and alternatives that pertain to achievement of the goals, and select the one alternative that offers the best margin of benefits over costs (Johnson 1996, p. 280). This is the ideal that policy-makers should approach as closely as possible (Simon 1957).

Public Choice Model

The public choice model also originated from the subfield of microeconomics, and is a spin-off of the rational model. It seeks to explain how public agencies make policy decisions. It is based on the notion that policy-makers, indeed, all human beings, are rational and seek to maximize their self-interests (Buchanan and Tullock 1962). The quest to maximize self-interest causes public office holders and administrators to seek to enlarge their programs and increase their budgets, resulting in what Niskanen (1971) calls the acquisitive and monopolistic bureaucracy. Therefore, according to the model, the pursuit of self-interest by public office holders is an important explanation for the dismal performance of American government.

Accordingly, public choice proponents argue that, wherever possible, governmental functions should be privatized. The use of the term, wherever possible, implies that there are certain government functions that cannot be privatized. Chief among the functions that cannot be privatized are the provision of public goods, such as national defense, which the private sector is unable or unwilling to handle, and regulations to curb such negative externalities (market failures) as air and water pollution. Public choice theory is probably one of the more important influences on the largely private health care system in the country.

Institutional Rational Theory

The institutional rational theory, as originally proposed by Kiser and Ostrom (1982, p. 179), combines a rational actor perspective with attention to institutional rules, intergovernmental relations, and policy choices. The model, therefore, appears to combine the rational, institutional, and public choice models presented above. It views individual choices as a function of both the attributes (values and resources) of the individual and the attributes of the decision situation (the product of institutional rules, the nature of the relevant good, and the attributes of the community, such as socioeconomic conditions and popular opinions) (Ostrom 1990, p. 132, 1991, p. 241; Sabatier 1991, p. 151).

Institutional rational theory defines three levels of institutional analysis. These are the operational level, where the agency allows decisions; the collective choice or the level at which stakeholders establish the rules that govern the agency's operations; and the constitutional level, which involves the regulatory effects of the

Constitution on the legislature. Therefore, the decisions of a given level set the institutional rules of the next lower level. For example, the Constitution sets the basic institutional rules for the legislature, while a legislative statute sets the basic rules governing agency decisions, such as the health policy decisions made by the US Department of Health and Human Services (DHHS). The decisions of the operational level, such as those made by the DHHS, directly affect citizens, while the decisions of higher levels, such as those made by the Congress, guide the DHHS (Sabatier 1991, p. 151).

Process Model

The process model focuses on the patterns of activities or processes that are involved in public policymaking, in general, or in health policymaking, in particular. Under the model, the policymaking process is seen as a series of political activities including problem identification, agenda setting, or bringing the perceived problem to the attention of policy-makers, problem definition, policy formulation and legitimization, implementation, and evaluation (Kingdon 1995, p. 16; Longest 1994, p. 57).

Issues do not typically move through the process model at the same pace or with the same results. For example, even if a problem is identified, it may not be placed on the agenda if it is felt that it is not a public problem that deserves government attention or action. Similarly, the definition of a problem that is on the agenda is contentious because different groups will stress different factors as causing the problem. For example, the introductory section of this chapter identified the various explanations and definitions that have been proffered for the problems afflicting the health care system. These conflicting explanations and definitions are serious road-blocks to policy formulation and legitimization.

Incremental Model

Most policy decisions involve limited information and incremental adjustments to existing policies. Incremental policymaking is pluralistic and fits the democratic political process in the United States. Incrementalism is widely used because it allows for successive limited comparisons and the ability to really make adjustments if mistakes are made; considers the expectations and demands of competing pressure groups—it strives to satisfy all groups and perspectives and involves bargaining and compromise; and does not seriously upset the existing arrangements which tend to favor the dominant and powerful groups in society (Wilson 2008, p. 35; Kettl and Fesler 2005, p. 293). The proposal to expand insurance coverage by allowing retirees below 65 years of age to buy into Medicare is based on the incremental approach. Similarly, some of the provisions of the PPACA, which build on the existing private insurance system, are incremental in nature.

The incremental model was proposed by Lindblom (1959, p. 79, 1965, 1977, p. 314, 1979, p. 517, 1980) in the course of his critique of the rational model. Since policy-makers operate in a political environment that is characterized by limited

information, conflicts, time, and financial constraints, they limit their analysis to a few alternatives rather than trying to identify and consider all the likely alternatives. Therefore, according to Lindblom, policy-makers “muddle through” or “satisfice.”

Group Model and Advocacy Coalitions

Group theory or the advocacy coalition's model (Denhardt and Grubbs 1999, p. 46) posits that public policy is the outcome of group struggle for their desired goals. According to Latham (1965, p. 36), “what may be called public policy is the equilibrium reached in this struggle at any given moment, and it represents a balance which the contending factions or groups constantly strive to weight in their favor.” For example, some of the existing health policies or programs, such as Medicare and Medicaid, can be considered the equilibrium that was reached among the competing groups that were involved in designing the policies or programs.

According to group theory, groups form in opposition to other groups and vie for access and influence in the policymaking process (Truman 1951). Since groups compete and counterbalance each other in the political process, no one group is able to completely dominate the process. However, since some groups have more access and influence than others, public policy, at any given time, is a reflection of the interests of the more dominant groups. Therefore, as groups gain and lose power and influence, there will be a shift in the direction of policy toward the interests of the groups gaining power and away from the interests of the groups losing power. Group politics is democratic when there is freedom of association and participation in the policymaking process and when policy-makers respond to groups' interests (Cobb and Elder 1983; Dahl 1970).

Members of advocacy coalitions act together, based on their shared belief systems, to manipulate the rules of various government institutions to achieve shared policy goals (Sabatier 1991, p. 153). They develop and use information in an advocacy mode to persuade policy-makers to enact policy alternatives favored by the coalitions; manipulate the selection of the units that will make particular decisions; and support policy-makers who share their views and beliefs. Major policy changes occur when coalitions engage in compromises, when coalition resources or perceptions of policy problems are altered by external events, such as economic conditions, when coalition belief systems are modified or altered due to trial-and-error learning that results from the adoption, implementation, and evaluation of programs, or when one or more coalitions' belief systems change in an enlightenment episode resulting from the accumulation of policy information (Schlager and Blomquist 1996, p. 657).

Elite Model

The elite model holds that power and policymaking are dominated by a small number of influential and well-positioned individuals who act in their own self-interests (Mills 1973). As an example, members of Congress make health and other sector policies that will enhance their reelection potentials. In addition to legislators and

top agency personnel, there are other elites from the corporate, military, and economic sectors (Dye and Zeigler 2003; Domhoff 1996).

Elite theory suggests that the belief or assumption that public policy results from the demands of the people is a myth, not the reality of American democracy. The majority of the people, it is argued, are apathetic and ill-informed about public policy. Therefore, elites actually shape public opinion on policy issues more than the masses shape elite opinion (Dye 2008, p. 21). As a result, the policies that are adopted and implemented by public officials and administrators are simply the preferences and choices made by elites. The penetration of the elite class by nonelites is carefully guarded to maintain stability and avoid revolution. Put simply, a few people govern the masses.

Game Theory

Game theory is applied to areas in policymaking in which there is not an independently best choice that the policy-maker can make (Dye 2008, p. 26). In this case, the best choice depends on what the other participants in the process do or are expected to do. Therefore, each policy-maker must adjust their conducts to reflect what they expect will be the conducts of the other participants.

Game theory has been used to evaluate policymaking in the areas of war and peace, nuclear disarmament talks, deployment of nuclear weapons, foreign policy, and bargaining and coalition building in the legislature. For our purposes, it can be used to evaluate the process of building majority coalitions in Congress to support proposed laws in the health care sector. It is very common for federal legislators to add their pet projects or earmarks to bills that are highly favored by the executive branch in the hope that the entire bill will not be vetoed because of the need to preserve the popular portion of it. For example, to ensure its passage in the conservative environment that characterized the Nixon Administration, the Medicare prospective payment legislation discussed in Chap. 8 was attached to a more popular bill that was designed to ensure the solvency of the Social Security program (Davis et al. 1990, p. 41). Those who did not like the hospital payment plan could not selectively oppose it.

Game theory also informs the doctrine of military strategy and national security policy called mutual assured destruction (MAD). The doctrine reasons that a full-scale use of nuclear weapons by two opposing combatants would effectively result in the destruction of both the aggressor and the defender. It is based on the theory of deterrence whereby the deployment of weapons of mass destruction is necessary to threaten the enemy in order to prevent the use of the same weapons (Wikipedia 2011). Accordingly, none of the antagonists will dare launch a first strike because of the expectation that the combatant that is attacked will launch a retaliatory strike, resulting in the destruction of both combatants. This theory is supported in real life by proponents of large defense outlays who argue that the best way to maintain peace is to demonstrate strength. Late President Ronald Reagan and his defense team were important and vocal advocates of this strategy.

The Garbage Can Model

The garbage can model, articulated by Cohen et al. (1972, p. 1), deviates significantly from rational models. It argues that policy choices emerge from a very diverse network of decision-makers that the authors called “organized anarchy.” The members of this network are diverse and the network itself is very fluid; the processes employed in the network are not fully understood by the decision-makers; and the members of the network do not share common and consistent preferences. The garbage can itself consists of a large collection of ideas about problems and solutions that the network participants can draw upon, depending on their preferences and opportunities.

When this model is applied to the health policymaking environment, there are multiple ideas about the solutions to the problems of the health care delivery system. For example, some of the solutions advocated to tackle inflationary expenditures include a nationalized health care system, tort reform, marketplace competition, government regulation of insurance and providers, etc. These solutions proposed for the ills of the health care system are many and varied, depending on who is advancing the proposal. Since all the decision-makers are involved in picking ideas and decisions out of the garbage can, they are very likely to pick the ones that are familiar and in agreement with their interests and preferences. In that instance, multiple and conflicting decisions can emerge.

The Structural Choice Model

The structural choice model was developed by Moe (1995, p. 116). It conceives of public policies as institutional arrangements. Public policies and the public agencies that implement them arise from the interaction of interest groups, politicians, and bureaucrats within the context of bureaucratic politics. There is a two-tiered hierarchy of political action, with one of those tiers being the internal hierarchy of the implementing agency, such as the internal organization of the DHHS, the Centers for Medicare and Medicaid Services (CMS), or any other agency for that matter, and the other being the political control structure that links the agency to politicians and interest groups. Viewed in this manner, the model resembles the workings of an iron triangle, where elected officials, interest groups, and relevant agency personnel work together to benefit their mutual interests.

Policymaking under the structural choice model is based on compromises, even with adversaries. The struggle for structural choice occurs among organized interests, their legislative supporters, and the president or executive branch. Some of the organized interests that could be involved in the health policy arena include the American Medical Association (AMA), the Health Insurance Association of America (HIAA), American Nurses Association (ANA), etc. Those who lose in the legislative arena align themselves with the president in hopes of having some of their desires met as the executive branch goes about interpreting and implementing

policies (Schlager and Blomquist 1996, p. 656). Moe's work, therefore, sees policymaking as not only involving the Congress but also involving Congress, the president, and interest groups.

Analyses

We would be seriously shortsighted to assume that any of the above theories of policymaking can singlehandedly and fully explain the complex policymaking process in the United States. While each theory may be more powerful than the other in a particular situation or context, each of the theories also has its weaknesses. For example, rational theory assumes an individual decision-maker, which is frequently not the case. Rational theory is also limited by the dearth of information on the alternatives to be pursued and their costs and consequences; the role of values in informing decisions; cognitive difficulties that decision-makers often experience in the course of their work; the fact that efficiency is not the only value we seek; and the fact that sunk costs or the large investments that have already been made in existing programs and policies may constrain the consideration of policy alternatives that involve radical change from the present.

The institutional rational choice model, while much broader in scope than the other models, also has limitations. For example, it neglects the role of substantive policy information as well as the variety of factors that intervene between policy choices and their effects on society (Sabatier 1991, p. 151). Similar to rational theory, the focus on individual behavior neglects the many and diverse institutions active in a policy community.

A shortcoming of the incremental model is its conservative nature. This conservative nature leads to the consideration of existing programs and policies as the base that should be increased, decreased, or augmented. This makes it difficult to use the model to solve major or fundamental social or political problems, or to innovate. The short time horizon of the model makes it difficult to commit lawmakers for many years to come.

Institutional theory focuses on the process of policymaking in governmental institutions—the presidency, the judiciary, the legislature, and the bureaucracy—but does not directly confront the question of who rules, or what drives the policy process (Anderson 2006, p. 23, 26). Similarly, the elite model, which addresses the question of who rules, ignores the masses. For example, mass revolts have been taking place in many parts of the world recently. At the time of this writing, such mass revolts are engulfing the countries of the Middle East. Mass revolts are more likely to occur at the ballot box in the United States than on the streets. In other words, the masses may not always matter, but they do matter. policy-makers who ignore the masses do so at their own peril—they are likely to be voted out of office.

The group model or advocacy coalitions approach fails to fully account for the fact that while there are many groups or coalitions, they do not have equal powers or access to policy-makers. This point was what informed the following statement

by Schattschneider (1960) about the lack of organization among the poor: “The flaw in the pluralist heaven is that the heavenly chorus sings with a strong upper-class accent.” The group or advocacy coalition model also does not fully account for the independent and purposeful roles that public officials play in the policy process, as well as the collective or group action difficulties experienced by groups, such as the free-rider problem (Olson 1965; Miller 1992).

As the name implies, the process model focuses on the routines involved in the policymaking process and ignores or does not fully account for the heavy lifting that occurs at each stage of the policy process, such as bargaining, coalition building, logrolling, or compromises and tradeoffs. Similarly, the public choice model employs a very simplistic explanation for government problems (the self-interest of public officials produces inefficient programs) and fails to recognize that public problems are inherently diverging—problems that have many potential definitions and solutions, most of which are not compatible with one another. The public choice model’s prescription of privatization and private sector competition within government ignores the other important values that public officials pursue, such as equality, equity, responsiveness, justice, etc.

The success of deterrence, which is the bedrock of game theory, depends on the credibility of the retaliatory threat if one of the participants takes action that hurts the other (Dye 2008, p. 27). If they do not believe that their actions will elicit a retaliatory response that imposes high costs on them, then they will not be deterred. In the legislative arena, members of Congress must be fully convinced that if they vote against a president’s proposal, then, the president will block legislation that is very important to them and their constituents. Further, the participants must be able to weigh the likely costs and benefits of their actions and come to the conclusion that the costs outweigh the benefits. If they think otherwise, they are unlikely to be deterred. The structural choice model also does not fully account for specific political actors, such as legislators, interest groups, and the president and his staff (Schlager and Blomquist 1996, p. 656).

Finally, the garbage can model is an extreme of the rational model (Johnson 1996, p. 283). According to the proponents of the model, since the problem, solution, and participant streams in the garbage can are independent of each other, the choice of an appropriate solution to any given problem, or the choice of an appropriate decision-maker to solve the problem, is as much a product of chance as it is of rationality in some settings, and perhaps more so. Therefore, like the other models, the garbage can model does not apply to all situations. There are times when public officials actually set out to solve problems, and there are times when problems search out for solutions. For example, when there are abnormally high rates of lung cancer, food poisoning, or serial rapes in a community, public officials look for the causes or sources of the problems in order to contain them. They set out to solve the problems.

The various models we have presented raise questions about different aspects of policymaking. They focus on different controversies and questions about politics and the policymaking process. Therefore, the models are not merely neutral alternatives for guiding policy analysis (Anderson 2006, p. 27). These models are not

competitive in the sense that any of them could be judged best. While some policies may seem to be more amendable to analysis using one particular model, most policies are a combination of the models. Combining models in analysis allows the analysts to address the concerns raised by each of the models combined (Dye 2008, p. 12). This is the understanding that guides this book.

The Approach of the Study

A textbook on health care policymaking cannot simply focus exclusively on the elites in the DHHS or in the White House, health interest groups, providers, etc. Such a singular focus on one particular group would be incomplete because it would ignore many other important factors. For example, the AMA was very powerful in the past, and policy-makers almost always deferred to their judgment and ignored the aspirations of the other less powerful and less well-organized groups. But that is not the case today.

The health policy environment today is more factionalized than ever, allowing more and more people, businesses, and groups with stakes in health care policy to organize and finance their own lobbies. These stakeholders hold views and goals that are significantly different than those of medical professionals and the AMA; they are expressing divergent messages (Peterson 1993, p. 411). Therefore, this study is modeled on the institutional or political systems model, also called open systems theory, which was analyzed earlier in the chapter, in order to demonstrate the multiple influences on health care policymaking. In spite of its limitations, we feel that it is the best model for the study for several reasons.

Even though globalization has increased the interdependency among nations of the world, health policies cannot simply be uprooted from one country to the other. For simplicity, let me put it this way: policies are made at a place, by the policy-makers at the place, for the people who live in the place, and with the resources available at the place. In other words, while nations can learn from each other, it is not possible for them to import a one-size-fits all model to address shared health concerns. Important cultural, social, and political factors make full-scale importation of one nation's health care system impossible (Graig 1999, p. 1, 2). The institutional or political systems model employed for this study is unique to the United States. But with necessary adjustments that take environmental differences into account, it can also be used to study other countries.

While trying to introduce the concept of ecology or situational factors into the public policy and administration literature more than 6 decades ago, Gaus (1947, p. 1) argued that the ecological approach was built from the ground up, from the elements of a place (soils, climate, location) to the people who lived there (their numbers, ages, knowledge, and the technologies they employed to earn a living). According to Gaus, the study of public policy and administration should take place in that setting. In other words, context matters for the study and

understanding of public policy and administration, whether the focus is on health, education, aviation, transportation, etc.

Recently, while living in Europe and trying to make sense of the differences in the practice patterns between European and American medical providers, the American medical writer, Payer (1996, p. 16), writes that “many of the practices she had taken for granted seemed to be not so much the result of scientific progress, but rather outgrowths of American cultural biases that in some cases harmed more than helped our health and well-being. In seeing how another country’s cultural prejudices affected its medicine, she found it easier to perceive how our prejudices affect our practice of medicine.” Appropriately, therefore, Payer titles her book, *Medicine and Culture*.

Under the parliamentary systems of government that are dominant in European countries and in Israel, the cabinet, headed by the political executive, makes most of the policy decisions. Therefore, the elite model would be more appropriate for the study of policymaking in those countries. By contrast, the legislatures in the United States can block executive proposals; the executive can block legislative actions; and the courts can block both executive and legislative actions. Furthermore, the population of the United States is very diverse and complex; there are very vocal and active interest groups in the United States, and increasing numbers of individuals contribute to political action committees (PACs) and become members of public-interest groups (Cigler and Loomis 1983, p. 1); and the sociocultural and economic environments of the United States are not necessarily the same as those of other countries. These peculiarities of the United States influence the approach used to study the policymaking processes in the country.

I believe it is for some or all of the reasons presented above that Anderson (2006, p. 39) writes that “policymaking cannot adequately be studied apart from the environment or context in which it occurs.” Therefore, this study involves studying the environment of the US’ health care policymaking process. Even though we cannot uproot policies from one nation to the other as stated previously, and unlike in the past when other nations became an important part of the environment only when foreign and defense policies were discussed (Anderson 2006, p. 39), global factors are considered as part of the environment of health care policymaking and, most likely, all public policymaking. For example, as we discuss in Chap. 6, there is hardly any health policy issue, or any policy issue for that matter, that does not have global or international implications. Things happening abroad affect local choices here in the United States, and vice versa. Considering global factors as part of the environment of the health care policymaking in the United States does not mean uprooting policies from other countries and transplanting them here. Rather, it means that policy-makers here keep an eye on what is going on abroad, and vice versa.

This book, therefore, conceptualizes the health care policymaking environment broadly to include social and cultural factors, including political culture and social structure; technological influences; demographic factors, such as age, racial composition, spatial distribution of the population, and population size; economic

influences; physical environmental factors, such as climate change and environmental control; health providers' influences; global factors, such as migration and population mobility, international trade and finance, infectious disease epidemics, and terrorism; and the supports the policymaking system gets from citizens, such as money and the grant of authority to policy-makers. The various elements of the model interact with each other. For example, economic factors and such demographic variables as age, level of education, minority status, etc., interact. Similarly, as we shall discuss in Chap. 5, technological and provider influences interact. These interactions and interdependencies make it difficult to assess causality empirically or quantitatively. However, they can readily be differentiated analytically.

To elaborate further, the actions taken by politicians and other stakeholders, including ordinary citizens, are expected to be guided by the Constitution. Furthermore, those who administer public health programs are also expected to be accountable to citizens through their elected officials. Longest (1994, p. 33) argues very plausibly that is impossible, as a practical matter, to consider health policy aside from its relationship to tax policy. We also believe that it is impossible to separate health policy from the environmental factors we have identified, as well the perspectives of those who implement health policies. It is this understanding of the multiple influences on health and health policymaking that informs Williams' and Jackson's (2005, p. 325) call for the broadening of health policy to include areas that are not usually considered when thinking about health. We have tried to answer that call to the best of our ability by identifying literature that links global factors and population dynamics, etc., to health.

This study focuses on health policymaking at the federal level of government. It starts from the premise that the US health care policymaking environment differs from those of other industrialized countries. Therefore, even though the health care systems in different countries of the world may experience identical problems, the solutions to these problems may not necessarily be the same because of political, social, and cultural differences, the levels of development of the different countries, and their locations (Payer 1996, p. 23; Kettl and Fesler 2005, p. 21; Ubokudom 2008, p. 2; Gawande 2009). Figure 1.1 organizes our thoughts on the factors that influence the health policymaking process in the United States.

As a result of the serious controversies and litigations trailing the *Affordable Care Act* of 2010, which the opposition party claims to be primarily due to the way they interpret the Constitution, but which may be more the result of problem framing than anything else, we have drawn the schematic framework of the study unconventionally, as shown below, in order to emphasize the significance of using the Constitution as a platform for launching attacks on proposed and enacted policies. The legal and political influences that produce policies are generally assumed to occur inside the policymaking system, within the context of the policymaking process (Longest 1994, p. 47). The numerous factors included in Fig. 1.1, especially the need to draw a circle which depicts the Constitution around the various factors in the model, do not give us room to draw the output line representing the policies that emanate from the policymaking system. This omission does not in any way minimize the utility of the framework because it is widely agreed that the political and

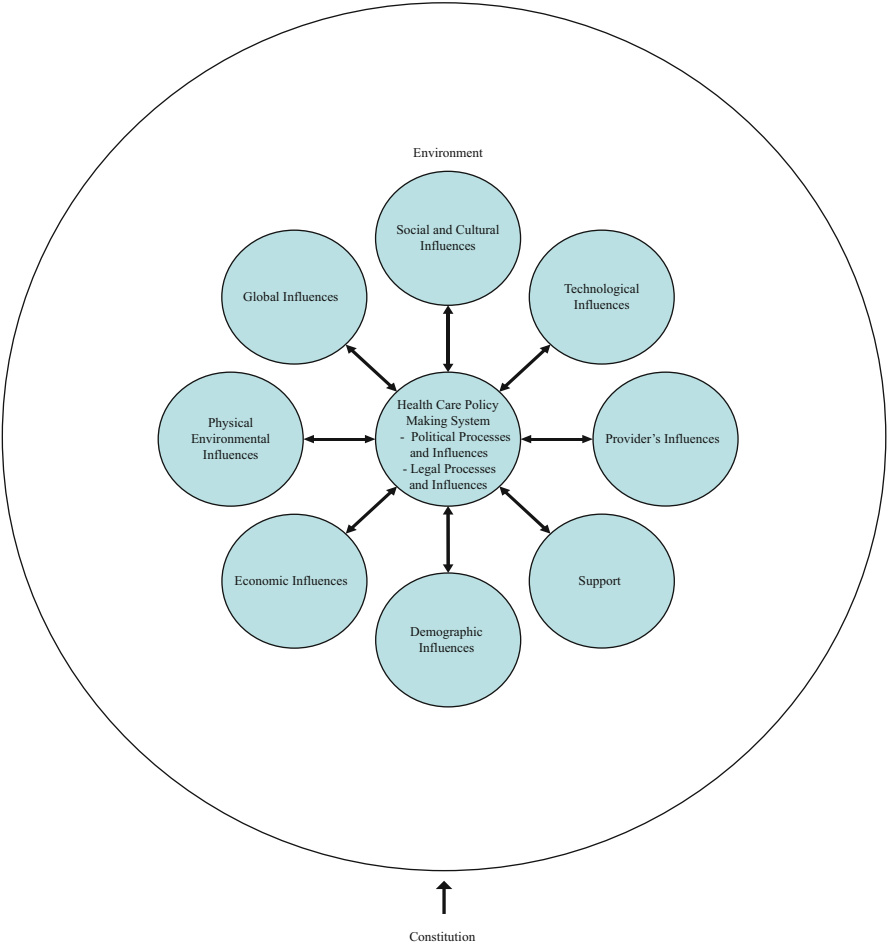


Fig. 1.1 Factors that influence health policymaking in the US

Note: The two-header arrows suggest that influence relationships may run in both directions; the congestion in the diagram does not give us room to draw a line depicting the outputs of the policy-making process (see text)

legal processes that occur inside the policymaking system produce policies, including inactions or, as Dye (2008, p. 38) calls them, “nondecisions.”

In a nutshell, the model presented in Fig. 1.1 represents an open system—one that interacts with the environment. The health care policymaking system receives inputs (support or resources and the various influences shown in the diagram) and converts those inputs into outputs through a process organization theorists call throughput. The two-header arrows in the diagram suggest that the system also operates a feedback process. Feedback can be negative or positive. Negative feedback

identifies problems, whereas positive feedback points to policies or parts of policies that work as intended. This information is used to adjust the inputs and the policy-making system in order to produce better and more acceptable outputs.

Having presented the model for the study, it is important to further clarify the contents of the policymaking system, at least as used in the study. The policymaking system comprises the legislatures, political executives, administrative agencies, and the courts. They have constitutional and legal authority to formulate public policies. They are the people or institutions that are frequently referred to as official policy-makers (Anderson 2006, p. 48). The official policy-makers are further divided into primary (Congress, the president, and the courts) and supplementary (administrative agencies and independent regulatory bodies) categories. As we discussed in the chapter under institutional rational theory, the Constitution sets the basic institutional rules for the legislature, the presidency, and the courts, while a legislative statute sets the rules governing administrative agencies' operations (Sabatier 1991, p. 151). This makes administrative agencies dependent on legislatures.

The primary policy-makers are joined by "nongovernmental participants," including interest groups, political parties, research organizations or think tanks, communications media, and individual citizens. Nongovernment participants are, at least theoretically, not legally authorized to make public policies; however, they exert great amounts of influence on the policymaking process and interact in significant ways with the primary policy-makers. The functions, modes of operation, and the interactions between most of the governmental and nongovernmental participants, as well as the interactions between the various elements of the environment, are discussed in greater detail in Chap. 3.

The external factors that are the main focus of our study developed over time and are continuously undergoing changes. For example, the US Constitution has undergone several formal and informal changes since it was adopted by the founding fathers in 1787. Similarly, the political system is not static. Technological, legal, economic, physical, global, demographic, and social and cultural changes are occurring even as this book is being written. In short, some of the features of the health care system that are usually targeted for reform are the intended and unintended consequences of past policies and practices. Therefore, before we analyze each of the external factors in Fig. 1.1, in the next chapter we undertake a comprehensive examination of the evolution of the health care system. The book is divided into ten chapters, as follows:

The Organization of the Book

Chapter 2 is based on the premise that the past is the key to understanding the present, a phenomenon social scientists call path dependence. The chapter reviews the history of the development of the health care system. The analysis should provide the context that will help us answer some of the questions posed in the introductory

pages of this chapter. For example, the historical information reviewed in Chap. 2 demonstrates that the dissatisfaction currently experienced by physicians is partly due to the recent expansion of corporate influence in medicine and the decline of provider autonomy. Similarly, the historical information will help explain why the nation still does not have universal coverage, and the reasons for the ongoing pursuit of cost containment and efficiency.

Chapter 3 analyzes the constitutional, legal, and political influences on the health care policymaking process. Some of the important concepts and ideas considered in this chapter are disagreements about the role of government in health care delivery; federalism, separation of powers, divided government, and the existence of multiple veto points in the policy process; the dual nature or “split personality” of Congress, or the institution’s conflicting policymaking and representative functions; the nation’s political culture and ideology; presidential leadership; health interest groups, political parties, public opinion, and the media; the electoral cycle and the government-politics model of decision-making; and the courts and other legal considerations.

Chapter 4 analyzes both the economic influences on the health policymaking process and the impacts of health providers’ behaviors and motivations, especially physicians’ attitudes, aspirations, and modes of operation. The quality of the health care system is only as good as the quality of the people who provide health services. Cost containment notwithstanding, drugs, surgery, and other health care inputs cannot be acquired without physician initiative and concurrence (McGuire 2000, p. 463). Therefore, economic issues and health providers’ perspectives are profoundly important considerations for health care policymaking and financing, and for the demand, supply, and utilization of health services. Economic considerations influence the types of health care services produced, the costs of producing the necessary services, where the services are produced, and the likely beneficiaries of the produced services. Most of the health policies and programs that have been implemented out of concern for efficiency and cost containment, such as health planning, health maintenance organizations (HMOs), prospective payment based on diagnosis-related groups (DRGs), consumer-directed health plans, risk sharing, disease management, etc., are discussed in this chapter.

Chapter 5 focuses on medical technologies or the standardized physical and social means employed to deliver health care. Medical technologies are divided into traditional, designed, and physical categories. The demand- and supply-side factors responsible for the growth and diffusion of medical technologies are examined, as well as the effects of these technologies on medical training and practice, costs and quality of care, quality of life and access to care, and the ethical concerns raised by technological innovations. The chapter also examines government and private sector roles in technology development and assessment.

Chapter 6 combines the physical, social and cultural, and global factors that influence health policymaking. Whereas physical, social, and cultural factors help determine the health status of the American people, the health care system itself, the locations of health facilities and personnel, and consumers’ health seeking and

utilization behaviors are deeply rooted in the traditional beliefs and values held by the American people. The chapter also explains and analyzes the implications of the wellness and medical models of health, the determinants of health, and the results of past studies on the leading causes of death in the United States. Most of the deaths in the country are preventive and are due to social, economic, behavioral, and environmental causes. Furthermore, not only do the nation's immigration laws determine whether foreigners can legally enter or reside in the country, migration and population mobility, trade and travel, terrorism, and the emerging and reemerging infectious diseases present new health challenges for the United States, other developed nations, and for the developing countries as well. The chapter explores how changes in migration and population mobility, international trade, and communication technologies affect the health policymaking process in the United States.

In Chap. 7, we look at access to health services among different population groups, the social and market justice principles and their effects on access to health care, the extent of uninsurance, and the causes and consequences of uninsurance in the country. The previously strong association between employment and the possession of health insurance, and the recent paradoxical link between employment and uninsurance, or the decline of employer-sponsored insurance (ESI), are examined. Furthermore, the racial, ethnic, geographical, and poverty-induced disparities in health experienced by the American people are examined in this chapter as well.

Chapter 8 argues that the health disparities discussed in the previous chapter would probably have been worse had it not been for the safety net programs of Medicare, Medicaid, and SCHIP (now simply called CHIP). The chapter looks at the characteristics of these programs and the politics they engender, the populations covered, enrollment information, and program expenditures.

In Chap. 9 we argue that perceptions of the inadequacies of the health care system have always fueled the calls for reform. The chapter revisits the data presented in Chap. 7, which show that Massachusetts and Hawaii were the two topmost states with the lowest non-elderly uninsurance rates between 2008 and 2009, and briefly examines the reforms that were enacted in those two states. After that, the chapter examines the *Affordable Care Act* (PPACA) of 2010, the anticipated effects of the law on costs, quality of care, health disparities, universality of coverage, and the controversies and litigations the legislation has engendered. Furthermore, the chapter looks at the four decision choices facing the Supreme Court with regard to the legal challenges to the PPACA.

Finally, Chap. 10 summarizes the arguments made throughout the book and examines the likely future direction of American health politics and policies. The future politics of health care policy will be greatly influenced by what happens to the PPACA. The future focus of health policy scholars will include analysis of the outcome of the challenges to the PPACA and determination of the consequences of any changes, if any, made to the legislation. Such analysis will help us understand the priorities of the law's opponents.

Conclusion

The problems afflicting the US health care system are many and include high costs, reduced access to care for millions of people, quality concerns, avoidable illnesses and premature deaths, and disparities based on race, geography, ethnicity, and income. The strong disagreements about the causes of these problems result in equally strong disagreements about the need for reform and, if reform is deemed essential, the appropriate remedies. In order to fully understand and appreciate the factors that are responsible for the difficulties experienced by the health system, and why there is no bipartisan agreement as to the measures that should be taken to alleviate the identified problems, we must study the environment of the health care policymaking system. Therefore, this book is about the factors that influence health care policymaking and reform in the United States. They involve constitutional, political, economic, technological, physical, social and cultural, legal, demographic, global, and health practitioner dimensions.

Review Questions

1. What are some of the problems that currently afflict the health care system?
2. What are the direct and indirect costs of government and private expenditures for health care services?
3. What are the effects of the direct and indirect expenditures on those who incur them?
4. Identify and briefly describe some of the quality problems facing the health care system.
5. Why do health care stakeholders disagree among themselves about the causes of the problems facing the health care system?
6. How is problem definition likely to affect policy formulation?
7. Identify the various models that can be used to study the health care policymaking process.
8. What are the limitations of the models you identified in Question 7?
9. What are the environmental factors that influence the health care policymaking process?

References

- AFL-CIO. 2009. *What's Wrong With America's Health Care?* Retrieved September 20, 2009, from <http://www.aflcio.org/issues/healthcare/whatswrong/index.cfm?RenderForPrint=1>.
- American Medical Association (2008). "Overview of the AMA Reform Proposal." Retrieved April 4, 2009, from <http://www.voiceforthefuture.org/amaproposal.html>.
- Anderson, J.E. 2006. *Public Policymaking*, 6th ed. Boston, MA: Houghton Mifflin.

- Bates, D.W. 2002. "The Quality Case for Information Technology in Health Care." *BMC Medical Informatics and Decision Making* 2002, 2:7. DOI:10.1186/1472-6947-2-7.
- Beard, C.A. 1940. "Administration, A Foundation of Government." *American Political Science Review* 34(2): 232–235.
- Buchanan, J.M., and G. Tullock. 1962. *The Calculus of Consent*. Ann Arbor, MI: University of Michigan Press.
- Cigler, A., and B. Loomis. 1983. "Introduction: The Changing Nature of Interest Groups." In *Interest Group Politics*, eds. A. Cigler and B. Loomis. Washington, DC: CQ Press, 1.
- Cobb, R., and C. Elder. 1983. *Participation in American Politics: The Dynamics of Agenda Building*. Baltimore, MD: Johns Hopkins University Press.
- Cohen, M.D., J.G. March, and J.P. Olsen. 1972. "A Garbage Can Model of Organizational Choice." *Administrative Science Quarterly* 17(1): 1–25.
- Cutler, D.M. 2004. *Your Money or Your Life: Strong Medicine for America's Healthcare System*. New York, NY: Oxford University Press.
- Dahl, R. 1970. *Who Governs? Democracy and Power in an American City*. New Haven, CT: Yale University Press.
- Davis, K., G.F. Anderson, D. Rowland, and E. Steinberg. 1990. *Health Care Cost Containment*. Baltimore, MD: Johns Hopkins.
- DeNavas-Walt, C., B.D. Proctor, and R.J. Mills. 2004. *Income, Poverty, and Health Insurance Coverage in the United States: 2003* (Census Bureau Current Publication Reports, No. P60–226). Washington, DC: U.S. Government Printing Office, 1–69.
- Denhardt, R.B., and J.W. Grubbs. 1999. *Public Administration: An Action Orientation*, 3rd ed. Fort Worth, TX: Harcourt Brace College Publishers.
- Domhoff, W. 1996. *State Autonomy or Class Domination?* New York, NY: Aldine de Gruyter.
- Dye, T.R. 2008. *Understanding Public Policy*, 12th ed. Upper Saddle River, NJ: Pearson/Prentice Hall.
- _____ and H. Zeigler. 2003. *The Irony of Democracy*, 12th ed. Belmont, CA: Wadsworth.
- Frist, W.H. 2005. "Shattuck Lecture: Health Care in the 21st Century." *The New England Journal of Medicine* 352(3): 267–272.
- Gaus, J. 1947. *Reflections on Public Administration*. University, AL: University of Alabama Press.
- Gawande, A. 2009. "Getting There From Here: How Should Obama Reform Health Care?" *The New Yorker* (January 26). Retrieved May 9, 2011, from http://www.newyorker.com/reporting/2009/01/26/090126fa_fact_gawande.
- Graig, L.A. 1999. *Health of Nations*, 3rd ed. Washington, DC: CQ Press.
- Haberstroh, C.J. 1965. "Organization Design and Systems Analysis." In *Handbook of Organizations*, ed. J.G. March. Chicago, IL: Rand McNally, 1171–1211.
- Hacker, J.S. 2009. "Yes We Can? The New Push for American Health Security." *Politics and Society* 37(1): 3–32.
- Institute of Medicine. 2002. "Care Without Coverage: Too Little, Too Late." Washington, DC: National Academy Press.
- Jacobs L.R., and T. Skocpol. 2010. *Health Care Reform and American Politics: What Everyone Needs to Know*. New York, NY: Oxford University Press.
- Johnson, W.C. 1996. *Public Administration: Policy, Politics, and Practice*, 2nd ed. Boston, MA: McGraw Hill.
- Katz, D., and R.L. Kahn. 1966. *The Social Psychology of Organizations*. New York, NY: John Wiley and Sons, Inc.
- Kendall, D.B. 2005. "Fixing America's Health Care System: A Progressive Plan to Cover Everyone and Restrain Costs." Washington, DC: Progressive Policy Institute.
- Kettl, D.F., and J.W. Fesler. 2005. *The Politics of the Administrative Process*, 3rd ed. Washington, DC: CQ Press.
- Kingdon, J.W. 1995. *Agendas, Alternatives, and Public Policies*, 2nd ed. New York, NY: HarperCollins College Publishers.

- Kiser, L., and E. Ostrom. 1982. "The Three Worlds of Action." In *Strategies of Political Inquiry*, ed. E. Ostrom. Beverly Hills, CA: Sage, 179–222.
- Kohn, L.T., J.M. Corrigan, and M.S. Donaldson, eds. 2000. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press.
- Latham, E. 1965. *The Group Basis of Politics*. New York, NY: Octagon Books.
- Levit, K., C. Smith, C. Cowan, A. Sensenig, and A. Catlin. 2004. "Health Spending Rebound Continues in 2002." *Health Affairs* 23(1): 147–159.
- Lindblom, C. 1959. "The Science of Muddling Through." *Public Administration Review* 19(2) (Spring): 79–88.
- . 1965. *The Intelligence of Democracy: Decision Making Through Mutual Adjustment*. New York, NY: Free Press.
- . 1977. *Politics and Markets: The World's Political-Economic Systems*. New York, NY: Basic Books.
- . 1979. "Still Muddling, Not Yet Through." *Public Administration Review* 39(6) (Nov./Dec.): 517–526.
- . 1980. *The Policy-Making Process*, 2nd ed. Englewood Cliffs, NJ: Prentice Hall.
- Longest Jr., B.B. 1994. *Health Policymaking in the United States*. Ann Arbor, MI: AUPHA Press/Health Administration Press.
- McGuire, T.G. 2000. "Physician Agency." In *Handbook of Health Economics*, Volume I., eds. A.J. Culyer and J.P. Newhouse. North Holland: Elsevier Science Publishers, 462–535.
- McGlynn, E.A., S.M. Asch, J. Adams, J. Keeseey, J. Hicks, et al. 2003. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine* 348(26): 2635–2645.
- Miller, G. 1992. *Managerial Dilemmas: The Political Economy of Hierarchy*. New York, NY: Cambridge University Press.
- Mills, C.W. 1973. *The Power Elite*. London, England: Oxford University Press.
- Moe, T. 1995. "The Politics of Structural Choice: Toward a Theory of Public Bureaucracy." In *Organization Theory: From Chester Barnard to the Present and Beyond*, ed. O.E. Williamson. New York, NY: Oxford University Press, 116–153.
- Niskanen, W. 1971. *Bureaucracy and Representative Government*. Chicago, IL: Aldine Atherton Press.
- Olson, M. 1965. *The Logic of Collective Action*. Cambridge, MA: Harvard University Press.
- Ostrom, E. 1990. *Governing the Commons*. New York, NY: Cambridge University Press.
- . 1991. "Rational Choice Theory and Institutional Analysis: Toward a Complementarity." *American Political Science Review* 85(1) (March): 237–243.
- Paul-Shaheen, P.A. 1990. "Overlooked Connections: Policy Development and Implementation in State-Local Relations." *Journal of Health Politics, Policy and Law* 15(4): 833–856.
- Payer, L. 1996. *Medicine & Culture*. New York, NY: Henry Holt and Co.
- Peterson, M. 1993. "Political Influence in the 1990s: From Iron Triangles to Policy Networks." *Journal of Health Politics, Policy and Law* 18(2) (Summer): 395–438.
- Reinhardt, U.E., P.S. Hussey, and G.F. Anderson. 2004. "U.S. Health Spending in an International Context." *Health Affairs* 23(3): 10–25.
- Sabatier, P. 1991. "Toward Better Theories of the Policy Process." *PS: Political Science and Politics* 24(2) (June): 147–156.
- Schattschneider, E.E. 1960. *The Semisovereign People*. New York, NY: Holt, Rinehart and Winston.
- Schlager, E., and W. Blomquist. 1996. "A Comparison of Three Emerging Theories of the Policy Process." *Political Research Quarterly* 49(3) (September): 651–672.
- Schroeder, S.A. 2007. "Shattuck Lecture: We Can Do Better—Improving the Health of the American People." *The New England Journal of Medicine* 357(12): 1221–1228.
- Simon, H.A. 1957. *Administrative Behavior*, 2nd ed. New York, NY: Free Press.
- Starfield, B. 2000. "Is U.S. Health Really the Best in the World?" *JAMA* 284(4), 483–485.
- Stone, D.A. 1988. *Policy Paradox and Political Reason*. Glenview, IL: Scott, Foresman and Company.

- Truman, D. 1951. *The Governmental Process*. New York, NY: Alfred A. Knopf.
- Ubokudom, S. E., and J. Khubchandani. 2010. "The Ecology of Health Policy Making and Reform in the United States of America." *World Medical and Health Policy* 2(1): Article 19. DOI: 10.2202/1948-4682.1010.
- _____. 2008. "The Ecology of Public Policy and Administration in Nigeria." *Public Policy Journal, APPA-Nigeria* 2(1), 1–19.
- United States Centers for Medicare & Medicaid Services (CMS). National Health Expenditure Web Tables. Retrieved April 6, 2009, from <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.
- Wikipedia. 2011. "Mutual Assured Destruction." Retrieved April 1, 2011, from http://en.wikipedia.org/wiki/Mutual_assured_destruction.
- Williams, D.R., and P.B. Jackson. 2005. "Social Sources of Racial Disparities in Health." *Health Affairs* 24(2): 325–334.
- Wilper, A.P., S. Woolhandler, K.E. Lasser, D. McCormick, D.H. Bor, and D.H. Himmelstein. 2009. "Health Insurance and Mortality in U.S. Adults." *American Journal of Public Health* 99(12): 2289–2295.
- Wilson, C.A. 2008. *Public Policy: Continuity and Change*. Long Grove, IL: Waveland Press, Inc.

Chapter 2

The Evolution of the US Health Care System

The previous chapter introduced the subject matter of this book, the environmental factors that influence the United States' health care policymaking process and reform. The problems facing the health care system, the role of problem definition in policy formulation, including the specification of different alternatives to solve the problems, and the failures of previous reform efforts, were briefly introduced. We ended that chapter by noting that the manner the Constitution disperses power at the federal level of government, the political processes in the country, and the other environmental factors identified in the chapter influence the health care policymaking and reform processes in the country. We further argued that since the factors that influence the health care policymaking system and impede reform evolved over time, it was necessary to devote a chapter of the book to examining how the health care system has been transformed from the early years to the present time. Therefore, this chapter of the book appropriately examines the history of the evolution of the health care system. The chapter is based on the notion of path dependence, in which the past provides useful lessons for the future.

The history of the evolution of the US health care system presented in this chapter is selective and brief, and benefits considerably from the publications of the pioneer writers on the history of American Medicine. These previous works are credited throughout the chapter. In order to meet our goals for the chapter, the analysis is divided into the following three broad historical periods which are not necessarily mutually exclusive: the preindustrial or rudimentary period (1750–1849), the postindustrial period (1850–1969), and the cost containment period (1970–present). The major highlights or milestones of the above three periods are summarized below in Table 2.1, followed by the narratives.

Table 2.1 Major milestones of the evolution of the US health care system

The preindustrial period (1750–1849)

- Care of the sick was undertaken within the family. Bloodletting was widely used to treat disease
- People, who wished to, including clergymen, took up medical practice and appropriated the title of doctor
- Substandard medical schools began to proliferate in America after the war of 1812
- The supply of physicians in the early and mid-nineteenth century was unrestricted
- Between 1870 and 1910, a large number of doctors moved from the rural areas to the large cities
- Toward the end of the period, people came to depend more on the medical profession to provide care than their family members
- By the early twentieth century, many doctors went to work at hospitals or at doctors' offices attached to hospitals

The postindustrial period (1850–1969)

- Represents the period of the growth of the power and authority of organized medicine
- Significant reductions in the occurrence of infectious disease epidemics occurred
- The AMA was founded in 1847 and incorporated in 1897
- Professionalization of nursing began about 1873
- Development of medical science began during this period
- In 1888, the Supreme Court ruled in favor of licensure in the case of *Dent v. West Virginia*
- In 1898, the Supreme Court added good moral character as another condition for licensure in the case of *Hawker v. New York*
- By 1901, about 20 states and the District of Columbia required presentation of an acceptable diploma and passage of an independent state examination to obtain a medical license
- The AMA created its House of Delegates in 1901, making the association a confederation of state medical societies
- Reform of medical education began at Harvard, University of Pennsylvania, and Johns Hopkins in the late 1800s
- The AMA Council on Medical Education was established in 1904 and mandated to upgrade and standardize medical training
- The Food and Drug Act was passed in 1906
- The Flexner Report was published in 1910
- The AMA Council on Medical Education changed its name to Council on Medical Education and Hospitals in 1920
- The Sheppard-Towner Act was passed in 1921 and repealed in 1927 because of the AMA's opposition
- The Great Depression began in the early 1930s; the Blue Cross insurance plans were adopted by the AHA in 1933; Blue Shield plans were established several decades after the emergence of Blue Cross plans; and the Social Security Act (SSA) was passed in 1935
- The Wagner Act of 1935 included wages and conditions of employment as subject to collective bargaining; the Wagner language was retained by the Taft-Hartley Act of 1947; the Supreme Court affirmed the Taft-Hartley language that unions could negotiate benefit plans
- The Hospital Survey and Construction Act (Hill–Burton) was signed into law in August 1946; the National Institute of Health (NIH) was established in the same year
- Commercial indemnity insurance enjoyed great expansion after WWII
- The Kerr-Mills Act was passed in 1960
- Medicare and Medicaid were passed in 1965
- The prices of hospital and physician services rose markedly after the passage of Medicare and Medicaid

(continued)

Table 2.1 (continued)

The cost containment period (1970–present)

- Represents the period of contraction and heavy regulation of the health care system
 - The Nixon Administration imposed a freeze on wages and prices in the entire economy, including the hospital industry, an approach labeled the Economic Stabilization Program (ESP)
 - Professional Standard Review Organizations (PSROs) were established in 1972
 - The Health Maintenance Organization (HMO) Act was signed in 1973
 - Certificates of need (CON) began as a voluntary program in the states in 1974
 - Medicare prospective payment system (PPS) based on diagnosis-related groups (DRGs) was begun in 1984
 - Utilization and Peer Review Organizations (PROs) were established in 1984
 - Prepayment, utilization controls, high deductibles, capitation, rate setting, health reimbursement accounts (HRAs), and case management became more common
 - The Health Insurance Portability and Accountability Act (HIPPA) was passed in 1996
 - The balanced budget amendment (BBA) of 1997 established Medicare Part C (Medicare Advantage Plans)
 - The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA 2003) authorized the start of a voluntary prescription drug program under Medicare (Medicare Part D)
 - There is serious decline in employer-sponsored insurance (ESI)
 - More and more Americans are uninsured
 - President Obama and his health policy team began another push for universal coverage and cost controls in 2009
 - A comprehensive health care reform law, the Patient Protection and Affordable Care Act (PPACA) of 2010, was passed by the Democratic party-controlled Congress and signed into law by President Obama in late March 2010; not a single Republican legislator in either the House or the Senate voted for the reform plan
 - Passage of the Obama health care reform law was followed by violent acts and threats against some Democratic party lawmakers; several lawsuits were filed challenging the constitutionality of the Affordable Care Act
-

The Preindustrial Period

The predominant health problems of the American people during the preindustrial or rudimentary period were related to infectious disease epidemics such as plagues, cholera, typhoid, smallpox, tuberculosis, influenza, yellow fever, and many other fatal infectious diseases. The occurrence of these diseases was associated with unsanitary foods and poor living conditions, contaminated drinking water, poor personal hygiene, and inadequate waste disposal systems. The methods used to treat these diseases were primitive and rudimentary.

Between 1830 and 1840, American physicians failed in their quest to establish themselves as an exclusive and privileged profession. Nontrained or lay practitioners, using native herbs and homemade remedies, flourished in the country and laid claim to their inalienable rights to practice medicine. These lay practitioners could not be stopped because the regular medical profession was weak, lacked cohesion and self-confidence, and did not speak with one voice.

During the preindustrial period, the care of the sick was undertaken within the family, usually by women who relied on advice from other family members and from published guidelines to domestic medical practice (Starr 1982, p. 30). One such publication, William Buchan's *Domestic Medicine* (1971), emphasized diet, simple preventive measures, fresh air, and simple cleanliness as being more valuable for maintaining health than anything else regular doctors could do (Blake 1977, p. 11).

In addition to diet and the other remedies, bloodletting occupied a central place in Buchan's guidelines as it did in many of the other books that came after his own. Therefore, American medicine was based on a narrow scientific base during the period and medical practice was largely a weak and insignificant trade (Shi and Singh 2008, p. 88; Ubokudom 2003, p. 59). Unlike in eighteenth century England, nineteenth century America did not provide physicians the means to guard entry into the profession or fix the boundaries that separated regular practitioners from the irregulars (Shryock 1960, p. 9). All forms of people took up medicine in the American colonies and appropriated the title of doctor. It was very common for the clergy to combine medical and religious services to their congregations. Gradually, however, those who practiced medicine in colonial America began to practice it as a primary occupation, and by the mid-eighteenth century, they emerged as a corporate group.

Later in the period, many ill-trained American doctors traveled to Europe to acquire medical education. On their return, they strived to create in America a profession with the standards and respect that European physicians enjoyed (Starr 1982, p. 39). Therefore, America's first wave of the professionalization of the medical profession began around 1750. This quest for professionalism led to the establishment of the first medical school in Philadelphia in 1765, the organization of the first provincial medical society in New Jersey in 1766, and to the passage of the first licensure law calling for prospective examination of doctors in New York in 1760 (Haber 1974, p. 237).

Medical schools began to proliferate in America after the War of 1812. By 1850, there were 42 medical schools in the country. But the requirements for graduation from medical school were neither standardized nor enforced. Also, the examinations were usually not rigorous because the professors, who were mostly unsalaried, were only paid by students who passed the examinations. The existing medical schools were not keen on raising standards due to lack of cooperation among them, and due to the fear of losing students and income. The licensing laws that were enacted in the early 1800s were rescinded in quick succession by the middle of the century because of public suspicion that licensure was an expression of favor rather than competence. Licensure conflicted with the Andrew Jackson administration's ideology of not allowing the establishment of executive privileges (Schlesinger 1945). Paradoxically, the prominent position of women in providing medical care as lay practitioners declined during the Jacksonian period.

Encouraged by the Women's Rights Movement of the 1840s, a few women secured formal medical training in colonial America. The New England Medical College was founded in Boston in 1848 as the first medical school exclusively for women in the world (Blake 1965, p. 99).

The market for medical services was limited during the early part of the preindustrial period because the real incomes of the people were low and most of the country was rural. As these economic conditions changed in the nineteenth century, the economic opportunities of the medical profession changed as well—the market for medical care expanded.

The Maximization of the Market

Nineteenth century America was influenced by two distinct or opposite impulses, the desire to expand the market as well as the desire to regulate it. Supporters of unregulated markets wanted private choice to govern the care of the sick. Consequently, they supported the abolition of medical licensing. On the other hand, the medical societies sought protection from an unregulated market by advocating limits on entry into practice, price cutting, and limits on advertising. These actions, in my opinion, signaled the beginning of the private nature of health care in the United States. In the late eighteenth and early nineteenth centuries, government relinquished control over professional fee regulation. After the collapse of licensure in the 1830s and 1840s, the state gave up involvement in the private transactions between medical practitioners and their patients. State involvement was limited to enforcing contracts and providing the legal means for determining and redressing negligence or malpractice. Government involvement in the economics of medicine was limited to reimbursing doctors for indigent care, providing subsidies to medical schools and hospitals, and maintaining a limited system of compulsory hospital insurance for merchant seamen.

During the period under review, most physicians were paid on a fee-for-service or a fee-per-case basis. Some physicians were retained for a fixed annual payment to provide all needed care for a family, a plantation, or the indigents in a community. This so-called contract medicine was disapproved by many practitioners who believed that they would be exploited under the contractual arrangement if they were required to provide unlimited services. But in spite of their fear of exploitation, much medical care was provided on credit and practitioners lost a large portion of their potential earnings because of unpaid bills.

The supply of physicians in the early and mid-nineteenth century was unrestricted. The cost of medical education was kept relatively low. Because licensing had failed to restrict entry into practice, and because there were no limits as to the number of students the existing medical schools could admit, the supply of doctors grew significantly. Barlow and Powell (1980, p. 386) report that between 1790 and 1850, the number of physicians in the United States increased from 5,000 to 40,000, an increase of 700% in 60 years. Complaints about overcrowding in the profession were common, even though there was no maldistribution of doctors between the urban and rural areas.

In the late nineteenth century, doctors moved to cities even more rapidly than the population as a whole. Starr (1982, p. 69) cites the AMA data that show that between

1870 and 1910, the number of physicians per 100,000 people jumped from 177 to 241 in the large cities, while it fell from 160 to 152 in the rest of the country. This occurred at a time when the overall ratio of doctors to population was still increasing. This development likely signaled the beginning of physicians' preference for urban as opposed to rural practice, and the beginning of the ongoing shortage of physicians in the rural areas of the country.

The emergence of telephones, automobiles, paved roads, and the growth of cities cut down the costs of medical care and increased the amount of time available for a doctor to spend with his patients, thereby putting medical care within the reach of more people. People came to depend more on the medical profession to provide care than their family members. Similarly, the growing institutionalization of patients contributed to the expansion of the opportunities for physicians. Whereas there was very little demand for general hospital services in the early nineteenth century, the middle of the century witnessed rapid growth in the numbers of general hospitals. However, the unsanitary conditions of hospitals and the frequency of nosocomial infections led families to manage illness at home if they could possibly do so.

Toward the end of the nineteenth century, medical treatments in physicians' offices and in the hospital were losing their negative perceptions, while the use of the patients' homes as the locus of physicians' services was experiencing declining popularity. By the early twentieth century, many physicians went to work at hospitals or doctors' offices attached to hospitals and had little contact with the homes or living conditions of the patients they treated. All of these changes widened the medical market and created new opportunities for specialization. The groundwork for the dominance of the medical profession over health care services was laid toward the end of the preindustrial period. Complete dominance of the market was achieved in the postindustrial period.

The Postindustrial Period

This period represents the growth of the power and authority of the medical profession in the United States, improvements in the methods of health care delivery, significant reductions in the occurrence of the infectious disease epidemics that were rampant during the preindustrial period, the building of hospitals, and the subjection of other health care professionals to physician control.

This section appropriately begins with a discussion of the growth of the authority of the medical profession because that was the instrument for achieving all the other changes witnessed during the period. For any interest or group, the accumulation of authority requires the resolution of the internal problem of consensus among group members and gaining the respect of the community. The resolution of internal group conflicts facilitates the formulation and attainment of common interests and group effort. Similarly, respect and deference from the larger population led to the granting of privileges and respect from the more powerful groups in society (Starr 1982, p. 80).

The internal divisions within the medical profession during the preindustrial period caused the profession to be unable to convince its members of the need for collective action in the interest of the entire profession. The efforts to overcome this situation involved the standardization of medical education and the pursuit of licensure. Toward this end, a convention of the younger, more active, and ambitious members of the profession was held in New York in 1846 to plan a national medical association for the country. This convention led to the founding and incorporation of the AMA in 1847 and 1897, respectively. The initial goals of the AMA were to raise and standardize the requirements for medical degrees and to enact a code of ethics for the profession. The code of ethics that was enacted denied fraternal courtesy to “irregular” practitioners or those who were considered quacks.

The AMA did not have much success during its first 25 years. The bitter feuds and divisions among medical practitioners weakened the profession through the late nineteenth century. The activities of the competing parties within the profession—the homeopaths, allopaths, and eclectics—hindered efforts by allopaths to reconsider the idea of licensing and to reform medical education. Eventually, the allopaths came to the realization that it was in the interest of the profession to reach a compromise with the other groups.

The development of medical science enhanced the chances of compromise and cooperation among the competing interests. As scientific knowledge was correlated with actual medical practice, the differences between the different groups within the profession were minimized. In other words, the growth of science and the need for collective action laid the groundwork for a consensus on the need for licensing. The eclectics and homeopaths were gradually co-opted into the regular medical profession.

Restoration of Licensing

In the 1870s and 1880s, the different groups within the medical profession supported efforts to win licensing laws to protect them against competition from untrained practitioners (Rothstein 1972). Once united, doctors were able to win supportive licensing laws that imposed moderate licensing fees and left the implementation to the profession itself. By 1901, about twenty states and the District of Columbia required that all candidates for a medical license must present an acceptable diploma and pass an independent state examination (AMA 1901, p. 138). Protests of medical licensure were silenced by the Supreme Court ruling on January 14, 1889, supporting licensing requirements in the case of *Dent v. West Virginia*. In the case of *Hawker v. New York*, decided on April 18, 1898, the Supreme Court extended the grounds for license denial to include the character of the applicant.

The AMA revised its constitution in 1901 to create a new legislative body, the House of Delegates. The House of Delegates had a fixed membership of 150 persons, drawn primarily from state medical societies in proportion to their membership. Membership on the body was periodically reapportioned as the memberships

of the state medical societies changed. This change essentially made the AMA a confederation of state medical societies, while the state medical societies became confederations of the states' county medical societies. Consequently, the membership of the AMA rose from about 8,000 members in 1900 to about 70,000 in 1910, or about 50% of the physicians in the country. By 1920, membership had reached 60% of the physicians in the country (Burrow 1963, p. 49). This was the beginning of what later came to be known as "organized medicine."

The enactment of licensing laws did not curtail the production of doctors. The oversupply of physicians remained a problem for the AMA. There was a greater increase in the population of physicians relative to the increase in the overall population of the country. The profession sought help from the existing medical schools to curb the production of doctors.

Reform of medical education began at Harvard University in 1871, followed by the University of Pennsylvania in the mid 1870s. Johns Hopkins started a 4-year medical school in 1893 and required that all entering students be college graduates. A hospital was built to support the medical school. Johns Hopkins modeled medical education as a field of graduate study, rooted in basic science and practical hospital experience. This later became the model for other institutions in the country.

The educational gains made at Johns Hopkins, Harvard, and the University of Pennsylvania were mitigated by the continuing growth of commercial medical schools. The AMA decided to be directly involved with improvements in the quality of medical education through state licensing boards. In 1904, the AMA established the Council on Medical Education and mandated it to upgrade and standardize medical training requirements in the country. The Council prescribed a minimum standard of 4 years of education each for high school and medical school, and passage of a licensing test after completion of the medical training. In addition, the Council began to inspect and grade medical schools based on their curriculum requirements, facilities, faculty, admission standards, and according to the performance of their graduates on state licensing examinations.

To avoid the perception of conflict of interest, the AMA Council on Medical Education invited an independent body, the Carnegie Foundation for the Advancement of Teaching, to conduct similar investigations of medical schools. The result of the Carnegie Foundation's independent investigations was the Flexner Report, published in 1910, which called for the upgrading of some medical schools and the closing of those deemed inferior. Eventually, the AMA Council on Medical Education became the national accrediting body for medical schools.

The next steps by the AMA were to regulate the competition from patent medicine companies, and to redefine hospitals and incorporate them into medicine. Negative revelations and stories about the patent medicine industry led to the passage of the Food and Drug Act of 1906, and to the creation of the Food and Drug Administration (FDA) to regulate drugs. The Food and Drug Act was strengthened at different times between 1912 and 1920. The initial law and the amendments essentially made patent medicine manufacturers more deferential to the medical profession and rechanneled drug purchases through physicians. From the changes so far documented, the medical profession gained legal privileges, economic power,

higher incomes, and enhanced social status (Starr 1982, p. 142). The high incomes were used to change medical institutions, especially hospitals, from charities dependent on philanthropists into market institutions. These institutions gradually opened their doors to physicians who were not their employees.

Hospitals Transformed

By the middle of the nineteenth century, hospitals had been transformed to active centers of treatment staffed by professional physicians. They came to rely less on charity and more on patient payments for the services they received. The transfer of contagious and incurable cases to pest houses and almshouses, respectively, led to the decline of mortality rates in the hospitals. It also allowed the hospitals to be more able to serve as centers of experiential learning for medical students. But even then, the hospitals still needed the merchants, bankers, lawyers, and politicians to contribute money and lead fundraising efforts on their behalf. Consequently, hospital boards and trusts, rather than physicians, retained the final decision-making powers in these institutions. Shortfalls in hospital revenues were made up by patients.

The professionalization of nursing, begun in 1873 with the establishment of three schools of nursing in New York, New Haven, and Boston, and the advent of antiseptic surgery, led to the establishment of order and cleanliness in hospitals. Accordingly, the effectiveness of nursing care became apparent. Nurses became indispensable caregivers of sick and injured patients, providing their physical, mental, and social needs. Although state governments continued to be the primary sources of funding for nursing education, the federal government increased its support for nursing education after World War II (WWII) through the *Nursing Training Act of 1964*, the *Health Manpower Act of 1968*, and the *Nursing Training Act of 1971*.

As nurses and other attendants were hired to do the menial tasks previously done by hospital patients themselves, hospital costs went up. Therefore, the need to achieve efficiency and reduce costs essentially caused hospitals to rely on physicians to generate incomes and increase efficiency. As a consequence, physicians became more important to the success of hospitals than the wealthy donor trustees. Physicians' indispensable role in generating revenues brought more privileges, prestige, and deference to their authority. Therefore, in 1920, the AMA's Council on Medical Education changed its name to the Council on Medical Education and Hospitals. In 1934, the AMA required all hospitals accredited for internship training to appoint only members of local medical societies to their staff. Minority groups, such as blacks who were excluded from local medical societies, were effectively denied hospital positions.

Physicians' domination of hospitals began to weaken in the 1930s and 1940s as administrators began to challenge their authority. This resulted in the development of the dual lines of authority structure, clinical and administrative. Currently, there are three separate centers of authority in hospitals, namely, trustees, physicians, and administrators. In the same manner, physicians preferred public health practices

that were complementary to private practice. Those who were diagnosed by public health facilities as being sick were referred to private physicians for treatment.

When the health center idea was revived in the 1960s, their functions were conceived of as being complementary to, rather than substituting for, the work of private physicians. Opposition to corporate enterprise in the practice of medicine was to achieve the same purpose, to discourage substitutes to physicians and to disallow the type of hierarchical controls that typically prevailed in industrial organizations. As the medical profession gained in prestige and the need for medical care rose, costs also went up beyond what many Americans could afford. The next task was to find ways to spread the financial risks associated with illness.

The Quest for Health Insurance

The quest for health insurance was the result of inflationary health care costs, the effects of uncontrolled costs on family income and the normal routine of family life, and the diminished industrial productivity caused by illness. Insurance was promoted as a means of spreading the risks of lost income to working-class families and reducing the inefficiencies in industrial production caused by illness. After nearly all the major European countries had adopted some form of health insurance on the eve of World War I (WWI), it was believed that the experience could be replicated in the United States. The intentions were noble, but the design and implementation were flawed.

Political discontent and unrest led to the introduction of social insurance in both England and Germany. Before the introduction of social insurance, these countries had established mutual benefit funds to provide sickness benefits to their people. But unlike Germany and England, there was no challenge to the political stability of the United States. The unrest that occurred in America in the 1890s because of an economic depression was agrarian and populist, and social insurance could not have cooled the tempers of the protesters. Socialism, which emerged in America in the early 1900s, did not pose nearly as serious a threat to the government as it did in Europe (Starr 1982, p. 240).

In addition to the absence of a significant threat to the US political system, labor unions, especially the American Federation of Labor (AFL) led by Samuel Gompers, opposed national health insurance for fear that the loyalty of their union members would be threatened. Similarly, employers generally saw compulsory health insurance as contrary to their interests; they rejected the argument that health insurance would increase productive efficiency. The Progressive Movement's proposal for health insurance died in the early 1920s because of opposition from the AMA, lack of support by labor unions, and the linking of the concept of social insurance to Nazi Germany, the perpetrator of WWI. The war essentially led to the demise of the Progressive Movement and their agenda.

Shortly before and during the Great Depression, there was very little direct government involvement in medical care. One of the few government programs enacted

to alleviate maternal and child health was the Sheppard-Towner Act of 1921. Taking advantage of the 19th Amendment, ratified in 1920 to extend voting rights to women, women reformers persuaded Congress to pass the legislation to provide matching funds to state governments for the building of prenatal and child health centers. These centers, which were staffed by women physicians and public health nurses, were opposed by the AMA and some state governments (Children's Bureau Publications 1978, p. 52). Consequently, the AMA pressured Congress to repeal the legislation and end the program in 1927 (Rothman 1978, p. 136; Starr 1982, p. 261).

The privately funded Committee on the Costs of Medical Care (CCMC) formed in 1926 concluded from one of its research activities that Americans needed more medical care than the existing system could provide. The Committee produced high estimates of the needs for different types of medical services and neglected such health-related factors as good nutrition, improved hygiene, better housing and more healthy work environments (Starr 1982, p. 264). The effect of this conclusion, deliberately or unintentionally, was to recommend programs and policies that would increase the demand for physician services. The final report of the Committee, which called for the promotion of group practice, group payment for medical care, and the enactment of voluntary insurance plans, was rejected by the AMA and the eight private practitioners that sat on the Committee. This controversy, coming around 1932 when Franklin D. Roosevelt assumed the presidency, persuaded the new administration to avoid health insurance.

The Great Depression

Ordinarily, the problems caused by the Great Depression could have been the impetus for agitation and passage of compulsory health insurance. Paradoxically, however, the hardships also changed the order of social reform by placing unemployment insurance on top of the social policy agenda, followed by old-age benefits and compulsory health insurance, respectively. As would be expected, health insurance was omitted from the Social Security Act (SSA), passed by wide margins in both houses of Congress in 1935. Even though the SSA did not include health insurance, it increased government involvement in public health, provided states with matching funds for maternal and infant care, rehabilitation of crippled children, and aid for dependent children under age 16.

The Depression led to steep declines in the utilization of medical services and in physicians' and hospitals' incomes. Payment for medical care became a significant function of welfare agencies and the Children's Bureau. Similarly, the Farm Security Administration (FSA) helped pay an agreed-upon fraction of billed medical services in the farming areas of the country. Many physicians who experienced severe losses of income were now willing to support some form of health insurance. The AMA's view, which was to restrict the supply of doctors rather than increase the demand for their services, prevailed and the Roosevelt administration was unwilling to invest its political capital to challenge the AMA and State Medical Societies.

Harry Truman, who succeeded Roosevelt, offered a national health plan involving a single system that would include all of American society (PBS 2009). Congressional reception for the Truman administration's entire plan, which included the expansion of hospitals, increased support for public health and maternal and child health services, and federal aid for medical research and education, was mixed. The proposal did not receive the support of physicians. A section of the plan, the expansion of hospitals, was signed into law as the *Hospital Survey and Construction Act* (Hill-Burton) in August 1946. The National Institute of Health (NIH) was also established in the same year, but the takeover of Congress by Republicans dealt a serious setback to the chances of passing the president's remaining health care priorities. However, amendments to the SSA in 1950 provided federal matching funds to states for payments to doctors and hospitals for welfare recipients' medical services. The numerous defeats of national health insurance proposals meant that health insurance in America would be predominantly private.

The Depression and Health Insurance

The development of health insurance began in the hospital industry during the Great Depression. The terrible economic conditions of the period encouraged hospitals to turn to insurance for financial relief and survival. In February 1933, the AHA approved hospital insurance as a "practicable solution" to the problem of allocating the costs of hospital care. The hospital plans sponsored by the AHA were nonprofit, covered hospital charges only, focused on the public welfare, provided free choice of physicians and hospitals, guaranteed services to covered beneficiaries regardless of the amount of reimbursement, and limited advertising to methods that the association considered appropriate. This was the beginning of the Blue Cross Plans. The success of these plans encouraged the growth of commercial carriers. After many years of resistance and standing on the sidelines, physicians established Blue Shield plans to pay for physician services, separate from hospital costs.

The nonprofit and commercial insurance plans experienced tremendous growth in the late 1940s when the *Taft-Hartley Act* of 1947 retained the language of the *National Labor Relations Act* (Wagner Act) of 1935, which included wages and conditions of employment as subject to collective bargaining. Soon after, the Supreme Court affirmed the Taft-Hartley language that benefit plans were within the conditions of employment that unions could negotiate with their employers (Munts 1960, p. 10). Therefore, by the end of 1954, more than 60% of the population had some type of health insurance coverage, 50% had some type of surgical insurance, and 25% had medical insurance (Anderson and Feldman 1956, p. 11).

Commercial indemnity insurance enjoyed great expansion after WWII. One of their most important attractions was their willingness to charge a lower price for healthy, low-risk subscribers, a practice called experience rating. This practice challenged the community rating approach employed by Blue Cross and Blue Shield (the Blues) and placed them at a disadvantage. Therefore, in order to survive, the

Blues reluctantly moved toward experience rating, and showed less interest in service-benefits. The convergence of the marketing practices of the Blues and commercial plans ultimately invited government intervention to prevent favorable selection or the unwillingness and inability to provide protection to high risk groups, such as the aged and disabled.

The Advent of Redistributive Health Policies

The end of the WWII marked the beginning of the great expansion of the federal government programs in support of medicine and medical care. The health expansions that were attained earlier, such as the Hill–Burton program, the revitalization of the Veterans’ hospital system, massive investments in science and medical research through the Office of Scientific Research and Development (OSRD), and the establishment in 1950 of the National Science Foundation (NSF), did not address or curtail the perceived deficiencies in the distribution of medical services. The aged, 65 years of age and above, were more likely to be hospitalized than their younger fellow citizens. At the same time, hospital care doubled in price during the 1950s. In 1960, Congress passed the Kerr-Mills Act, the predecessor of Medicare and Medicaid, which extended federal support for the needy or indigent medical care programs in the states. The benefits were subject to a few limits, and the federal financial participation (FFP) ranged from between 50 and 80% of the funds, with higher percentages going to the poorer states. Kerr-Mills beneficiaries were limited to the aged-poor who met the program’s financial standards. However, the means-tested provision of Kerr-Mills was attacked by liberals as being a source of humiliation to the aged.

In 1965, Congress reached two other major milestones, the passage of the Medicare (Title XVIII of the SSA, or Health Insurance for the Aged and Disabled) and Medicaid (Title XIX of the SSA) programs. The Medicare program is wholly financed by the federal government and beneficiaries’ premium payments. Medicaid, which provides medical benefits to the poor who meet income and assets requirements, is jointly financed by the federal and state governments. Both programs, which have undergone significant changes since 1965, along with similar newer programs that serve a distinct subset of the population, are discussed in more detail in Chap. 8.

The AMA and private insurance companies were initially opposed to the Medicare legislation. To gain their support, the program’s supporters in Congress included some loopholes in the legislation, such as the specification that physicians and hospitals would be paid their “usual and customary fees,” the use of private and nonprofit insurance companies as fiscal intermediaries instead of providers billing the Social Security Administration directly, and the Medicare statute’s stated objective of nonintervention in health care organization and delivery. Since the passage of Medicare, the prices of hospital and physician services rose markedly (Marmor 2000, p. 84; Ubokudom 1997, p. 18). In addition, Medicaid’s adoption of Medicare’s

implementation and bill payment approaches led to spending increases that were beyond expectation. The stage was now set for the next thrust of federal health care policy—cost containment.

The Cost Containment Period

The policies designed to improve the health care infrastructure by building hospitals, training physicians, investing in biomedical research, granting of authority to practitioners, hospitals, researchers, and medical schools to run their affairs, and providing health insurance of some form or another to the aged, disabled and the poor, led to health care inflation in the United States. Cost concerns began approximately in 1970 and continue till today. In short, the two premises that had guided government health policy—that Americans needed more medical care than the market alone could provide, and that medical professionals and private voluntary institutions were best equipped to decide how to organize health services—came under severe attack due to unbearable costs (Starr 1982, p. 379; Jennings 2001, p. 224; Tewes 2009, p. 3). The prevailing assumptions about the need for more medical care were reversed. The new understanding was the need to curtail the health care system's almost insatiable appetite for resources. Rising costs brought medical care under more critical scrutiny led by the federal government, a major buyer of health services.

In 1960, national health expenditures accounted for about 5.2% of the nation's gross domestic product (GDP); by 1970, it had consumed about 7.2% of the GDP. Private and public per capita expenditures in 1960 were \$111 and \$36, respectively; by 1970, private and public per capita expenditures rose to \$222 and \$134, respectively. Similarly, the public share of these expenditures increased much faster than the private share. Indeed, while the private share declined, the public share was continuously on the increase (CMS 2010). These statistics led to unprecedented federal government intervention to curb the rising costs.

Concerns about inflationary expenditures were accompanied by much publicity about other troublesome aspects of the health care system. These included significant jumps in medical malpractice claims and awards; fraud and abuse; medically unexplainable variations in patterns of care and high levels of defensive medicine; disparities in health based on income, race, ethnicity, geography, age, and gender; medical commercialism; and conspicuous conflicts of interest (Gray 1997, p. 34). Paraphrasing Paul Starr (1982, p. 379), while enormous increases in costs seemed ever more certain, corresponding improvements in health were ever more doubtful. In addition, it was argued that even though the United States spent more money for health care than any of the other Western industrialized countries did, it covered a smaller percentage of its population than these other countries. In other words, the supposedly free and unregulated market in the United States did not eliminate noninsurance. Therefore, the health care market had failed or was not free (Moran 1997, p. 7), because some or most of the conditions necessary for a free market were not met.

In a free market, buyers (consumers) and sellers (providers) should have sufficient information to make informed and independent decisions without third-party influences. Second, a large number of buyers and sellers should be involved with the market in order to allow buyers or consumers the freedom to dump sellers they perceive to be ineffective and inefficient. Third, each seller's product or services should be satisfactory substitutes for those of their competitors. Fourth, the quantity of products or services available in the market should neither be too large nor too low as to swing the balance of power toward either buyers or sellers. Fifth, in a free market, the demand for services should be driven by the prevailing prices, thereby allowing prices to decrease as demand decreases and vice versa. Sixth, in a free market, there should be unrestrained competition among suppliers based on price and quality, and buyers or consumers should directly bear the costs of services received (Apgar and Brown 1987, p. 224; Shi and Singh 2008, p. 12).

The health care market in the United States was said to have violated most of the above assumptions of a free market. Briefly, complexity reduced the ability of consumers to make informed choices without the guidance of the providers; the entry of sellers into the market was heavily regulated, thereby giving providers near monopoly power; and widespread insurance coverage influenced the supply and the demand for services. Since consumers did not bear the full costs of services received, and since providers were certain to be reimbursed for services provided, there were both overutilization and overprescription of health services. In addition, while there were significant inequities in the distribution of services, some consumers who were financially able to pay for the services they received purposefully avoided to pay for them. In other words, there were free-riders and negative externalities that led to increased costs for other consumers. Cost containment policies and practices were designed to address the identified market failures.

To simplify matters, the market failures that were blamed for the inflation in the US health care market were divided into demand- and supply-side categories. As the names suggest, demand-side variables are related to consumers' health care seeking and utilization behavior, while supply-side factors involve the delivery or prescription of health care services by providers. This implies that consumers and providers were blamed for the uncontrollable expenditures experienced in the health care market. As a consequence, most of the measures devised to contain expenditures during the period targeted these two population groups. We briefly list these measures below and examine them and their expected impacts on costs in greater detail in Chap. 4 under the economic influences on the health care system.

Summary of Cost Containment Measures, 1970–Present

Beginning in the late 1960s and continuing till the advent of the Clinton and Obama administrations, the focus of United States' health care policy has been to control costs. Both the Clinton and Obama administrations included cost containment and universal coverage as some of their primary objectives. As we stated in Chap. 1, the

Clinton administration's reform plan failed in 1994. But, unlike President Clinton, President Obama and the Democratic party-controlled Congress succeeded in enacting a major health care reform plan along party line voting toward the end of March 2010.

Prior to the enactment of the *Patient Protection and Affordable Care Act* (PPACA) of 2010, some of the measures that were enacted to stem the tide of rising expenditures, and which have been widely documented in the literature, include: The Nixon Administration's 1971 Economic Stabilization Program (ESP); the establishment of Professional Standard Review Organizations (PSROs) through amendments to the Medicare legislation in 1972; the signing of the Health Maintenance Organization (HMO) Act by President Nixon in 1973; the passage of the *Health Planning and Resources Development Act* of 1974, which set up the health systems agency (HSA) networks and required Certificate of Need (CON) programs in the states; the institution of a prospective payment system (PPS) for Medicare based on diagnosis-related groups (DRGs) in 1984; and the establishment of the Utilization and Quality Control Peer Review Organization (PRO) in 1984 to replace PSROs (Davis et al. 1990; Brown 1983, 1992, p. 17; Fein 1986; Ubokudom 2003, p. 63; Ubokudom 2008, p. 21).

Other measures that were employed to control costs during the cost containment period were budget cuts in the 1980s by the Reagan administration; new and novice payment methods, such as prepayment, rate setting, case management, utilization controls, limits on provider authority, and new insurance and delivery mechanisms labeled managed care. In addition, the *Balanced Budget Amendment (BBA) of 1997* mandated the establishment of Medicare Part C or a managed care program for the elderly under Medicare; other measures included the establishment of the so-called consumer-directed health plans (CDHPs) or high cost deductible plans, health reimbursement accounts (HRAs), spousal surcharges, Medicare and Medicaid cost controls through the *Deficit Reduction Act of 2005*, disease management approaches, and paying providers for efficient and effective performance, to name but a few of the fragmented approaches used to control costs.

Although it cannot be considered a cost containment measure by any means, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA 2003) established Medicare Part D, a voluntary prescription drug program under Medicare. As I have acknowledged, even though this program is expansionary rather than a cost-minimizing measure, I briefly include it in this discussion because of the time period it was enacted. Therefore, for political or other reasons, a new program that had the effect of negating the gains made by the cost containment measures introduced to date was mandated in 2003 and fully implemented in January 2006. This program is discussed in more detail in the book chapter that deals with Medicare and other programs enacted for select segments of the population.

The most drastic form of cost containment that preceded the passage of the *Affordable Care Act of 2010* was the dropping of health insurance coverage for retirees and current workers by employers. The percentage of nonelderly Americans covered by employer-sponsored insurance (ESI), as well as the proportion of firms offering health care benefits, was on the decline. At its peak in 2000, ESI covered

about 67% of the nonelderly American population (Blumenthal 2006, p. 83). By 2004, however, only about 61% of nonelderly Americans under age 65 were covered by ESI, a decline of 6% in about 4 years (Clemens-Cope and Garrett 2006, p. 6). Similarly, the proportion of all firms offering health insurance benefits is reported to have fallen from 69% in 2000 to 60% in 2005, thereby causing five million employees to lose their insurance coverage in about 5 years (Collins et al. 2005, p. 6).

The narrative on the evolution of the US health care system was undertaken to allow us to understand how the influences of the environmental factors discussed throughout this book evolved over time. The chapter demonstrates that the policy goals of expanding health care facilities and services, and expanding insurance coverage to select segments of the population were replaced by cutbacks and cost containment. The broad grant of authority to professionals to operate the health care system was replaced by limits on supply and demand. Put mildly, corporate influence expanded while professional autonomy declined. Also, funds for medical facility expansion and modernization were no longer abundant, while cutbacks in reimbursement rates by government and private insurance programs threatened health practitioners' incomes and the survival of the "safety net" providers that catered to a disproportionate proportion of the poor and uninsured.

Unlike in the past, the AMA has not been able to stop these cost containment measures because of divisions within its ranks. Specialization and political differences have led to sharp splits within the AMA and to the break-up of the parent association into splinter groups, such as the American Academy of Family Physicians, American Academy of Surgeons (ACS), American College of Physicians, American Society for Clinical Pathologists (ASCP), etc. (Peterson 1998, p. 181). Furthermore, membership in the AMA is said to have declined to less than 20% of practicing physicians (Wikipedia 2011).

But even with the cost containment measures that were put in place, health care cost increases and uninsurance and underinsurance continued at a fast pace at a time of declining resources. These problems led the Obama White House to advocate, and gain approval for, a massive health care reform proposal, which is the primary subject of Chap. 9 of this book. Because the constitutional and political frameworks in the United States provided the vehicle for passage of the identified cost containment measures and the 2010 reform plan, the next chapter is devoted to determining how constitutional, legal, and political factors shape the health care system.

Conclusion

The history of the evolution of the US health care system presented in this chapter is divided into three broad historical periods that are not necessarily mutually exclusive. These include the preindustrial or rudimentary period (1750–1849), the postindustrial period (1850–1969), and the cost containment period which began approximately in 1970 and continues till today. During the first period, the care

of the sick was undertaken by women within the family. The available medical technology during the period was primitive and rudimentary. The postindustrial period represents the era of the growth of the power and authority of organized medicine and the building of hospitals and other health care facilities. The internal divisions that had plagued the medical profession during the preindustrial period were healed during the postindustrial period. Equally important were the reform of medical education, the transformation of hospitals to active centers of treatment staffed by professional physicians, the growth of health insurance, and the enactment of redistributive health policies. Finally, as the name implies, the cost containment period brought medical care under more critical scrutiny by the federal government and private health care purchasers. The US health care system underwent a gradual transformation from infancy to expansion and growth to redistribution and to contraction. Cost containment pressures and concerns have informed health care policymaking and delivery since the early 1970s to the present time. This trend is expected to continue into the foreseeable future.

Review Questions

1. Identify the foci of health care policymaking during the postindustrial and cost containment periods described in the chapter. What issues of the preindustrial period precipitated the changes that were made during the postindustrial and cost containment periods?
2. How are today's medical schools different from their first-generation counterparts?
3. What effects did the emergence of telephones, automobiles, paved roads, and the growth of cities have on medical practice in the late nineteenth century?
4. How did the professionalization of nursing, begun in 1873, transform hospitals and medical practice during the postindustrial period of the evolution of the health care system?
5. Why did the United States not adopt some form of health insurance as nearly all the major European countries did on the eve of WWI?
6. Why did President Franklin Roosevelt not include health insurance as part of the SSA of 1935?
7. Why was the AMA opposed to the idea of a national health insurance program for the country?
8. What are some of the conditions necessary for a free and unregulated market?
9. How does the US health care system violate the free market assumptions you identified in question 8?
10. How have past policies contributed to the need for health care cost containment?
11. What were the consequences of the initial Medicare legislation paying physicians their "usual and customary" fees?

References

- American Medical Association. 1901. "Laws Regulating the Practice of Medicine in the Various States and Territories of the United States," *JAMA* 37(November 16): 1318.
- Anderson, O.W., and J.J. Feldman. 1956. *Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey*. New York, NY: McGraw-Hill.
- Apgar, W.C., and H.J. Brown. 1987. *Microeconomics and Public Policy*. Glenview, IL: Scott, Foresman and Company.
- Barlow, W., and D.O. Powell. 1980. "To Find a Stand: New England Physicians on the Western and Southern Frontier, 1790–1840." *Bulletin of the History of Medicine* 54 (Fall): 386.
- Blake, J.B. 1965. "Women and Medicine in Ante-Bellum America." *Bulletin of the History of Medicine* 39(March-April): 99–123.
- . 1977. "From Buchan to Fishbein: The Literature of Domestic Medicine." In *Medicine Without Doctors: Home Health Care in American History*, eds. G.B. Risse, R.L. Numbers, and J.W. Leavitt. New York, NY: Science History Publications, 11–30.
- Blumenthal, D. 2006. "Employer-Sponsored Insurance in the United States—Origins and Implications." *The New England Journal of Medicine* 355(1): 82–88.
- Brown, L.D. 1983. *Politics and Health Care Organization: HMOs as Federal Policy*. Washington, DC: Brookings.
- . 1992. "Political Evolution of Federal Health Care Regulation." *Health Affairs* 11(4): 17–37.
- Buchan, W. 1971. *Domestic Medicine; or The Family Physician*, 2nd ed. Philadelphia: Printed for R. Aitken.
- Burrow, J.G. 1963. *AMA: Voice of American Medicine*. Baltimore, MD: Johns Hopkins Press.
- Clemens-Cope, L, and B. Garrett. 2006. "Changes in Employee-Sponsored Health Insurance Sponsorship, Eligibility and Participation: 2001–2005." Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.
- Collins, S.R., K. Davis, and A. Ho. 2005. "A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to Employees." *Inquiry* 42(1): 6–15.
- Davis, K., G.F. Anderson, D. Rowland, and E. Steinberg. 1990. *Health Care Cost Containment*. Baltimore, MD: Johns Hopkins.
- Dent v. State of West Virginia, 129 U.S. 114 (1889).
- Fein, R. 1986. *Medical Care, Medical Costs: The Search for a Health Insurance Policy*. Cambridge, MA: Harvard University Press.
- Gray, B.H. 1997. "Trust and Trustworthy Care in the Managed Care Era." *Health Affairs* 16(1): 34–49.
- Haber, S. 1974. "The Professions and Higher Education in America: A Historical View." In *Higher Education and the Labor Market*, ed. M.S. Gordon. New York, NY: McGraw Hill, 237–280.
- Hawker v. People of State of New York*, 170 U.S. 189 (1898).
- Jennings, C.P. 2001. "The Evolution of U.S. Health Policy and the Impact of Future Trends on Nursing Practice, Research, and Education." *Policy, Politics, & Nursing Practice* 2(3): 218–227.
- Marmor, T.R. 2000. *The Politics of Medicare*, 2nd ed. NY: Aldine De Gruyter.
- Moran, D.W. 1997. "Federal Regulation of Managed Care: An Impulse in Search of a Theory." *Health Affairs* 16(6): 7–21.
- Munts, R. 1960. *Bargaining for Health*. Madison, WI: University of Wisconsin Press.
- Peterson, M. 1998. "The Politics of Health Policy: Overreaching in the Age of Polarization." In *The Social Divide: Political Parties and the Future of Activist Government*, ed. M. Weir. Washington, DC: Brookings Institution, 181–229.
- Public Broadcasting Service. 2009. "Healthcare Crisis: Healthcare Timeline." Retrieved October 26, 2009, from <http://www.pbs.org/healthcarecrisis/healthcaredtimeline>.
- Rothman, S.M. 1978. *Woman's Proper Place*. New York, NY: Basic Books.

- Rothstein, W. 1972. *American Physicians of the Nineteenth Century*. Baltimore, MD: Johns Hopkins University Press.
- Schlesinger, A.M. Jr. 1945. *The Age of Jackson*. Boston, MA: Little, Brown.
- Shi, L., and D.A. Singh. 2008. *Delivering Health Care in America: A Systems Approach*, 4th ed. Sudbury, MA: Jones and Bartlett.
- Shryock, R.H. 1960. *Medicine and Society in America: 1660–1860*. New York, NY: New York University Press.
- Starr, P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York, NY: Basic Books.
- Tewes, R. 2009. “Evolution of the Health Care System in the United States.” Health Care Background Paper, League of Women Voters of the United States: 1–5.
- Ubokudom, S.E. 1997. *Physician Participation in Medicaid Managed Care*. New York, NY: Garland Publishing, Inc.
- _____. 2003. “Managed Care and the Agitation for a Patient’s Bill of Rights: A Historical and Theory-Based Analysis.” *Journal of Public Affairs & Issues* 7(1), 57–76.
- _____. 2008. “Employer-Sponsored Insurance (ESI), Medicare and Medicaid Policy Changes, and the Future,” *Pulse* (Ohio Chapter, American College of Surgeons, Membership Edition, 2008 Desktop Reference Guide): 19–25.
- United States Centers for Medicare & Medicaid Services (CMS). “National Health Expenditure Web Tables.” Retrieved February 8, 2010, from <http://www.CMS.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.
- U.S. Department of Health, Education and Welfare (HEW). Children’s Bureau Publications 1978 (November 22), U.S. Government Printing Office, 52.
- Wikipedia. 2011. “American Medical Association.” Retrieved April 1, 2011, from http://en.wikipedia.org/wiki/American_Medical_Association.

Chapter 3

Constitutional, Political, and Legal Influences

As shown in Fig. 1.1 of Chap. 1, the myriad influences on the US health care policymaking process occur within the country's constitutional framework. Constitutionalism is used to hold both elected and appointed officials politically and legally accountable for their actions. It involves checks and balances, federalism, separation of powers, rule of law, due process, and the bill of rights. These arrangements require that our leaders listen, think, bargain, and explain to the electorate the reasoning behind the laws they make (Magleby et al. 2006, p. 6). Therefore, because the Constitution orders and shapes the political, policymaking, and legal processes in the country, this chapter appropriately combines the constitutional, legal, and political influences on the health policymaking process. We begin the discussion with the constitutional environment of the United States.

Constitutional Influences

The opinion of conservative bloggers and politicians about the role of government in health care is that the Constitution does not give the Congress of the United States the power to enact mandatory health insurance plans; the Constitution does not grant anyone the right to health care; and the Constitution does not even mention health care. They argue that health care is an individual welfare and, therefore, the federal government has no business attempting to provide it or dictating to state governments how to provide the service. Further, it is argued that the Tenth Amendment reserves all powers not explicitly given to Congress to the states. Therefore, the states may provide socialized health care, if their citizens allow them to do so.

Liberals or the so-called Progressives argue, on the other hand, that Article 1, Section 8, of the Constitution gives Congress the power to provide for the “general welfare.” Congress is also given the power to “regulate commerce,” and the marketing of health insurance is a commercial activity. Additionally, it is argued that the “Necessary and Proper” clause of Article 1 gives Congress the power to make all laws necessary and proper for carrying out all other powers the Constitution vests in the government of the United States. Accordingly, even though health care might not be a right, it is a benefit Congress can provide to the people as part of its constitutional powers (Seaborn 2009; Schilling 2009; Shaw 2009; Herringpost 2009; Masse 2008; Eternalhope Blog 2006).

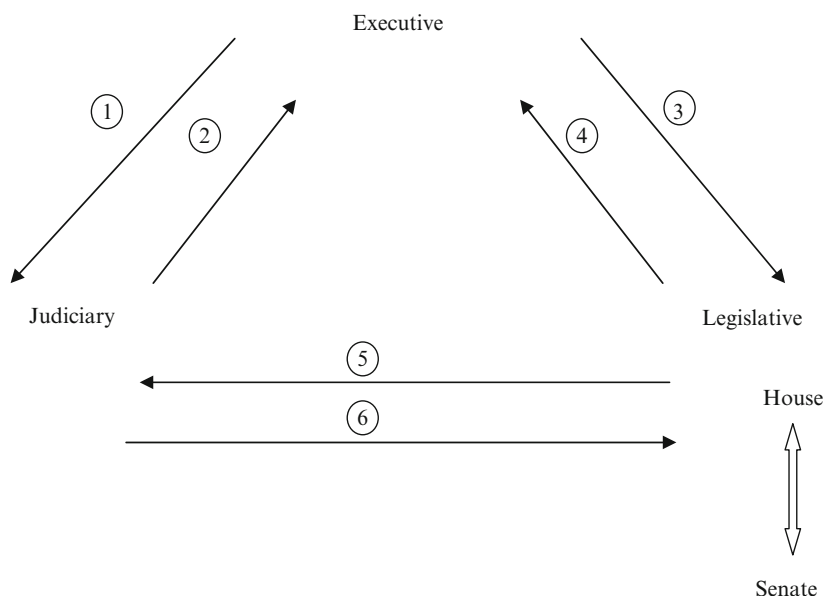
Since there has been no authoritative legal or legislative prohibition of federal involvement in health policymaking, the power for making health policy at the national level is divided among the executive, legislative, and judicial branches of government. Therefore, as shown below in Fig. 3.1, the ability of health policymakers and reformers to achieve their desired goals is constrained by this power arrangement, and by federalism, a system whereby governmental authority is divided between the national and 50 state governments (Anderson 2006, p. 35; Ubokudom and Khubchandani 2010, p. 6).

Those who oppose federal involvement in health policymaking and reform are usually advantaged when there are multiple veto points in the policymaking process, as is the case in the United States, depicted in Fig. 3.1 (Immergut 1992; Jones 1994, p. 16; Patel and Rushefsky 2006, p. 4).

Hacker (2009, p. 8), and Steinmo and Watts (1995, p. 329), posit that the existence of multiple veto points inherent in federalist governmental arrangements explains why the affected nations, such as the United States, Canada, and Switzerland, have not adopted a national health service, and why the share of medical spending financed by government is strongly correlated with the number of institutional veto points. According to Hacker, Switzerland, with its strong federalism and tradition of the use of popular referenda by organized groups, “has historically been characterized by the most anemic government role in health policy of all European nations, moving only recently to ensure universal insurance through mandatory private coverage.” Similarly, until the passage of the 2010 *Affordable Care Act*, which is yet to be fully implemented, and which does not guarantee full universal coverage, the United States remained the only advanced industrialized country without universal coverage and a public cost containment program, relying, for the most part, on employer-sponsored insurance.

Another constraint to congressional health policymaking not shown in Fig. 3.1 is divided government. A White House facing at least one legislative chamber controlled by the opposition party has to map a different strategy from what would have been employed if the president’s party controlled both chambers. This involves reliance on the veto power and grassroots lobbying. This is because members of the opposition party will strategize to defeat and weaken the president and his party as

The Dispersion of Power at the National Level of Government.



Federalism and Intergovernmental Relations

Federal government ↔ State government ↔ Local government

Fig. 3.1 The dispersion of power at the national level of government. 1. Nomination of judges. 2. Judicial review. 3. Vetoing legislation. 4. Budget control, veto override, oversight functions, impeachment power, confirmation of appointments. 5. Impeachment of judges, confirmation of judicial appointments. 6. Judicial review. (Source: Ubokudom and Khubchandani 2010)

much as possible in order to defeat them in the next election (Kernell 1991, p. 97; Weissert and Weissert 2002, p. 96).

We do not imply from the above discussion that a president who enjoys a unified Congress will always be able to push through his legislative proposals. The Clinton administration's failure to pass the *Health Security Act* in 1994 is very informative in this regard. At the time, the Clinton White House enjoyed a unified Congress, but this partisan majority could not be translated into a policy majority as well. Therefore, although the unified Congress that the Obama White House enjoyed since inauguration in 2009 was one of the factors that facilitated the passage of the *Affordable Care Act*, there is no guarantee that future policy proposals will be equally successful. This is due to the fact that other than partisanship, there are other obstacles to policy formulation and implementation.

Another constitutional issue that must not be overlooked is the dual nature of Congress or what Magleby et al. (2006, p. 293) call "split personality." On the one hand,

Congress is a lawmaking institution that legislates and makes policy for the entire United States. The performance of this role implies that members should be expected to forgo their personal ambitions and the narrow interests of their constituents and pursue the broad interest of the nation.

On the other hand, Congress is also a representative body, comprised of 535 politicians who look after the interests of their districts and the pressure groups they identify with or depend on for political and financial support to execute their campaigns. This dual nature of Congress causes its members to play a balancing game, weighing national interests against the interests of their districts or states. This dual role poses problems for national health policymaking. The representative function makes the Congress more likely to embrace narrow policies than broad national policies.

The dual nature of Congress has led to the use of such terminologies as delegates, trustees, or politicians to describe the roles members of Congress are likely to play at any time, depending on the particular policy being considered and the efficacy of constituent interest. At certain times, legislators may act or vote as delegates, following the opinions or inclinations of their constituents; at other times, they may act as trustees, voting according to their own view of what is best for their districts or states as well as the nation; still at other times, they may act as politicians, moving back and forth between the delegate and trustee roles. For example, legislators from Florida, where there is a large population of citizens 65 years of age and older, are unlikely to vote to cut Social Security or Medicare benefits. Similarly, those representing conservative localities are less likely to vote for increased taxes or funding for abortions (Magleby et al. 2006, p. 294; Losco and Baker 2009, p. 263).

Although the intent of the framers of the Constitution was to use the elaborate scheme we described under the separation of powers to prevent tyranny or abuse of power, these arrangements have had other positive and negative consequences, including decentralization of power, inefficiency in government operations, cooperation, deference, bargaining and compromise among policy-makers, turf battles, gridlock, inability to formulate consistent and comprehensive sets of policies, duplication of efforts, finger pointing, and passing the buck or the dodging of responsibilities by the two levels of government (Anderson 2006, p. 140; Weissert and Weissert 2002, p. 86; Ubokudom and Khubchandani 2010, p. 8). These conflicts caused by competing and opposing values are dealt with through the political process. Therefore, the following section examines the political influences on health care policymaking.

Political Influences

As was discussed in the introductory chapter, we define the political environment of health policymaking in the United States broadly, to include the country's political culture and ideology, presidential leadership in the health policy arena, the congressional policymaking process, public opinion and the media, interest groups,

political parties, the electoral cycle or how near to an election a health policy proposal is presented, and what Graham Allison calls the government-politics model of decision-making. Any overlap among these subjects is not intentional. We begin the discussion with the political culture and ideology of the United States.

US Political Culture and Ideology

Health care policymaking in the United States is influenced by the country's political culture, and by the values held in common by the people. Culture refers to the shared views that a group of people have formed about the way their world works, and about the methods of problem-solving that will be effective in that world (Schein 1985, p. 6). In addition to this worldview, the people's value systems, which reflect what they think are the appropriate and desirable things for government to do, are important considerations.

We operationalize the world political culture in this book to include the widespread social and political values held by the American people. The American political culture centers on such democratic values as liberty, equality, individualism, democracy, justice, rule of law, patriotism, optimism, idealism, limited government, diversity, majoritarianism, freedom, private property, respect for human dignity, equality of opportunity, unity, and the right of the people to assemble and to petition government for the redress of their grievances.

In listing the above values, we are very mindful of the fact that there is no "official" list of American political values, and that the values identified overlap and sometimes conflict (Magleby et al. 2006, p. 82). We also recognize the fact that people differ in their interpretation of these values. Therefore, we briefly elaborate on these values and how some of them may or may not be related to health care policymaking below.

The notion of liberty simply implies that Americans should be free to act and think as they choose so long as their actions do not infringe on the freedoms and well-being of others. Liberty is said to be the single most important value in American history. Its essence is self-determination or the opportunity of all individuals to realize their own goals. Liberty does not mean that governments will not constrain behavior that may hurt others; rather, it is individual freedom and opportunity to act affirmatively to reach their own goals.

Closely related to liberty are the values of private property and individualism. Individualism implies a commitment to self-sufficiency, personal initiative, and material accumulation. The American emphasis on individualism is blamed for the slow and limited development of welfare programs, and for the intense criticisms of already existing welfare programs (Anderson 2006, p. 41).

Constitutional democracies are expected to make the citizens—rich or poor, male or female, black or white—the central measure of value. In a modern democracy, the nation and the community should be less important than individual citizens.

These citizens should be free to accumulate or own property through legal means, and the government should not deprive them of their properties without due process. In other words, the rule of law should govern all governmental actions.

Opponents of health care reform argue that mandated health care for all Americans is unconstitutional because it infringes on the liberty, individualism, freedom of choice, and other personal freedoms of the citizens. They further argue that since one of the goals of the Founding Fathers was to set up a limited government, a federal government mandate that all Americans buy a specific good or service has never happened and would be uncalled for.

Supporters of federal efforts to promote universal insurance coverage through individual mandates argue, on the other hand, that state governments are allowed to require that all drivers buy car insurance. In an attempt to counter this argument, the opponents of mandatory health insurance argue that since driving is a voluntary activity, a person who does not operate a vehicle does not have to buy auto insurance (Herringpost 2009).

In order to present the opposing viewpoints and allow the readers to use them to make up their minds, it is necessary to ask the following questions: Is it not possible for a person who does not have health insurance to get afflicted with an infectious disease that can be easily spread to the rest of the population? Is it not true that the costs of emergency room care for the uninsured are shifted to those who have insurance? If the responses to these questions are in the affirmative, what actions should be taken to mitigate these negative externalities? If it is agreed that some action should be taken, who should be assigned the responsibility of taking the action?

Still on the relationship between the political culture of the United States and universal or mandatory health insurance coverage, some proponents of health insurance reform do not argue that the US Constitution grants anyone the right to health care. Rather, the issue, as they see it, is that health insurance companies discriminate by declining to insure people with preexisting conditions, a process called *skimming*, *redlining*, or *favorable risk selection*. This discrimination, they argue, infringes on such values as equality, diversity, respect for human dignity, and justice. The argument is furthered that these insurance company practices of deciding who to cover and how large a premium to charge also violate the Constitution's protection of all citizens, regardless of health conditions.

Opponents of the application of the Fourteenth Amendment to insurance company marketing practices dismiss the invocation of the Constitution in this instance (Schilling 2009). They argue that the Fourteenth Amendment prohibits the government, not individuals or private companies, from engaging in certain forms of discrimination. Writing in the *Badger Herald*, Masse (2008) argues that even though "a private actor may be statutorily barred from engaging in certain forms of discrimination, the Constitution itself does nothing to prevent you or me (or insurance companies) from excluding and discriminating to our hearts' content."

The political and social values we have identified and analyzed also influence the ways Americans orient themselves in the political system, the standards they use to evaluate government and public officials, and how they feel about government and politics at any particular time. Furthermore, Americans' beliefs and values have

important impacts on the training and general orientation of health care providers, the organization of medical practice, the understanding that high technology is synonymous with high quality care, and on the acknowledgment that physicians are private entrepreneurs who should practice medicine as they were trained (Ubokudom and Khubchandani 2010, p. 15).

The belief that government should be limited to the exercise of functions that the private sector is either unable or unwilling to perform explains the near complete grant of authority to the medical profession to operate the health care system discussed in Chap. 2. It also explains why the majority of the population is generally supportive of calls for health system reform, but less supportive or opposed to government-led reform efforts.

Presidential Leadership

The first clause of Article II of the Constitution vests the executive power “in a President of the United States of America.” This executive power includes serving as the Commander in Chief of the Army and Navy, and of the Militia of the several States. The president is also authorized to require the opinion, in writing, of the principal officers of the executive departments. This is interpreted to mean that the president has the basic authority to oversee the federal bureaucracy, the federal budget, and the selection of the senior appointees of the federal government. Article II also requires the president to give Congress periodic information on the State of the Union, and to recommend, for their consideration, such measures as he shall judge necessary and expedient. This suggests that the president’s primary policymaking role is agenda-setting or putting items on the public and governmental agendas.

Presidents, not being members of Congress, cannot introduce legislation in any of the two congressional chambers. Rather, they must find a legislator or legislators who are favorably disposed to their ideas to introduce any measure they want to put forward for congressional consideration. Once the measure is introduced in the Congress, the president is expected to monitor, encourage, persuade, and provide the incentives needed to acquire support for the legislation.

When discussing the dispersion of power in the United States, we said that Congress has a dual nature or split personality—a lawmaking institution for the country and a representative assembly for the people. We further argued that this split personality makes Congress more suited to formulating narrow policies. On the other hand, the constituency of the presidency consists of the entire country or all the people of the United States. Presidents are less likely to focus on narrow interests than members of Congress. Therefore, the presidency is more suited to formulating such broad national policies as health care, immigration, national defense, etc. The implication is that a health care reform proposal is unlikely to succeed or pass unless it has a strong presidential push.

Presidential leadership in health policymaking and reform can be evaluated along the following five dimensions: issue raising or agenda setting, design of specific

proposals, building support for his proposal, legislative roles and strategies, and implementation of enacted policies (Lammers 1997, p. 111).

- (a) *Issue Raising*: Issue raising involves the ability to convince the public that a problem exists that warrants government action. As was stated earlier, the Constitution's requirement that the president must periodically address the Congress on the State of the Union, and must also continually recommend such measures as he shall judge necessary and expedient for their consideration, gives the president immense opportunities to put items on the public and congressional agendas.

When, in 1991, a little-known Democratic candidate, Harris Wooford, focused his campaign on health care reform and pulled a stunning upset of former Governor Richard Thornburgh in a special election called in Pennsylvania to fill the seat of the late Senator John Heinz, national interest in health care reform increased dramatically. During his campaign, Wooford focused on the continuing increases in health care costs and in the population of the electorate without health insurance.

Presidential candidate William Clinton seized on this issue during his campaign and raised it to the top of the political agenda. It is believed that this issue, along with several other important pocketbook issues and the third-party candidacy of Ross Perot, helped Clinton win the presidency over George H.W. Bush. Clinton and his advisers were credited with raising the problems of uninsurance and high health care costs to national prominence during the 1992 presidential election. However, they did not fare quite as well in the design of their specific proposal, building support for the proposal, and in their legislative strategies or dealings with the Congress.

- (b) *Design of Specific Proposals*: Polls continuously show that a significant proportion of the population of the United States agrees that there are serious problems with the health care delivery system (Weissert and Weissert 2002, p. 75; Patel and Rushefsky 2006, p. 392). But that is as far as the agreement goes. As was discussed in Chap. 1, among the members of the population who agree that there are problems with the health care system, there are those who believe that these problems do not belong in the public domain and, therefore, do not merit government action. Among those who agree that the country's health system problems merit government action, there is no agreement as to the cause or causes of the problem. This lack of agreement about causality leads to disagreements as to the appropriate solutions to the problems. Consequently, every time health care reform is attempted, there are major conflicts involving different reform proposals among members of Congress, interest groups, the presidency, and the generality of the American people. These conflicts may cause the executive branch to seek accommodation with the various groups, and to attempt to incorporate their ideas into specific proposals. This phenomenon is further elaborated upon under our discussion of the government-politics model of decision-making.

As we shall discuss in Chap. 9, the Clinton administration's 1993 reform proposal is faulted for being too complex and difficult for the average American to

understand. The Administration is given credit for placing the issue on the agenda, but faulted for a poorly designed proposal. The presidential task force that was charged with designing the proposal is also said to have involved too many people, making it difficult for the members to reach a consensus among themselves. The long time it took for task force members to reach agreement on a proposal delayed the presentation of the reform plan, thereby missing the so-called honeymoon period of the Clinton presidency when the proposal was likely to get a more favorable reception in the Congress than later.

There are substantial and different approaches that presidents can utilize to design their policy proposals. For example, they can rely on some segments of the executive branch of government, such as the staffs of the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (DHHS). Alternatively, they can use interagency task forces or cabinet members and their subordinates (Lammers 1997, p. 112).

The Clinton White House used a combination of cabinet members and outside experts to design their 1993 proposal. President Obama and his top advisers initially left the design of their proposal to the Democratic leaders in the Congress who consulted widely with medical practitioners, cabinet agency staffs, the business community, other White House staffs, and outside experts. The opposition party complained that it was not involved or consulted on the design of the specific proposal. None of the policy design approaches I have discussed is perfect. Each approach has both advantages and disadvantages. The choice of any particular approach or combination of approaches depends on perceptions of the method that is more politically acceptable and likely to yield more benefits than costs.

The design of the Obama administration's proposal appears to have benefitted from the mistakes the Clinton administration made in 1993. For example, only excerpts or minute details of the specific proposals and the compromises reached by House and Senate members were revealed publicly by the Speaker of the House of Representatives and Senate Majority Leader. Also, the Congressional Budget Office (CBO) was requested to analyze the proposals for costs and their impacts on the deficit before they were presented to the rank and file members of Congress. Similarly, as is discussed in Chap. 9, the following provisions of the 1993 *Health Security Act* appear to have been excluded from the Obama Plan: employer mandates, a standard acute care package, global health care budgets, and dismantling Medicaid and requiring the health purchasing networks or exchanges that were to be established to issue policies to Medicaid beneficiaries. These omissions and the fact that specific aspects of the Obama administration's plan were closely guarded left the opposing party and insurance companies with little ammunition to attack the proposal. These tactics appear to have made a difference in the final outcome of the legislation.

- (c) *Building Support for the President's Proposal*: In order to be successful and effective, the president and his staff must lobby and build support for their administration's agenda. This is necessary in order to counter attacks by the opposition and to negate the effects of negative world events.

Presidents use several strategies to gain public support for their administration. These include giving speeches, holding town hall meetings, sending cabinet officials and key legislators and supporters to appear on talk shows and on the different Sunday television programs, commissioning investigations into administrative actions that have attracted negative publicity, and by appealing to citizens to contact Congress and demonstrate their approval of the administration's programs (Kernell 1986; Collier, 1995, p. 1; Miller 1993, p. 314; Losco and Baker 2009, p. 305). Heith (2004, p. 66) writes that during his campaign for reelection to a second term, President Clinton and his campaign staff used a process called triangulation—advocating positions that were closest to or near the midpoint of public opinion in order to demonstrate that most voters would benefit from his reelection.

While strong public support can strongly enhance the chances of passing presidents' policy proposals, the strategy has limitations. One such limitation is that public opinion may be flirting and unsustainable. Second, presidential messages to the public allow the opposition to frame their counterarguments. Third, the public may get bored with a particular subject and shift attention to another issue. In other words, an "issue-attention cycle" may cause the problem or issue to fade from public view (Downs 1972, p. 38). This cycle has been used extensively to analyze how problems are displaced from the public agenda. It has five stages that vary in duration, namely, the pre-problem stage; alarmed discovery and euphoric enthusiasm; realization of the costs of significant progress; gradual decline in the intensity of public interest; and the post-problem stage.

The pre-problem stage of the "issue-attention cycle" signifies a period where an undesirable social condition exists but has not received much public attention. However, some elites and interest groups may have become concerned about the problem. During the second stage, the public becomes aware of the problem and is alarmed by it. There is a strong desire to solve the problem as quickly as possible. In the third stage, there is increased awareness that solving the problem will entail huge costs, tangible and intangible, including giving up some privileges and benefits that many people currently enjoy. As a result of the awareness of the associated costs in stage three, some people are discouraged, others are threatened, and some just get bored by the discussion of the problem. As public attention to the issue subsides, the problem moves to the last stage characterized by less attention and interest.

Not all major problems go through the "issue-attention cycle." Those that go through the cycle are likely to possess three qualities in some degree. First, they affect a small segment of the population. Second, they involve arrangements beneficial to a majority of people or painful to a powerful minority. Finally, the dearth of exciting events associated with the problem, such as television coverage or protest movements, causes issues to fade quickly from public view (Anderson 2006, p. 98).

Neither Anderson nor Downs suggested that uninsurance and underinsurance had at any time gone through the "issue-attention cycle." But these problems do appear to me to possess the three qualities described above. First, only about 46 million out of more than 300 million people lack health insurance. That number is

not even fixed as some groups report fewer people than that as lacking insurance. Second, insurance reforms and health care cost containment strategies impose costs on a small and powerful minority in the population—insurance companies and various health care providers who wield enormous economic and political power. Consequently, these small but powerful interests were successful in helping to defeat the Clinton *Health Security Act*. Third, although media coverage of the problems of uninsurance and high health care costs may be steady at any given time, it is not certain that attention to these issues can be sustained over an extended period of time. Moreover, those who lack health insurance do not engage in protests or other social activities to call attention to their plight.

There is no doubt in my mind that the 1993 *Health Security Act* did go through the “issue-attention cycle.” Instant polls after President Clinton’s speech to a joint session of Congress on September 22, 1993, showed that about 73% of those polled supported the president’s idea. It is very likely that the instant poll reflected support for the speech, which was well delivered, more than support for the ideas embodied in the speech. In other words, that poll could not be relied upon because it was taken just after a presidential address. Time was needed to ascertain whether that support was stable. But not withstanding those concerns, there was some early support for the proposal (Patel and Rushefsky 2006, p. 392).

But by the first quarter of 1994, public support for the *Health Security Act* was on a steep decline. Sensing that support for the plan was dwindling, Republicans were in no hurry to line up behind the measure. Even some members of the group that designed the proposal, most notably Alan Enthoven, attacked the plan, perhaps a direct result of the difficulty reaching agreement by the health care reform task force. The Health Insurance Association of America (HIAA) was not left out of the fray. It spent a lot of money on advertisements aimed at expanding the scope of the conflict by arguing that the majority of the population would be worse off under the plan. This was an attempt to increase the costs of reform for employers, middle class Americans, and those who already had health insurance coverage through their employers. Republicans in both the House and the Senate also sensed that defeating the proposal would be to their advantage in the November 1994 elections. They were right. By the end of August 1994, it was clear that no version of health care reform would be passed in the Congress. The *Health Security Act* was doomed. The Clinton administration was not able to sustain the initial support for the proposal.

- (d) *Legislative Roles and Strategies*: One of the principal functions of legislatures in the United States is to make laws and formulate policy in the political system. The budget process or the so-called “power of the purse” also allows legislatures in the United States to shape policies in their domains. They, especially federal legislators, are aided in their policymaking roles by their expert staff assistants or aides.

The executive branch depends on the legislature to enact their policy proposals. This means that the president makes policy proposals and Congress enacts those proposals it finds appealing. Since Congress disposes of executive proposals, presidents and their staff members seek to develop support among legislators “by helping

with issues relating to their districts and addressing patronage concerns, while also gaining information about individual lawmakers whose voting decisions may be modified by various presidential actions” (Lammers 1997, p. 113).

As was discussed earlier, members of Congress try to take care of their state and local interests as well as promote broad national goals and interests. Pressures are put on them by their constituents, the White House, and by their party leaders, resulting in conflicting loyalties. These pressures are in addition to their individual values, motivations, and ideologies. This situation makes it almost impossible to balance expectations. No matter how they vote, somebody is bound to be short-changed or alienated. Perhaps this explains why a Democratic-controlled Congress could not pass the Clinton *Health Security Act* in 1994.

An important strategy presidents employ to deal with Congress is forging compromises and logrolling or agreeing to support a legislator’s favored program in exchange for the legislator’s support for their agenda. While there was much talk by the George W. Bush administration to do away with earmarks, these just turned out to be mere symbolic statements because the earmarks were put in the budget by important legislators the Bush administration depended upon for support on key policy issues. When all is said and done, the same is likely to be true of the Obama administration or any other administration for that matter. Logrolling obligates presidents to ignore these earmarks.

To aid the president’s legislative role, the White House maintains the Office of Legislative Affairs which consists of a group of policy and institutional experts that can be relied upon to write legislation, negotiate with members of Congress, and gain legislative support. When presidents lose the legislative vote, they may employ the veto power to influence the course of the legislation. Presidential vetoes are effective because two-thirds of both Houses of Congress must vote to override the veto. Presidents can also impact the implementation of legislation through the addition of signing statements to laws they approve with some reservations. There is no agreement on the constitutionality of signing statements and the practice has not yet come up before the Supreme Court. Whether the use of signing statements will be challenged and whether the Supreme Court will agree to hear, affirm, or nullify it remains to be seen.

- (e) *Policy Implementation:* The agencies responsible for implementing national health policies fall under the Executive branch of government. Additionally, national policies that are implemented by state governments are overseen by federal agencies. For example, although states have great discretion for designing and implementing the joint federal-state Medicaid program, they are guided or restricted by federal laws and regulations. As we discuss in Chap. 8, the executive branch also grants Section 1915(b) and Section 1115 waivers to state governments to forgo freedom of choice and state-wideness provisions, respectively, of the federal Medicaid law. Also, the president has, in some cases, been able to act in his administrative role even while Congress is debating a change in policy. For example, Lammers (1997, p. 115) cites occasions in 1995 when President Clinton and his advisers used their administrative role to quickly

grant waivers to states in order to experiment with new variations in their AFDC and Medicaid programs at a time Congress was still debating the possible grant of greater responsibility for those programs to state governments.

In the course of implementing existing policies, administrative agencies may come across some unforeseen circumstances and consequences, loopholes, needed changes in policy, as well as new problems they believe should be addressed through legislation. The proposals to deal with such matters, including statutory language, are channeled directly to the White House or reported to congressional committees during testimonies and hearings on the subject matter. Furthermore, the cabinet members who head executive departments and their subordinates represent both the interests of the federal, state, or local governments they work for, as well as the interests of their agencies. Consequently, they experience conflicting loyalties that make their work more difficult (Rieselbach 1995, p. 212).

The Congressional Policymaking Process

One interesting paradox about the United States Congress is that although there is much public dissatisfaction with the institution, politicians still run for open congressional seats or attempt to maintain their seats by seeking reelection. This is due to the attractions in Congress, such as the power and prestige attached to the job, generous health and retirement benefits, other benefits such as research support, travel allowances, staff persons, above average salaries, franking privileges, and the strong likelihood of securing high profile and well-paid private sector jobs once they retire from Congress.

There are 535 members of the US Congress, 435 and 100 members of the House of Representatives and the Senate, respectively. The terms descriptive and substantive representation have been used to describe congressional members. Descriptive representation is a measure of how much the membership of Congress mirrors the population from which it is drawn. Substantive representation, on the other hand, is a measure of how much the membership represents various interests and groups in America, such as farmers, manufacturers, business executives, educators, health care providers, etc. The Congress is more substantively representative than it is descriptively representative. It consists of an elite group of citizens with above-average education and incomes, wealth, family backgrounds, etc. These characteristics are likely to influence the positions they take and the issues they support.

The US Congress and every state legislature except Nebraska are bicameral—divided into upper and lower legislative chambers. The bicameral legislature dilutes the power of Congress and creates one of the single most important obstacles to making laws (Magleby et al. 2006, p. 278). The power arrangement presented in Fig. 3.1 balances Congress against itself, and by the presidency and judiciary. These additional constraints make congressional policymaking, or policymaking in general, even tougher.

The House of Representatives is more centralized, more hierarchical, and less anarchic. Party loyalty and party line voting are more common in the House than in the Senate. The Senate, on the other hand, is less disciplined and less centralized. Because the Senate is a much smaller body than the House, its procedures are more informal and permit more time for debate than the House. The Senate is a more open, fluid, and decentralized body. Magleby et al. (2006, p. 285) quote some retired Senators as alluding to the fact that the Senate has 100 separate power centers and is so splintered that party leaders have difficulty arranging the day-to-day schedule. The opposition party can employ a filibuster to block legislation they do not like. Sixty votes are needed for cloture or to block the filibuster and halt debate, a tough number of votes to muster given the independence of each Senator.

Congressional work is done through committees and subcommittees. Falcone and Hartwig (1997, p.135) argue plausibly that congressional structure and reforms alone do not explain the changes that have taken place in health policy legislation. But it is difficult to argue that the institutional structure has no bearing on policy-making. It is more plausible to argue that, as the title of this book demonstrates, a myriad of environmental factors coupled with the reforms that have taken place in the federal legislature since 1970, including declines in the powers of committee chairmen, the increased independence of individual legislators, decentralization of the functions of congressional committees, meetings that are more open to the public, ability of junior legislators to defy the party leadership without fear of sanctions, roll call votes that allow the constituency to monitor the voting behavior of their representatives, and so on, have had important effects on policymaking in all arenas, including health. In the health policy arena, the effects of the reforms include the inability of congressional leaders to muster the consensus necessary to advance legislation, interest groups' ability to take advantage of the lack of strong party and congressional leadership to block policies they view as undesirable, and the change in the character of legislation from redistribution to regulation or cost containment.

Another issue I want to discuss before leaving this topic is the organization of Congress. Congressional organization is both formal and informal. The formal organization involves leadership and committee structure. The informal organization may be based on trust, mutual interest, friendship, ideology, geography, gender, race, etc. Examples of informal organizations include the Congressional Women's Caucus and the Congressional Black Caucus. Both organizational types affect the policymaking process. For example, during the 2009–2010 debate of health care reform about 12 abortion opponents in the House of Representatives led by Rep. Bart Stupak (D-MI) threatened to withhold their support for the health reform bill if it allowed federal funds to be used to obtain abortions. Similarly, when the Democrats had a 60-vote majority in the Senate, Sen. Ben Nelson (D-NB) was in a position to deny Senate Democrats the filibuster—proof majority they needed to pass their version of the health care reform bill. Consequently, the White House and Democratic Congressional leaders were concerned about the interests of abortion foes (an informal group) and quickly negotiated an agreement with them in order to win their votes.

Public Opinion and the Media

All politicians and governments in the United States are concerned with public opinion. In a constitutional democracy, the electorate may express their opinions in several ways, such as through demonstrations, letters to their elected representatives, letters to newspaper editors, and voting in free and periodic elections. According to Magleby et al. (2006, p.192), there are clear and direct connections between what voters want and what democratic governments do. In other words, democracy and public opinion are said to go hand in hand.

Public opinion is the publicly expressed belief that a person holds about some external object. It involves individual preferences for, or evaluations of, a given issue, political party candidate, or institution of government. This implies that there are opinions about almost any issue in our society, such as health care, environmental regulation, taxes, welfare programs, etc. Politicians, who owe their jobs to the electorate, must constantly evaluate the opinions citizens hold on particular issues.

The communications media—newspapers, television, radio, news magazines, and the Internet—shape public opinion by transmitting information. The information the media transmit helps shape the public and governmental agendas, determines what issues are on people's minds, and helps shape the people's opinions and attitudes (Anderson 2006, p. 64). These opinions and attitudes are likely to be most influential in publicly visible debates, for issues that could affect the outcomes of elections, and for issues decided by initiatives or referenda. They are likely to matter less in the case of more technical policymaking where the public lacks knowledge, interest, and views regarding the possible policy outcomes (Blendon and Brodie 1997, p. 202).

Not only are public officials influenced by the media, but they also attempt to use the media for their own purposes. For example, public officials may use the media to test and influence the attitudes among the general public and other officials toward particular policy proposals or actions. Similarly, those who oppose a proposal may put out adverse information about it in order to defeat it. The “Harry and Louise” and “Libby and Louise” television advertisements unleashed by the HIAA against the 1993 Clinton Health Security Act are excellent examples of the use of adverse and sometimes misleading information against a policy proposal. Those, like me, who were old and attentive enough at the time, would agree that these advertisements were an important and effective component of the HIAA's fight against the *Health Security Act*. As was also discussed earlier, the Republican congressional delegation's opposition to the reform measure was emboldened by their recognition that public support for the proposal was dropping precipitously. In fact, Blendon and Brodie (1997, p. 201) report that public opinion was found to be the second most influential factor on congressional decision-making in the 1993–1994 health care reform debate.

Interest Groups

The right of the people to organize and petition their government is enshrined in the First Amendment to the Constitution of the United States which states, in part, that Congress shall make no law abridging “the right of the people peaceably to assemble, and to petition the government for a redress of grievances.” The dilemma of this Amendment is that if the government does not allow people to pursue their self-interest, it takes away their political freedom. But permitting people to advocate whatever they want has disadvantages. One such disadvantage is that interest groups constantly push government to enact policies that benefit small constituencies at the expense of the general public (Berry 1989, p. 1; Loomis 1983, p. 175).

James Madison was well aware of the above dilemma. But he was also convinced that for a government whose authority extended over a large and diffused population, the effects of faction would be minimized by the clash of many competing interests in the country. In other words, interest group pluralism in a country with a representative form of government, characterized by checks and balances, would impede the dominance of any particular faction. Consequently, America has been a country of diverse interest groups advocating for different causes and wielding immense but unequal powers.

From the above discussion, then, we define interest groups as organizations of “people” with similar policy goals entering the political process to try to achieve those goals. Groups try to persuade the general public and, particularly, elected officials that their policy goals and preferences serve the public interest and, therefore, should be enacted into law. But as we discussed in Chap. 1, groups may not always act in the public interest. In a lot of cases, their contribution to public policymaking is to veto policy changes, innovations, and reforms (Weissert and Weissert 2002, p. 119).

There is a large group of interests in the health policy arena (Feldstein 1991, p. 209). Some of them include the HIAA, which we have already mentioned as being very active during the 1993–1994 health care reform debate, the AMA, American Health Care Association (AHCA), which represents a large segment of the nursing home industry, American Nurses Association (ANA), American Association of Health Plans (AAHP), and the American Association of Retired Persons (AARP), one of the primary groups representing America’s senior citizens. These groups may lobby members of Congress and the federal executive branch, state legislatures and agencies, local governments, and the general public.

In addition, interest groups try to influence politics and policymaking by using their political action committees (PACs) to contribute money to federal, state, and local election candidates. For example, the Center for Responsive Politics reported in 2009 that during the 2008 election cycle, about 127 health PACs contributed a total of \$49.3 million to federal candidates. A breakdown of this contribution shows that about 55% of the money was given to Democrats and the remaining 45% was given to Republicans.

Professor Feldstein’s (1997, p. 220) research and publications about the behavior of health care interest groups will help us understand the goals these groups seek to achieve. He notes that although differences exist in the objectives of health

associations representing health professionals, such as hospitals, medical schools, dental schools, and Blue Cross and Blue Shield plans, the members of these associations all try to make as much money as possible. Health professionals retain the money they make for themselves while the nonprofit hospitals and medical schools spend the money to achieve prestige goals. Therefore, each association or group tries to achieve for its members what they cannot achieve through the competitive market, namely, a monopoly position.

To achieve the above goal or to enhance their members' economic interests, health associations are likely to seek legislation that increases the demand for its members' services, such as having government subsidize the purchase of insurance for the members' services; secures the highest method of reimbursement, such as supporting fee-for-service payment plans and opposing capitated or prospective payment schemes; reduces the price or increases the quantity of complements, such as lobbying government to subsidize the training of nurses and nurse aides; decreases the availability or increases the price of substitutes, such as lobbying against the granting of prescriptive authority to nurse practitioners who work independently; and limits increases in the supply of providers, such as lobbying for restrictive licensing laws that have the effect of limiting the numbers of providers of a service. For example, it can be recalled that during the 2009–2010 health reform debate, the various health associations and insurance companies supported government expansion of insurance for the uninsured, a strategy that would increase the demand for their members' services. Similarly, they opposed limits on exclusion from coverage due to preexisting conditions, global budgets, caps on the size of insurance premium increases, and other strategies that would effectively curtail their incomes.

Political Parties

Political parties are defined as associations or groups of people who seek power through duly constituted elections in order to convert their policy positions and preferences into public policy. Their most important functions involve organizing the competition in a duly constituted election, unifying members of the party, helping to organize the government when they win office and translating preferences into policy, and providing opposition or closely monitoring the actions of the party in power (Magleby et al. 2006, p. 162).

The Democratic and Republican parties differ significantly about what should be the role and scope of government in virtually all policy arenas, including health care. Equally, the views Americans hold about the role of government in health care are strongly influenced by their party identification. Those who identify themselves as Republicans are much more likely to be conservative, to advocate for a limited government and to oppose more government involvement with the health care system. They are also more likely to hold individuals accountable for purchasing their health services, while Democrats are much more likely to argue for a collective responsibility for health care (Brodie and Blendon 2008, p. 259).

The Democratic and Republican platforms for the 2008 presidential election shows major differences in beliefs and health care policy preferences between the two parties. To sum up, the Democrats advocated affordable and comprehensive health care for every American; the ability of individuals and families to keep their current coverage or to choose from a wide array of public and private insurance plans; shared responsibility for health between employers, workers, insurers, providers, and government; an end to insurance discrimination or favorable risk selection; insurance portability; an emphasis on prevention and wellness; a modernized system that lowers costs and improves quality; a strong health care workforce; a commitment to eliminate race, gender, and poverty-based disparities in health; healthy environments; a strong partnership with states, local governments, tribes, and territories; support of older people and the disabled; support of a woman's ability to make her own life choices and obtain reproductive health care, including birth control; and fiscal responsibility (Woolley and Peters 2008).

The Republican platform for health, on the other hand, proposed to give control of the health care system to patients and their providers, rather than to bureaucrats in government or business; to ensure portability of health insurance; to correct inequalities in the current tax code that drive up the numbers of the uninsured; to level the playing field so that individuals who choose a health insurance plan in the individual market would face no tax penalty; to improve the quality of care and lower costs; to support federal investment in basic and applied biomedical research; to protect individuals' right of conscience; to confront the special challenges posed by the growth of Medicare costs; to give Medicaid patients more health care options in order to remove the Medicaid "stamp" from their foreheads; to focus taxpayer money on caring for US citizens and legal residents; and to build a health care system for future emergencies (Woolley and Peters 2008).

We presented the two parties' 2008 platforms in order to analyze the political directions of their preferences. Even though the platforms lacked specifics, embedded in the Democratic platform was the need for redistributive health policies; universal coverage; the public health insurance option; insurance regulation; a wellness model of health care to complement the existing medical model; a commitment to end health disparities based on race, gender, geography, and economic status; and abortion and reproductive rights. Embedded in the Republican platform were emphases on distributive health policies; individual responsibility; less government regulation and involvement in health care; tax cuts or adjustments of government tax expenditures as they relate to health care; Medicare and Medicaid reforms; and barring illegal residents from enjoying government health insurance programs.

The Electoral Cycle

The hierarchy of government agencies, including those responsible for managing public health programs, can be drastically changed after elections as a new Administration takes hold (Hall 1987, p. 221; Ubokudom 2008, p. 7). All levels of

government—national, state, and local—face this possibility after every election when top patronage appointees are changed at the discretion of a new administration. In the health care arena, those changes may result in the replacement of pro-reform political appointees with those who are anti-reform or indifferent, and vice versa.

The Obama administration's first nominee for the post of Secretary of the DHHS was former US Senate minority leader Tom Daschle (D-SD), a pro-reformer who had written a book on the subject of health care reform. When Daschle withdrew his nomination because of revelations about late payment of taxes, Kathleen Sebelius, governor and former Kansas Insurance Commissioner, herself a pro-health care reformer, was nominated and confirmed as the DHHS Secretary.

Other than the president appointing pro- or anti-reformers, depending on his political ideology, legislative policymaking is influenced by the electoral cycle and the desire for reelection. Therefore, legislative voting behavior and position-taking are influenced by perceptions of the likely political effects, negative or positive, of such decisions (Weissert and Weissert 2002, p. 57; Arnold 1990). For example, one of the primary reasons for the solid Republican opposition to the 2010 *Affordable Care Act* was their calculation that opposition to the proposal would not cost them votes, and could possibly lead to significant political gains for them in the 2010 midterm election. Also, Congress could not reach a consensus on a patients' bill of rights in 2000 because legislators from both parties were more concerned about exploiting the issue for political advantage in the 2000 election cycle than they were on a compromise (Families USA 2001).

The Government-Politics Model of Decision-Making

This model depicts decisions as the outcome of the bargaining that takes place among those who participate in the decision-making process. When decision-makers get together to take some decision, the result is very often likely to be different from what any one of them intended before their interaction began. This assertion is grounded in appreciation of the fact that authoritative power is most often shared (Allison 1971, p. 144; Allison and Zelikow 1999, p. 258).

The problems of the health care system fit the government-politics model. Whether it is cost control or universal coverage, the participants include the federal and state governments, employers, insurance companies, managed care plans, and various health care providers (Ubokudom and Khubchandani 2010, p. 11). The success of any policy proposal is influenced by the actions of the participants in the decision-making process, participants who differ in their ability to shape the outcome of the process (Allison 1971, p. 6), and by the political feasibility of any solution proposed to solve the problem (Huitt 1970, p. 400). Incrementalism and consensus-building are uniquely suited to this pluralistic and competitive environment of the government-politics model of decision-making, where interpersonal agreement is integral to basic decisions and where every participant claims some

part in the action. According to Professor Johnson (1996, p. 299), the “buck” may not stop anywhere in this model but may keep revolving around the circle of the participants.

Another important perspective on the government-politics model of decision-making is the degree of difficulty of the decisions to be taken. Unlike convergent problems, where all lines of thinking begin at one purpose and lead logically to one solution, the problems afflicting the health care system are divergent or have many potential definitions and solutions, most of which are incompatible (Johnson 1996, p. 296). We illustrate this point using escalating health care expenditures as an example.

As we discussed in Chap. 1, the problem of inflationary health care expenditures may be blamed on consumers, providers, medical equipment manufacturers, government regulations, malpractice lawsuits, wastes and fraud, insurance practices, etc. Just as the problem may be defined in different ways, different solutions may also be proffered to solve it. These potential solutions may include reducing services, regulating provider prescription and consumer utilization behaviors, establishing a government controlled, single-payer system, controlling health care unit and input prices, providing universal coverage, rationing of services, reforming the tort system, etc. These proposed solutions, as well as the problem definition itself, do not meet with everyone’s approval. Therefore, there is the need for the participants to compromise or seek a common ground. This would be the ideal situation, but recent experience shows that bipartisanship is difficult to attain in the present political environment in the United States. That last statement is evident from the recent experience with the health care reform debate in the Congress.

Legal Influences

Professor Anderson (2006, p. 54) writes that “nowhere do the courts play a greater role in policy formation than in the United States.” The courts, notably the national and state appellate courts, have frequently affected the content of public policy through the exercise of their powers of judicial review and statutory interpretation.

Statutory laws, judicial opinions, and legislative and administrative rules and regulations relating to health care are intended to subordinate medical practice and health care financing and organization to the rule of law. Even though the legislative and executive branches of government have primary responsibility for making policy, the judiciary also plays an important role for several reasons.

First, the legislature and the executive delegate to the courts the power to determine health providers’ liability for medical negligence (Rosenblatt 2008, p. 128). Specifically, courts determine the substantive and procedural rules to be followed in the course of deciding individual cases of fraud, negligence, and malpractice.

Second, because administrative and legislative rules and regulations are often unclear, ambiguous, conflicting, or vague, courts must determine the constitutionality and meaning of the regulations.

And third, even though the US Constitution makes no specific mention of health care, the provisions and Amendments protecting citizens from malicious, arbitrary, erroneous or capricious deprivation of life, liberty, due process and property at the hands of government, and guarantees of equal protection of the laws, have been used by courts to rule on issues such as access to contraceptives, abortion rights, and the right to die. We discuss these issues in greater detail below by examining medical malpractice lawsuits, the tort system in the United States, and the Supreme Court cases involving abortion and contraceptives.

Medical Malpractice

The United States' laws covering medical malpractice and liability were derived from British common law (DeVile 1990). Before the early 1800s, medical malpractice was almost unknown in the United States (Sandor 1957, p. 459). However, a large number of malpractice suits, most of which “involved fractures and dislocations with imperfect results or deformities such as shortened or crooked limbs,” were filed between 1835 and 1865. The arguments in these cases were that doctors did not provide due proper care, skill, and diligence (Spiegel and Kavalier 1997, p. 283).

Medical malpractice can be defined as unskillful, negligent or unlawful, or willful acts committed by a physician in treating his or her patient, resulting in death or injury to the patient. Medical malpractice is professional negligence by a health care provider that causes an injury. Practitioners other than physicians and surgeons, such as chiropractors, dentists, and nurses may be liable for malpractice in the broad sense of the word. Registered and authorized health maintenance organizations cannot be considered to be practicing medicine and, therefore, may not be held liable under a traditional malpractice complaint. However, medical malpractice lawsuits are increasingly being filed against managed care organizations (MCOs) under enterprise liability. Enterprise liability shifts the liability burden to MCOs for malpractice (Patel and Rushefsky 2006, p. 304).

Liability of MCOs for negligence generally falls into two categories. First, direct liability involves claims that seek to hold the MCO directly liable for negligence. Such claims normally involve two areas of the MCOs work—utilization reviews (UR) and plan design. Second, vicarious liability holds the MCOs secondarily liable for errors made primarily by their treating physicians (Hall and Agrawal 2003, p. 138).

A plaintiff must establish all four of the following elements for a successful medical malpractice claim: duty, breach of duty, proximate cause, and damages. First, a legal duty is established whenever a hospital or health care provider undertakes care or treatment of a patient. Second, a breach of duty refers to failure of the health care provider to meet a relevant standard of care for the time and place of the alleged injury. Third, the claimant must also demonstrate that the failure to conform to the relevant standard of care was a proximate cause of the damages sustained, or that the physician's negligence led to the stated injury. Fourth, unless the patient

sustains damages of some sort, there is no basis for a claim, regardless of whether the provider was negligent.

Malpractice damages can be divided into direct, indirect, and punitive categories. These include lost earnings as well as current and future medical expenses; pain and emotional distress; a loss of “consortium” or loss of services performed by a domestic partner, such as companionship, homemaking, and future reproductive capabilities; and damages awarded when conduct is intentionally harmful or grossly negligent, such as the intentional or wanton omission of care that is proper to provide, or doing what is improper to do, respectively (New Haven Medical Center 1997).

The threats of lawsuits against doctors and hospitals have been blamed for the rising health care costs in the United States. Therefore, calls have been made to reform the current tort system in the country. By contrast, some studies argue that contrary to political rhetoric and popular belief, malpractice lawsuits have very little impact on overall health care and physician practice costs. According to these studies, the costs associated with medical malpractice account for only a small fraction of physicians’ operational expenditures and overall health care costs. Rather, defensive medicine or the inclination of doctors to run more tests to avoid the possibility of being sued are said to increase overall health care expenditures more than malpractice costs (Thorpe 2004, p. 20; U.S. Congress 1994; Rodwin et al. 2006, p. 750). Those who think that malpractice costs are minor relative to other factors do not see the need for tort reform.

Pros and Cons of the Existing Tort System

The existing tort system in the United States, which enables claimants to seek redress for alleged injury to their person, reputation, or property, has been the subject of controversy in recent times. Supporters of the tort system claim that it promotes the values of fairness and deterrence. The fairness doctrine claims that the tort system allows the victim to recover damages from the party at fault. The deterrence doctrine claims that the prospects of being sued and having to pay for damages deter physicians from providing substandard care.

Critics of the present tort system argue that only a very small percentage of negligent behavior actually generates claims; of the claims that are filed, only about 50% have the chance of success resulting in compensation for the victim (Weiler 1991). It is further argued that the current tort system fails to compensate sensibly because no matter how serious judges are in fairly compensating victims, they are limited by the administrative structure of the tort law and the rules of damages. Furthermore, it is argued that jurors are not competent to understand and weigh complex medical issues. The use of expert witnesses poses special problems for jurors because they are left to determine whether to believe the plaintiff’s or defendant’s witnesses. These experts can easily mislead jurors. The present tort system is also said to impair the doctor–patient relationship and to lower job satisfaction among physicians.

Because of the criticisms of the present tort system, several reform proposals have been advanced. These proposals, which have been well documented, include placing caps on jury awards for noneconomic damages, accelerated and fair compensation, collateral offset, shortening the statute of limitations, limiting attorneys' contingency fees, the use of expert panels, making the current tort system more transparent, alternative dispute resolution, enterprise liability, channeling, and a no-fault compensation system (Patel and Rushefsky 2006, p. 284; Greene 1996, p. 563; Sage 2003, p. 26; Thorpe 2004, p. 20; Struve 2004, p. 33; Cantor and Wadlington 1994, p. 229; U.S. Congress 1994).

Briefly, the caps proposed on noneconomic damages, such as pain and suffering, would limit jury awards to plaintiffs who successfully prosecute their cases; as the name implies, the accelerated and fair compensation proposal would provide for fair and rapid compensation for medical injury without the need to prove negligence, thereby, cutting down on litigation time and costs; the collateral offset would deduct payments a plaintiff receives from other sources, such as health insurance payments, from the damages assessed against the defendant; a shortened timeframe for filing claims would reduce the number of cases and discourage lawsuits filed as an afterthought after a lengthy period (Patel and Rushefsky 2006, p. 285); limiting attorneys' contingency fees would discourage them from seeking very large awards.

Furthermore, the use of expert panels would address the perceived difficulties jurors have understanding complex medical information; if the tort system were more transparent, there would be no need to try to hide medical errors; alternative dispute resolution would limit the reliance on courts and juries, and instead rely on neutral evaluators, medical practice guidelines, neutral third parties, pretrial screening panels, arbitrators, etc.; both channeling and enterprise liability would remove the burden of malpractice liability from individual physicians to groups or institutions; and, finally, the no-fault compensation system would replace the existing fault-based system and compensate patients for any injury incurred during the process of care regardless of whether it was due to provider negligence or whether it was an unavoidable risk of normal care.

The criticisms of the present tort system have not generated any significant reform efforts at the federal level because of differences in the philosophies of the two political parties. The reforms that have taken place have occurred at the states' level of government. The cap that was placed on medical malpractice damages in Illinois was invalidated by the state Supreme Court, but several other states' laws remain on the books. The future of tort reform at the federal level of government is not clear at this time.

Court Cases Involving Abortion and Contraceptives

In the 1965 case of *Griswold v. Connecticut*, the Supreme Court struck down a 1879 Connecticut law that prohibited the use of contraceptives and also made it a crime to "assist, abet, or counsel" someone on birth control. The basis of the ruling was

that the law violated the constitutionally protected right of privacy. The decision was controversial because, according to critics, a right of privacy is not specifically enumerated in the Bill of Rights.

But the most prominent, controversial and politically significant Supreme Court case involving abortion, a reproductive health issue in its own right, was the *Roe v. Wade* (1973) decision which struck down a Texas law prohibiting abortion, a “fundamental right” that cannot be readily regulated or limited by governments. In a companion case, *Doe v. Bolton* (1973), the majority of the Supreme Court went on to specify the standards future abortion laws would have to meet to comply with the Constitution. Specifically, during the first trimester of pregnancy, the decision about abortion was left to the pregnant woman and her physician. During the second trimester, abortion could be regulated to protect the mother’s health. During the third trimester, when the fetus must have been viable, abortion could be prohibited except when necessary to protect the mother’s life or health.

Although members of the judiciary are usually thought to be nonpolitical, merely following the law or legal precedent, they are often deeply and willingly involved in what Professor Anderson (2006, p. 54) calls policy politics. This is evident from the Supreme Court rulings issued after *Roe v. Wade*. As the composition of the Supreme Court became more conservative after the *Roe v. Wade* decision, the Court issued contradictory rulings, sometimes upholding several abortion restrictions and modifying the Roe trimester framework (See *Webster v. Reproductive Health Services* (1989); *Planned Parenthood v. Casey* 112S. Ct. 2516 (1994); *Stenberg v. Carhart* (2000); and *Gonzales v. Carhart* (2007)).

Courts are not only called upon to make reproductive health decisions; rather, they are also involved in reviewing benefit coverage decisions made by public and private health care payers, analyzing the adequacy of Medicaid payments for hospitals and nursing homes, reviewing hospital mergers to ensure compliance with anti-trust laws, and examining the tax-exempt status of nonprofit hospitals. In these cases, the courts’ rulings have been contradictory, depending on the time period the rulings are made and on the composition of the court.

For example, during the 1960s and early 1970s, the courts interpreted federal program funding laws, such as Medicaid, as creating rights for their beneficiaries, including low income patients and their health care providers. Critics of these rulings argued that they focused on the concerns of the individuals or groups involved in specific cases rather than on the broader implications and overall objectives of the health care system. Since the 1980s, the Courts, especially the Supreme Court led by William Rehnquist, issued opinions denying that beneficiaries of public health programs were entitled to the benefits provided by those programs, and vastly increasing agency power “to reduce important statutory provisions to meaningless formalities” (Anderson 1992, p. 95; Rosenblatt 1993, p. 439). These decisions can be expected to change back and forth as the appointees of both Democratic and Republican presidents dominate the court system at various times.

Another area of health care that is affected by public laws and administrative rules and regulations is health insurance, regulated by state governments. In some cases, state laws may impose premium taxes on insurance plans and health care providers in order to generate money to pay for care given to uninsured persons in

the state (disproportionate share payments); state insurance laws may also impose certain mandatory benefits and other consumer protection requirements. These regulations are said to increase the costs of health insurance premiums.

Although the primary purpose of the federal Employee Retirement Income Security Act (ERISA) of 1974 was to improve the security of retirement pension benefits for private or nongovernmental employees, it also exempts self-insured employers from paying any premium taxes imposed by state governments, and allows these self-insured firms to avoid other types of state insurance regulations, such as financial reserves and consumer protection requirements. This federal law essentially undermines states' authority for health insurance regulation. As we have pointed out in Chap. 9, only one state, Hawaii, is exempt from the provisions of the ERISA.

Conclusion

Because the US Constitution orders and shapes the political, policymaking, and legal processes in this country, this chapter is devoted to analyzing the constitutional, political, and legal influences on the health care system. The constitutional environment consists of separate institutions (the executive, legislative, and judiciary) sharing power. This allows for multiple veto points that complicate policymaking. The political environment consists of the nation's political culture and ideology, presidential leadership, the congressional policymaking process, public opinion and the media, interest groups, political parties, the electoral cycle, and the government-politics model of decision-making. These factors pull and push the health policymaking process in different directions, necessitating bargains and compromises. Finally, the judiciary uses its power of judicial review to sanction or disapprove executive and legislative decisions. While members of the judiciary are expected to refrain from partisan politics, they are influenced by ideological considerations and are often deeply and willingly involved in policy politics. Consequently, their decisions may not always follow precedent, and may differ depending on who is on the Court and the time the ruling is made.

The decisions that are made on constitutional grounds in the political and legal environments affect, and are affected by, current and anticipated economic conditions. Sometimes, proposals may be shelved, expanded, curtailed, or abandoned because of economic factors. Therefore, in the next chapter we discuss the economic environment of the US health care system.

Review Questions

1. How does the constitutional framework of the United States affect health care policymaking? Elaborate.
2. What is divided government and how does it constrain health care policymaking?

3. What are the conflicts between the lawmaking and representative roles of Congress? How do these conflicts affect health care policymaking?
4. Identify some of the elements of the political culture of the United States.
5. How does the political culture affect the health care policymaking process?
6. Identify the various dimensions of presidential leadership in health care policymaking.
7. Why do problems fade from public view? Elaborate.
8. Identify the various factors that influence the congressional policymaking process.
9. Identify some of the interest groups that operate in the health care policymaking arena, and the goals they pursue.
10. What methods do health care interest groups employ to try to achieve their goals?
11. What are the different perspectives of the two main political parties concerning health care delivery and policymaking?
12. Why does the chapter conclude that the problems facing the health care system are diverging, not converging?
13. What role does the judiciary play in health care policymaking?
14. What is medical malpractice and how is it resolved?
15. What are the limitations of the US tort system and what proposals have been advanced to address them?

References

- Allison, G.T. 1971. *Essence of Decision: Explaining the Cuban Missile Crisis*. Boston, MA: Little, Brown and Company.
- and P. Zelikow. 1999. *Essence of Decision: Explaining the Cuban Missile Crisis*, 2nd ed. New York, NY: Addison-Wesley.
- Anderson, G.F. 1992. "The Courts and Health Policy: Strengths and Limitations." *Health Affairs* 11(4): 95–110.
- Anderson, J.E. 2006. *Public Policymaking*, 6th ed. Boston, MA: Houghton Mifflin.
- Arnold, R.D. 1990. *The Logic of Congressional Action*. New Haven, CT: Yale University Press.
- Berry, J.M. 1989. *The Interest Group Society*, 2nd ed. Glenview, IL: Scott, Foresman/Little, Brown.
- Blendon, R.J., and M. Brodie. 1997. "Public Opinion and Health Policy." In *Health Politics and Policy*, 3rd ed., eds. T.J. Litman and L.S. Robins. Albany, NY: Delmar, 201–219.
- Brodie, M., and R.J. Blendon. 2008. "Public Opinion and Health Policy." In *Health Politics and Policy*, 4th ed., eds. J.A. Morone, T.J. Litman, and L.S. Robins. Clifton Park, NY: Delmar, 249–270.
- Cantor, J.C., and W.J. Wadlington. 1994. "Addressing the Malpractice Problem: The Robert Wood Johnson Foundation's Programs."
- Center for Responsive Politics. 2009. "Health PACS Contribution to Federal Candidates, 2008 Election Cycle." Retrieved June 9, 2009, from <http://www.opensecrets.org/pacs/sector.php?cycle=2008&txt=HO1>.
- Collier, K. 1995. "The President, the Public and the Congress." Paper presented at the Annual Meeting of the Midwest Political Science Association, Chicago, IL, April 6–8.

- DeVile, K.A. 1990. *Medical Malpractice in Nineteenth Century America: Origins and Legacy*. New York, NY: New York University Press.
- Doe v. Bolton, 410 U.S. 179 (1973).
- Downs, A. 1972. "Up and Down with Ecology: The Issue Attention Cycle." *Public Interest* XXXII: 38–50.
- Eternalhope Blog. 2006. "Health care is a right contained within the U.S. Constitution." Retrieved February 15, 2010, from http://eternalhope.blog-city.com/health_care_is_a_right_contained_within_the_us_constitu...
- Falcone, D., and L. Hartwig. 1997. "Congress and Health Policy: Dynamics Without Change?" In *Health Politics and Policy*, 3rd ed., eds. T.J. Litman and L.S. Robins. Albany, NY: Delmar, 135–154.
- Families USA. 2001. "Whither the Patient's Bill of Rights?" Retrieved March 15, 2001, from <http://www.familiesusa.org/asap/up720pbr.htr>.
- Feldstein, P.J. 1991. "Health Associations and the Legislative Process." In *Health Politics and Policy*, 2nd ed., eds. T.J. Litman and L.S. Robins. Albany, NY: Delmar, 209–225.
- _____. 1997. "The Demand for Legislation and National Health Care Reform" In *Health Politics and Policy*, 3rd ed., eds. T.J. Litman and L.S. Robins. Albany, NY: Delmar, 220–230.
- Gonzales v. Carhart, 550 U.S. 124 (2007).
- Greene, R.B. 1996. "Federal Legislative Proposals for Medical Malpractice Reform: Treating the Symptom or Effecting a Cure?" *Cornell Journal of Law and Public Policy* 4(2): 563–607.
- Griswold v. Connecticut, 381 U.S. 479 (1965).
- Hacker, J.S. 2009. "Yes We Can? The New Push for American Health Security." *Politics and Society* 37(1): 3–32.
- Hall, R.H. 1987. *Organizations: Structures, Processes & Outcomes*. Englewood Cliffs, NJ: Prentice Hall.
- Hall, M.A., and G. Agrawal. 2003. "The Impact of State Managed Care Liability Statutes: Despite Some Erosions, ERISA Preemption Remains a Hill that Plaintiffs Must Climb." *Health Affairs* 22(5): 138–145.
- Heith, D.J. 2004. "Continuing to Campaign: Public Opinion and the White House." In *Polls and Politics: The Dilemmas of Democracy*, eds. M.A. Genovese and M.J. Streb. Albany, NY: State University of New York Press, 55–68.
- Herringpost Conservative Political Blog. 2009. "Mandate the Constitution Not Health Care." Retrieved February 15, 2010, from http://herringpost.blogspot.com/2009/12/mandate_constitution_not_health_care.html.
- Huitt, R. 1970. "Political Feasibility." In *Policy Analysis in Political Science*, ed. I. Sharkansky. Chicago, IL: Markham, 399–412.
- Immergut, E. 1992. *Health Politics: Interests and Institutions in Western Europe*, New York, NY: Cambridge University Press.
- Johnson, W.C. 1996. *Public Administration: Policy, Politics, and Practice*, 2nd ed. Boston, MA: McGraw-Hill.
- Jones, C.O. 1994. *The Presidency in a Separated System*. Washington, DC: Brookings Institution.
- Kernell, S. 1991. "Facing an Opposition Congress: The President's Strategic Circumstance." In *The Politics of Divided Government*, eds. G. Cox and S. Kernell. Boulder, CO: Westview Press, 97–112.
- _____. 1986. *Going Public: New Strategies of Presidential Leadership*. Washington, DC: CQ Press.
- Lammers, W.W. 1997. "Presidential Leadership and Health Policy" In *Health Politics and Policy*, 3rd ed., eds. T.J. Litman and L.S. Robins. Albany, NY: Delmar, 111–134.
- Loomis, B. 1983. "A New Era: Groups and the Grass Roots." In *Interest Group Politics*, eds. A. Cigler and B. Loomis. Washington, DC: CQ Press, 175–186.
- Losco, J., and R. Baker. 2009. *AM GOV*, New York, NY: McGraw-Hill.
- Magleby, D.B., D.M. O'Brien, P.C. Light, J.M. Burns, J.W. Peltason, and T.E. Cronin. 2006. *Government by the People: National version*, 21st ed. Upper Saddle River, NJ: Pearson/Prentice Hall.

- Masse, R. 2008. "Health Care Not in Constitution." Retrieved February 15, 2010, from http://badgerherald.com/oped/2008/03/27/health_care_not_in_c.php.
- Miller, G.J. 1993. "Formal Theory and the Presidency" In *Researching the Presidency*, eds. G.C. Edwards III, J.H. Kesssel, and B.A. Rockman. Pittsburgh, PA: University of Pittsburgh Press, 289–336.
- New Haven Medical Center. 1997. "Malpractice: Issues in Risk Management." http://info.med.yale.edu/caim/risk/malpractice/malpractice_2.html.
- Patel, K., and M. Rushefsky. 2006. *Health Care Politics and Policy in America*, 3rd ed. Armonk, NY: Sharpe.
- Planned Parenthood v. Casey, 112 Ct. 2516 (1994).
- Rieselbach, L.N. 1995. *Congressional Politics: The Evolving Legislative System*, 2nd ed. Boulder, CO: Westview.
- Rodwin, M.A., H.J. Chang, and J. Clausen. 2006. "Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict with Empirical Evidence." *Health Affairs* 25(3): 750–758. DOI: 10.1377/hlthaff.25.3.750.
- Roe v. Wade, 410 U.S. 113 (1973).
- Rosenblatt, R.E. 2008. "The Courts." In *Health Politics and Policy*, 4th ed., eds. J.A. Morone, T.J. Litman, and L.S. Robins. Clifton Park, NY: Delmar, 127–152.
- _____. 1993. "The Courts, Health Care Reform, and the Reconstruction of American Social Legislation." *Journal of Health Politics, Policy and Law* 18(2): 439–476.
- Sage, W.M. 2003. "Medical Liability and Patient Safety." *Health Affairs* 22(4): 26–36.
- Sandor, A.A. 1957. "The History of Professional Liability Suits in the United States." *JAMA* 163:459–466.
- Schein, E.H. 1985. *Organizational Culture and Leadership: A Dynamic View*. San Francisco, CA: Jossey-Bass.
- Schilling, C. 2009. "'Obamacare': What Does the Constitution Have to Say?" Retrieved February 15, 2010, from <http://www.wnd.com/index.php?fa=PAGE.view&pageId=106694>.
- Seaborn, J. 2009. "Health care and the Constitution." Retrieved February 15, 2010, from <http://www.statesman.com/blogs/content/shared-gen/blogs/austin/grapeshot/entries/2009/0....>
- Shaw, J. 2009. "Is National Health Insurance Constitutional?" Retrieved February 15, 2010, from http://blog.heritage.org/2009/08/20/is_national_health_insurance_constitutional/print/.
- Spiegel, A.D., and F. Kavalier. 1997. "America's First Medical Malpractice Crisis: 1835–1865." *Journal of Community Health* 22(4): 283–308.
- Steinmo, S., and J. Watts. 1995. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." *Journal of Health Politics, Policy and Law* 20(2): 329–372.
- Stenberg v. Carhart, 530 U.S. 914 (2000).
- Struve, C.T. 2004. "Improving the Medical Malpractice Litigation Process." *Health Affairs* 23(4): 33–41.
- Thorpe, K.E. 2004. "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms." *Health Affairs—Web Exclusive* W-4: 20–30.
- Ubokodom, S.E. and J. Khubchandani. 2010. "The Ecology of Health Policy Making and Reform in the United States of America." *World Medical & Health Policy* 2(1), Article 19: DOI: 10.2202/1948-4682.1010.
- _____. 2008. "The Ecology of Public Policy and Administration in Nigeria," *Public Policy Journal (APPA—Nigeria)* 2(1), 1–19.
- U.S. Congress, Office of Technology Assessment. 1994. "Defensive Medicine and Medical Malpractice." (OTA-H-602), Washington, DC: U.S. Government Printing Office.
- Webster v. Reproductive Health Services, 492 U.S. 490 (1989).
- Weiler, P.C. 1991. *Medical Malpractice on Trial*. Cambridge, MA: Harvard University Press.
- Weissert, C., and W. Weissert. 2002. *Governing Health: The Politics of Health Policy*, 2nd ed. Baltimore, MD: Johns Hopkins.
- Woolley, J.T., and G. Peters. 2008. "The American Presidency Project: Democratic and Republican Party Platforms." Retrieved March 26, 2009, from <http://www.presidency.ucsb.edu/ws/print.php?pid=78283&78545>.

Chapter 4

Economic and Provider Influences

At the end of Chap. 3, we noted that health care policies made through the political and legal systems in the United States affect, and are affected by, current and anticipated economic conditions. Similarly, we argued in Chap. 1 that health care providers, especially physicians, were the drivers of the health care system, and that the services they produce and supply, have economic implications. As a result, this chapter examines the impacts of economic factors on the health care system.

Economic issues are important considerations in public policy discourse (Dye 2008, p. 24). The availability of money influences how much services are produced and consumed, who produces the services, where the services are produced, the types of services produced, and the distribution of the produced services. Similarly, innovations and new services proliferate when there is adequate reimbursement for them. Additionally, the availability of the necessary financing influences both the supply and distribution of health professionals.

As was discussed in Chap. 2, the most significant expansions of federal social policy occurred in the 5 years that followed President Franklin D. Roosevelt's inauguration in 1933 (Magleby et al. 2006, p. 494), but the Roosevelt administration's expansions did not directly involve health care.

The second major expansion of social policy came in the 1960s, with the Johnson administration's *Great Society* program. In his commencement speech at the University of Michigan in May 1964, President Johnson announced a broad social agenda that was to "rest on abundance and liberty for all." In addition to a vast array of other programs, the Great Society produced Medicare, a vast new entitlement program to cover most hospital and other health care costs for older Americans, as well as Medicaid, which was to provide basic health services for poor families. Both programs signaled the beginning of serious health care inflation and the shifting of the focus of health care policy from expansion to contraction or cost containment.

Health Care Expenditure Growth

Since about 1970 to the present time, one of the major problems facing health policy-makers in the United States has been related to inflationary health care costs. During the period, health care costs have grown at rates that are significantly higher than the rates of growth of general inflation and the gross domestic product (GDP). Health care expenditure data are presented below in Table 4.1, followed by some extensive analyses of the data (see note about 2009 expenditures at the end of the chapter).

The approximately \$28 billion from all sources spent for health care in 1960 accounted for about 5% of the nation's GDP. By contrast, total health care expenditures amounted to about \$2.3 trillion in 2008 or 16% of the nation's GDP. If we divide the total 2008 expenditures by the estimated US population of 304 million for that year, we get an average of \$7,681 spent on health care for every man, woman, and child in the country. By contrast, the 1960 per capita expenditure was only \$148.

Except for 1980, when the rate of growth of health care expenditures paralleled the rate of growth of general inflation, between 1990 and 2000, the rate of health expenditure growth doubled the rate of general inflation in the economy; the rate of expenditure growth was more than three times the rate of general inflation in 2003, and more than double the rates of general inflation for 2004 (not shown in Table 4.1), 2005, and 2006. During these years, medical care prices went up faster than prices in the economy as a whole. By contrast, the rate of growth in expenditures between 2006 and 2008 paralleled the rate of growth of general inflation.

Another important insight that can be gained from Table 4.1 is the rate of decline in private health care expenditures and the corresponding rate of growth of the public share. The private share of total spending was 75% in 1960 while the public share accounted for the remaining 25%. In 2008, the private share of the total expenditures was 53% while the public share was 47%. This trend is maintained for the entire period 1960–2008. In other words, as the private burden of high health care costs increases, there is more pressure on government to share the burden. Alternatively, the increase in the public share of expenditures could be due to the fact that cost shifting from public to private payers may have reached its limit (Rettig 1994, p. 10).

The increased public share of expenditures shown in Table 4.1 does not include government employee health insurance costs and federal tax subsidies for private health insurance and health spending. If those expenditures were included in calculating total public spending, the public share of expenditures would be more alarming than it is currently. It is no doubt, then, that the public sector has taken the lead in health care cost containment since 1970 to the present time.

Another important factor to consider before we look at the measures that have been employed to curtail expenditure growth is what the money pays for. This analysis will allow us to fully understand why almost all cost containment practices target providers and consumers. We begin this analysis by presenting the chart below, labeled Fig. 4.1, which describes the amount spent in various health care

Table 4.1 Growth in national health care expenditures for selected calendar years from 1960 to 2008

Item	1960	1970	1980	1990	1997	2000	2003	2005	2006	2008
Total national expenditures (\$ billions) ^a	28	75	253	714	1,125	1,353	1,735	1,983	2,113	2,339
Private	21	47	147	427	613	757	957	1,083	1,137	1,232
Public	7	28	106	287	512	596	779	900	976	1,107
Total per capita expenditures (\$)	148	356	1,100	2,814	4,103	4,789	5,973	6,701	7,071	7,681
Private	111	222	638	1,684	2,237	2,678	3,293	3,660	3,805	4,046
Public	36	134	462	1,130	1,866	2,111	2,680	3,041	3,266	3,635
Total percent distribution of expenditures	100	100	100	100	100	100	100	100	100	100
Private	75	63	58	60	54	56	55	55	54	53
Public	25	37	42	40	46	44	45	45	46	47
Total expenditures as percent of GDP	5	7	9	12	14	14	16	16	16	16
Average annual percent growth from previous year shown or from the year before the year shown ^b	–	10.5	13.0	10.9	5.4	6.9	8.3	6.9	6.6	4.4
Private	–	8.5	12.1	11.3	4.6	6.7	8.6	6.6	5.0	2.6
Public	–	15.3	14.2	10.4	6.3	7.3	7.9	7.1	8.4	6.5
Average annual real GDP growth rate from previous year shown or from the year before the year shown ^b	–	3.9	3.3	3.3	2.9	4.1	1.6	3.8	3.2	2.0
US population (millions) ^c	186	210	230	254	274	283	291	296	299	304
GDP (\$ billions)	526	1,038	2,788	5,801	8,332	9,952	11,142	12,638	13,399	14,441
Average percent general inflation rate	1.46	5.84	13.58	5.39	2.34	3.38	2.27	3.39	3.24	3.85

^aSome fractions have been rounded up to the nearest whole numbers

^bAverage annual GDP and health expenditure percent growth for 1997, 2000, 2003, 2005, and 2008 are calculated from 1993, 1999, 2002, 2004, and 2007 GDP real growth rate and total national expenditures, respectively

^cCensus resident-based population less Armed Forces overseas and population of outlying areas

Sources: Centers for Medicare and Medicaid Services (CMS) (2008a), InflationData.com (2010), and the World Bank, Development Data Group (2008)

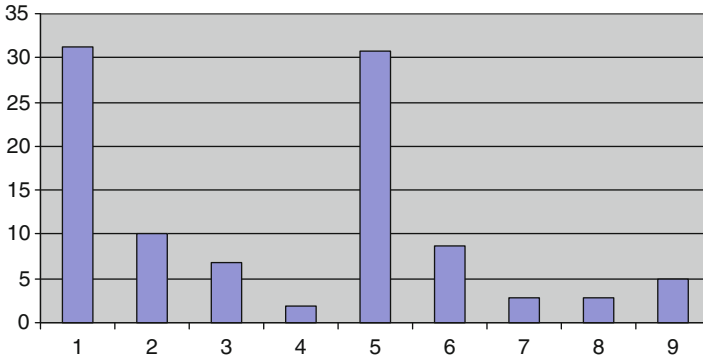


Fig. 4.1 Percentage distribution of health expenditures, 2008. 1. Professional Services (31.3) 2. Prescription Drugs (10.0) 3. Govt. Admin. & Net Cost of Private Insurance (6.8) 4. Research (1.9) 5. Hospital Care (30.7) 6. Nursing Home & Home Health Care (8.7) 7. Other Medical Products (2.8) 8. Govt. Public Health Activities (2.9) 9. Structures & Equipment (4.9)

Source: Centers for Medicare and Medicaid Services (CMS) (2008a), Office of the Actuary, National Health Statistics Group, at www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.

establishments for services and products delivered in 2008, based on the following brief definitions of the expenditure categories (CMS 2008b).

The objects of expenditure in the professional services category include physician and clinical, dental, and other professional services. “Other Professional Services” covers spending for services provided by health practitioners other than physicians and dentists, including those provided by private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational, and speech therapists, among others.

The “Other Medical Products” category in Fig. 4.1 includes both durable and nondurable medical products that generally have a life of over 3 years, or less than 3 years, respectively. Similarly, the “Government Public Health Activities” category includes expenditures for organizing and delivering publicly provided health services such as epidemiological surveillance, inoculations, immunization or vaccination services, disease prevention programs, the operation of public health laboratories, and other such functions.

The “Research” category involves expenditures by nonprofit or government entities. It does not include research and development expenditures by drug and medical supply and equipment manufacturers because the value of that research is deemed to be recouped through product sales (CMS 2008b, p. 11).

The “Structures and Equipment” category identifies the value of new construction in health care, excluding construction of retail establishments that sell durable and nondurable medical goods, and the value of new capital equipment, including software purchased or acquired by the medical sector during the year reported.

Finally, the “Government Administration and Net Cost of Private Health Insurance” category represents the net cost of private health insurance, the administrative expenses of government programs and the net cost of the private insurance intermediaries that administer government programs, as well as the administrative expenses associated with health activities of philanthropic or donor organizations that channel money to providers or researchers (CMS 2008b, p. 11).

Figure 4.1 shows that health professional services accounted for the largest share of health spending in 2008, followed by hospital care spending. In fact, data not shown in Fig. 4.1 reveal that professional services overtook hospital care as the biggest single category of health care spending beginning in 1999 and continuing to the present time. Before 1999, the biggest single category of health spending was hospital care. While hospital care spending grew by about 82% between 1999 and 2008, the growth of spending for professional services during the same period was 84% (CMS 2008a).

The third highest category of health spending in 2008 was pharmaceuticals or prescription drugs. Nursing home and home health expenditures were generally much higher than the costs of prescription drugs between 1980 and 2000. However, prescription drug costs have surpassed nursing home and home health care costs since 2001. Between 2001 and 2008, prescription drug costs grew by about 69%, while nursing home and home health care costs grew by 52% during the same period.

The highest expenditures under the professional services category are for physician and clinical services, with dental services coming second. For each year from 1990 to 2008, expenditures for physician and clinical services have been about five times the expenditures for dental services, although the total rate of growth in dental expenditures surpassed the total rate of growth in costs for physician and clinical services during the same period (CMS 2008a). This increased growth rate for dental costs might be due to better record keeping or to the realization of the importance of dental health to overall health.

The expenditure data we have presented and summarized remind us of Evans' (1997, p. 269) theory that "the total revenues raised to pay for health care from any society must equal to the expenditures on health care, and each in turn must exactly equal the total incomes earned from its provision." In other words, the \$2.3 trillion raised from all sources to pay for health care in 2008 was the product of the quantities of health care services provided in that year, and their average prices, which in turn were the product of the average incomes of health workers, and the hours they expended to provide care.

The incomes of health workers include salaries or net incomes from professional practice and the interest on hospital bonds or dividends from private pharmaceutical or equipment companies. These incomes are earned by doctors, nurses, dentists, pharmacists, podiatrists, etc., and by the employees of firms selling health insurance or providing health care consulting services (Evans 1997, p. 269).

There were approximately 11.2 million health care workers in the United States in 2008 (The Henry Kaiser Family Foundation 2008). These included, but were not limited to: 991,066 nonfederal physicians, about 2.5 million registered nurses, 73,893 physician assistants, 147,295 nurse practitioners, and 233,104 dentists. As we discussed in Chap. 3 under interest groups, these health workers and their professional associations are interested in enhancing their economic interests. They are less concerned about total health care expenditures and more concerned about trying to keep costs rising. According to Evans (1997, p. 270), while, for the sake of political credibility, they may wish to be seen as being concerned about escalating expenditures, in actual fact, many providers of health care believe that the adoption of appropriate and sensible priorities would lead to more spending for health care, not less.

Of all the health care workers we have identified, physicians are first in line. They are the captains of the health care ship or, according to Fuchs (1974), they are the

captains of the team. This is due to the fact that they control most facets of health care delivery—they admit patients to, and discharge them from, hospitals, they prescribe drugs and other medical equipment, they directly provide primary and specialty services, they diagnose abnormalities, they are involved in medical education and research to find new and better treatments, and some are involved in the prevention of illness. In brief, physicians control most of the objects of health care expenditures shown in Fig. 4.1. According to McGuire (2000, p. 463) cited in Chap. 1, drugs, surgery, and other health care inputs cannot be procured without physician initiative and concurrence. This explains why they are almost always the first targets of health care reformers.

The Physician as Captain of the Health Care Ship

The history of the evolution of the health care system reviewed in Chap. 2 shows that in the nineteenth century, the medical profession was weak, insecure in its status and income, and unable to control entry into the practice of medicine or to raise the standard of medical education. In the twentieth century, medicine became a powerful, prestigious and wealthy profession that was able to shape the basic organization and financial structure of the United States' health care system (Starr 1982, p. 19; Ubokudom 1997, p. 37).

The ability of the medical profession to gain control over the practice of medicine kept consumers and buyers from setting the terms of exchange, especially price. By significantly influencing demand and controlling supply, physicians were able to define and secure higher returns for their services. Medical services were sold to individual patients rather than large organizations, in order to ensure that the large organizations did not use their immense buying power to negotiate price reductions. But the general population and health policy analysts of the period did not see these schemes as attempts to control the field of medicine and increase physicians' incomes because the medical profession was very successful in creating an image of itself as being altruistic and service-oriented.

Talcott Parsons and the Physician–Patient Relationship

The success of the medical profession to present itself as altruistic and service-oriented informed Parsons' (1951) theory of the physician–patient relationship. According to Parsons, physicians were expected to be “universalistic, functionally specific, affectively neutral, and collectively oriented.” The collectivity orientation of the medical profession, Parsons argued, was the reason why the society allowed physicians complete autonomy over the practice and organization of medical care.

In Parsons' mind, society would not grant the business community the same privileges it granted physicians. Physicians could not advertise, they could only modestly announce their qualifications in the yellow pages of telephone directories

and classified sections of newspapers in order to show that they were available to provide care. Further, Parsons contended that physicians could not bargain over fees with patients, and they could not refuse to treat those who were unable to pay the prescribed fees. Rather, physicians were willing to charge their fees on a sliding scale or in proportion to the patient's income.

After Parsons' theory of the physician-patient relationship was published, Arrow (1963, p. 941) wrote on the complex of services that centered about the physician, private and group practice, hospitals, and public health.

Kenneth Arrow and the Medical Market

The main focus of Arrow's paper, which has become a seminal essay in the field of health economics, was on the manner in which the practice of medical care and the efficacy with which it satisfied the need of society differed from the "norm" or "the operation of a competitive model." The competitive model was defined as "the flows of services that would be offered and purchased and the prices that would be paid for them if every stakeholder offered or purchased services at the going prices as if his decisions had no influence over them, and the going prices were such that the amounts of services which were available equaled the total amounts which other individuals were willing to purchase, with no imposed restrictions on supply or demand" (1963, p. 942). According to Arrow, an optimal state did not exist when the above conditions were not met.

The medical care market that Arrow analyzed consisted of two distinct, but inter-related markets. These were the market for health services and the market for health insurance. Insurance was meant to insulate the insured against the consequences, financial and nonfinancial, of illness. In the health insurance market of the time, the insurer did not interfere with the insured choice of doctors or with doctors' recommended treatments. Reimbursement of providers was on a fee-for-service (FFS) basis (Chernew 2001, p. 887).

The health care market that Arrow described was not perfect. Some of the market failures or gaps that were apparent to him included the fact that many people lacked insurance; insured individuals were not insulated from the nonfinancial consequences of illness or treatment, such as iatrogenic illnesses; the availability of insurance insulated the insured and the provider from high out-of-pocket costs and uncompensated care, respectively, thereby causing medical prices and consumption to rise above optimal levels, a phenomenon generally referred to as moral hazard (Arrow 1963, p. 961; Pauly 1968, p. 231; Manning et al. 1987, p. 251; Newhouse 1992, p. 3; Chernew 2001, p. 888).

The other market failures that Arrow observed were information asymmetry or the fact that the complexity of medical knowledge made the information possessed by the physician as to the consequences and possibilities of treatment to be much greater than that possessed by the patient; the absence from the market of certain insurance policies, or limits on the set of policies available in the market; and, finally, the prevalence of unusual attitudes and pricing methods in the medical care

market, such as the existence of extensive price discrimination and physicians' insistence on FFS payment methods.

According to Arrow, when the market failed to achieve an optimal state as described above, society would recognize it and use nonmarket social institutions to bridge the gap. This was exactly what Arrow thought would happen to the medical care market that he studied. The special structural characteristics of the medical care market that existed at the time were largely attempts to overcome the optimality gaps. Some of the nonmarket social institutions that he identified as being used to bridge the identified gaps in the medical care market included the medical profession's code of conduct, which specified that the behavior of the physician was to be governed by a concern for the patient's welfare, unlike what would be expected of a salesman.

Furthermore, the professional relationship between the physician and the patient limited moral hazard because the physician, by making judgments on the need or otherwise for a given treatment, acted as a controlling agent on behalf of the patient's insurance. It is noteworthy that Arrow foresaw the possibility of deviation or leakages in his assertion that physicians could control patients' health care utilization behavior. Therefore, he was quick to make a counterargument that his conclusion or assertion was far from perfect because physicians themselves were not under any control and, as a result, it could be convenient for them or pleasing to their patients to prescribe more expensive treatment, more utilization of private nurses, more frequent treatments, and other marginal variations of care (Arrow 1963, p. 961, 962).

The other nonmarket norms that were expected to bridge the gaps in the medical care market involved direct institutional control of the process of price setting; the participation of nonprofit hospitals and insurance carriers reduced the incentives for them to use the profit motive to disadvantage patients; and government intervention to minimize patient discrimination based on health status or other high risk factors, a process called adverse selection (Rothschild and Stiglitz 1976, p. 629). But, did things work out as Arrow anticipated? The answer, of course, is "No."

Freidson (1970) was one of those who criticized the claims that physicians were only driven by selflessness and altruism. Freidson's concerns were along the lines that the theory failed to convey the ambivalence of the doctor–patient relationship and the contradictory expectations that each party in the relationship contended with. Parsons, according to critics, particularly did not question or critically examine the ideological claim of the medical profession that it was altruistic or collectively oriented, and failed to recognize that the doctor–patient relationship was not wholly voluntary. To Freidson, the medical profession was dominant in the medical division of labor or among the set of occupations that provided medical care.

Eliot Freidson and Professional Dominance

Eliot Freidson contended that the approach of many medical sociologists of his time to the problem of providing medical care was based on commonsense individualism, reinforced by the ideological individualism of the medical profession's view of

itself and its work. Leaders of the medical profession were very likely to see solutions to ethical problems as the need to recruit better motivated and more capable medical students, to improve professional medical education, and to raise standards generally. The problem with this approach, Freidson argued, was of two dimensions. First, the approach assumed that the social environment did not influence physician behavior. Second, commonsense individualism was based on the unproven assumption that physicians' attributes and characteristics were formed "at some point in time into a stable and fixed bundle of knowledge, motives, and values," regardless of the influence of the environments they practiced their profession. In other words, like the theme of this book, environmental factors influenced physicians' behavior.

According to Freidson, the most important single element in the social structure of medical care was the medical profession itself. The structural characteristics of the profession had far more influence on the nature of medical care in the United States than either the good intentions and skills of individual professionals or the economic and administrative structures that were usually targeted for reforms. Freidson went on to write that the physician was the ultimate expert on health and illness, and how to attain the former and cure the latter. Given the highly visible miracles that medicine had worked over the years, the public was inclined to ask the profession to deal with problems that were thought to be related to health. As a result, what were once regarded as economic, religious, and personal problems had been redefined as medical problems, thereby greatly impacting the allocation of the available medical resources.

Freidson identified four specific factors that acted as catalysts for the establishment of the medical profession's dominance. The first of this was autonomy over their work. While autonomy over work by itself was not sufficient to establish dominance, it had much impact when applied in conjunction with the other factors. The second factor that enabled the establishment of professional dominance was control over the work of other health professionals. Control over others in the medical care domain provided power well beyond autonomy. The third source of professional dominance that Freidson identified was the general population's cultural beliefs and their willingness to defer to the judgments of physicians. Finally, the fourth source of professional dominance that Freidson identified was what he called institutional power or the ability of the medical profession to translate its claim of valuable medical knowledge into cultural, legal, and institutional authority. This professional authority allowed physicians to choose their practice settings, specialties, and to practice price and patient discrimination.

In general, the professional dominance theory implied that physicians controlled both their work and the work of other health practitioners, enjoyed deference from their patients and the general population, and commanded cultural, legal, and professional authority within their task environments, defined as those parts of the general environment that were relevant to their ability to set professional and practice goals and to strive to attain the set goals.

Professional dominance impaired the ability of the nonmarket norms and institutions that Arrow thought would arise to bridge the optimality gaps in the medical

care market. For example, insurance companies and other health care payers did not influence the practice of medicine and the organization of medical services. As a result, the problems of the health care system continued unabated and culminated in buyer revolt.

Health Insurance and Medical Care Since Parsons, Arrow and Freidson

The shortcomings of Parsons' physician–patient relationship, Arrow's reliance on nonmarket social institutions to fill the gaps in the medical care market, and Freidson's professional dominance theory of the medical profession, were clearly visible shortly after their research was published. Specifically, technological growth, the enactment of programs, such as Medicare and Medicaid, to provide insurance to select segments of the population, the reimbursement of physicians on a FFS basis, and the complete delegation of health policy implementation to providers whose economic interests were closely intertwined with the system, led to high expenditures that created significant budgetary problems for governments, private employers, and consumers. According to Pauly (2001, p. 833), when services became ever more expensive, provider trust became the casualty of pocketbook protection.

In addition to high expenditures, research revealed substantial variations in physician practice patterns throughout the country. These practice variations could not be explained by the acuity levels of the patients served (Wennberg et al. 1982, p. 811; Wennberg and Gittlesohn 1982, p. 120). In addition to practice variations, there was substantial inappropriate use of health care services (Brook et al. 1990, p. 1173). Because of the uncertainty inherent in medical practice, providers were often unable to make rational, evidence-based judgments about the appropriateness and levels of care (Moran 1997, p. 7). But more importantly, it was argued that the incentives in a FFS payment system were actually for providers to provide many more services in order to increase income. Similarly, Arrow's and Parsons' arguments that costs should not matter in decisions regarding the provision of care implied that any and all care that were deemed valuable should be provided (Chernew 2001, p. 892).

It was also observed that Arrow's argument that the participation of nonprofit health institutions in the medical market would check the undesirable behaviors of profit-maximizing participants did not materialize—nonprofit firms virtually disappeared from the health insurance and specialized medical services markets. Even though hospitals remain nonprofit in nature, researchers and other observers of the health care market note that they engage in the same behaviors and have identical financial concerns as their for-profit adversaries (Pauly 2001, p. 832).

Despite the severity of the problems noticed in the United States medical care market, policy-makers and private health care payers have been reluctant to use economic concerns and evaluations openly and explicitly to determine what ser-

vices to cover, and how much to pay for the covered services. While many countries that faced the same problems as the United States adopted, at various times, nationalized systems to address the problems, a broader national system or response was not successful in the United States until the passage in March 2010 of the *Affordable Care Act*, which cannot, by itself, be described as fully comprehensive (Chernew 2001, p. 892; Neumann and Sullivan 2006, p. 1163). As was stated in the introductory chapter, this difference between the United States and the other countries is due to the decentralized manner in which the United States health care system is organized, financed, and delivered, as well as political, social, cultural, and attitudinal differences. Put differently, the environment of the health care system in the United States dictates the various measures that are employed to tackle perceived problems. Therefore, in the remainder of this chapter we describe and analyze the various measures that have been employed to address various problems in the United States health care market from 1970 to the present time.

Cost Containment and the Corporatization of American Medicine

The economic environment of the United States' health care market that has just been analyzed gave rise to various attempts to reform the health care system and control its insatiable appetite for money. As a result of resource scarcity in the early 1970s, in stark contrast to a lengthy post-World War II period of prosperity when affluence was assumed to be a permanent feature of American life, efficiency emerged as the most sought-after value (Battistella et al. 1991, p. 66). Although other important values such as equality and equity have been advocated and pursued at various times, the most predominant value that has guided health policy-makers during the period under review is efficiency. We begin the analysis of the quest for economic efficiency with the economic stabilization program pursued by the Nixon administration.

The Economic Stabilization Act of 1970 (84 Stat. 799)

The *Economic Stabilization Act* (ESA) authorized the most comprehensive peacetime economic regulation in American history. It authorized the president to issue such orders and regulations as he deemed appropriate to stabilize prices, rents, wages, salaries, interest rates, dividends, and similar transfers, at levels not less than those prevailing on May 25, 1970. The freeze on wages and prices applied to the entire economy, including the hospital sector. A Democratic Congress passed the law at a time of very serious and persistent inflation. President Nixon signed the legislation, although he indicated in his signing statement that he would have

preferred to veto it and that he had no intention of invoking the authority of the law. Republicans dismissed the legislation as an election year gimmick and accused the Nixon White House of failing to curtail rising unemployment, high interest rates, and a balance of payment deficit (Silk 1973).

The ESA was implemented in phases. The first phase, the imposition of wage and price freezes, was followed in December 1971 by the signing of the *Economic Stabilization Act Amendments*, which provided authority for continuing the wage and price freezes of 1970 through April 30, 1973. A ceiling of 6% was imposed on price increases; limitations on specific cost increases were 5.5% for wages, 2.5% for non-labor costs, and 1.7% for new technology and services (Davis et al. 1990, p. 16).

The Economic Stabilization Program (ESP) expired in April 1974, but the controls on the hospital sector, which were enforced through Executive Order 11632, remained. Attempts by the Congress to continue the controls were seriously opposed by the hospital industry. Further efforts to continue the controls were defeated after the hospital industry promised to voluntarily contain costs.

The termination of the ESP controls on the hospital sector was followed by rapid increases in health care costs. Consequently, regulations written in 1975 to implement the amendments to the Medicare statute that were passed in 1972, allowed officials to deny payments for inefficient and unnecessary Medicare charges. In effect, Medicare and Medicaid administrators were allowed to deny payments to hospitals for costs that were not comparable to other hospital costs. Also, the 1972 amendments created Professional Standards Review Organizations (PSROs) to promote efficiency in health care delivery.

PSROs

The Social Security amendment legislation, PL 92-603, was passed by both houses of Congress on October 17, 1972, and signed into law by the president on October 30 of that year. Section 249F of the law required that PSROs be set up “in order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment can be made, in whole or in part, under the Social Security Act.” This language gave the federal government responsibility for professional standards review for health care services, effective January 1, 1973 (*California Medicine* 1973, p. 39).

Under the PSRO law, the Secretary of the Department of Health, Education and Welfare (DHEW) was to designate the PSRO areas by January 1974; as soon as possible thereafter, he was to designate the PSRO for each area. PSROs were charged with the responsibility of collecting data and information and records (Ermann 1988, p. 688) as directed by the HEW Secretary, who was to have access to the assembled data. The PSROs were to utilize only medical doctors (MDs) and doctors of osteopathy (DOs) to review medical services and decisions taken by their peers. Up till January 1, 1976, physician organizations had priority in establishing PSROs.

After that date, the DHEW Secretary could designate a “qualified” public or non-profit organization to serve as the PSRO. The expenses of these organizations were to be underwritten by the DHEW (*California Medicine* 1973, p. 39).

As was stated earlier, the primary focus of the PSRO programs was to monitor health services to ensure that they conformed to appropriate professional standards, were provided only when medically necessary, and were provided in the most economical but medically appropriate settings. Therefore, the program’s primary goals were to curb the growth in health expenditures by curtailing unnecessary utilization by the consumers designated by the Social Security amendments, and to assure the quality of care delivered under the program. Despite the stated dual focus on costs and quality, up till 1979 the program’s primary focus was on curtailing expenditures (Congressional Budget Office 1979, p. 1).

The PSRO program utilized concurrent review to try to meet its expenditure curtailment goal. Concurrent review involved two activities—admissions review shortly after a patient was admitted in a hospital to determine if the admission was necessary, and periodic continued-stay review or the reevaluation of cases to determine if continued inpatient care was warranted. A negative determination could result in denial of reimbursement by Medicare or Medicaid for continued inpatient care. PSROs were active in only about half of the nation by about 1978. A year later, by about the end of 1979, the program had expanded to include most of the nation (Congressional Budget Office 1979, p. 1).

The CBO released its evaluation of the PSRO program on June 27, 1979. In a testimony to the Subcommittee on Oversight, Committee on Ways and Means of the US House of Representatives on the same date the CBO evaluation results were released, CBO Deputy Director Robert D. Reischauer estimated that the PSRO program’s concurrent review had reduced Medicare days of care by about 2% throughout the country. However, the CBO went on to add that expenditure savings that were derived from the 2% decline in Medicare inpatient days were 30% less than the program’s costs. This finding was in sharp contrast with the 1978 Health Care Financing Administration (HCFA) estimates that the PSRO program saved about 10% more than it cost.

The primary reason for the different conclusions by the HCFA and the CBO was the acknowledgment that the savings reported by the HCFA were nothing more than Medicare costs transferred or shifted to other patients, third-party payers, or insurance companies. The CBO concluded that it was unlikely that the Congress conceived the PSRO program “as a \$150 million per year mechanism to transfer financial burden from the Medicare Trust Fund to the private sector.” If the PSROs were working, the CBO argued, they should have been freeing resources consumed in the delivery of hospital care so that they could be put to other uses (Congressional Budget Office 1979, p. 2). In other words, in the CBO’s opinion, the PSRO program did not work.

The CBO and other analysts have identified several reasons why the PSRO program was not effective. First, the requirement that only physicians could monitor and evaluate the care provided hospitalized patients was criticized. Second, the program’s emphasis on local medical practice made it difficult to eliminate regional variations

in practice patterns and to establish national admission and care standards. Third, sanctions for negative evaluations were limited to hospitals, while physicians were not penalized. This created conflicts between physicians and the hospitals that granted them admitting privileges. Fourth, it was argued that PSRO activities could be improved by moving toward “focused review.” In other words, rather than reviewing all cases, PSROs could begin to review only those cases that were most in need of review, based on criteria such as severity of illness and intensity of services, rather than on specific norms for length of stay. Fifth, it was argued that the overall effectiveness of the program could change if the reviews were expanded to include other types of medical care, such as ambulatory care, long-term care, and hospital ancillary services. And sixth, problems arose because PSRO areas chose for themselves whether or not to undertake PSRO activities. In other words, self-selection of the active PSRO areas distorted any assessment of their effectiveness (Congressional Budget Office 1979, p. 3). These criticisms and declining consumer and provider support very likely paved the way for the eventual termination of the PSRO program.

The implementation of prospective payment based on diagnosis-related groups (DRGs) for the Medicare program in 1983 was a bold attempt to move away from the previously dominant retrospective reimbursement method. To address public and consumer concerns that quality of care would suffer under the prospective payment system (PPS), the Utilization and Quality Control Peer Review Organization (PRO) program was established in 1984 to replace the PSRO program.

Like its predecessor, the PRO program was expected to ensure quality through retrospective reviews of hospital records and discharge data, to educate physicians regarding any observed deficiencies in the quality of care, to deny payments for inappropriate care, and to impose penalties on hospitals and physicians who failed to meet professionally accepted standards of care. However, PROs differ from PSROs in many ways (Ermann 1988, p. 689; Wickizer 1990, p. 336). First, there are fewer PROs. Second, PROs operate under fixed-price, performance-based contracts as opposed to the loosely structured federal grants that funded PSROs. Third, PROs are given more power and authority than PSROs were given to deny payments to deficient or poor quality hospitals.

Certificates of Need (CON) or Health Planning

The Congressional and the Nixon administration’s health care cost containment programs were multifaceted. It was based on strengthening already existing cost containment measures as well as enacting new innovations. For example, lawmakers sought to strengthen the amendments to the *Hospital Survey and Construction Act* (Hill-Burton) that were authorized in both 1964 and 1966.

Amendments to the Hill-Burton program in 1964 established 318 local health facility planning councils to plan the development of new facilities. In 1966, the health facility planning councils were replaced with Comprehensive Health Planning Agencies. Further, the Social Security Amendments (PL 92-603) that President

Nixon signed on October 30, 1972, also authorized the setting up of state-designated planning agencies to review hospitals' request for expansion and modernization. All plans for facility expansion and modernization were to be preapproved. Unapproved expansions were not eligible for capital reimbursement under the Medicare, Medicaid, and Maternal and Child Health programs, but hospitals could charge other third-party insurance carriers to recover the costs of such projects. This provision essentially shifted the costs of unapproved facility expansions and modernizations to third-party insurance carriers. There was, however, nothing to stop these third-party carriers from adopting rules barring their programs' reimbursement of such projects.

The setting up of planning agencies to review health facilities' requests for modernization and expansion was strengthened by the passage of the federal *Health Planning and Resources Development Act* of 1974. The law required all 50 states to have health planning agencies to oversee the submission and granting of approvals or CONs before the beginning of any major capital projects, such as building expansions or the ordering of new high technology devices. Many CON laws initially were put into effect across the country, in part because of the incentive of receiving CON federal funds. By 1975, barely 4 years after the enactment of the federal legislation, 20 states had enacted CON laws; by 1978, 36 states had CON laws in place (National Conference of State Legislatures 2010, p. 1).

The federal CON requirement was repealed in 1987, along with its federal funding. About 10 years after, 14 states terminated their CON programs. According to the available evidence, about 36 states presently maintain some form of CON program, and even the 14 states that terminated their programs still maintain some structures intended to regulate costs and duplication of medical services. In addition, the District of Columbia and Puerto Rico have active CON programs.

The CON program, like any other regulatory measure, is very controversial. Advocates argue that because of failures in the health care market, there was a need to use the CON program to promote appropriate competition while maintaining lower costs for services. By controlling facility construction and equipment procurement, state governments would be able to determine the expenditures that are necessary and where those funds could be invested more effectively. Further, it is argued that new or improved facilities or equipment would be approved based only on a genuine need in the community. This, of course, assumes that other considerations, other than efficiency, do not influence the decision making process.

In addition, the advocates of CON programs argue that the programs have the ability to distribute care to areas that could be ignored by new medical centers. Similarly, CON programs are credited with improving the quality of care. For example, it is argued that when facilities and equipment are monitored, hospitals and other treatment centers can acknowledge the types of services that are in demand, and how effectively patients are being cared for (National Conference of State Legislatures 2010, p. 2). Improvements can then be made where the available evidence shows that patients are not effectively cared for.

The opponents of CON programs argue that it is not clear that the programs actually control costs. For example, by restricting new construction, CON programs

may actually reduce price competition between facilities and keep prices high. Further, it is argued that there is little direct broad support for Roemer's (1961) charge that overcapacity or duplication leads to higher charges. Rather, barriers to new construction are seen as unfair restrictions that affect both existing facilities and their potential new competitors.

In addition, opponents of CON programs argue that new federal reimbursement methods, such as prospective payment based on DRGs, subject health care facilities and organizations to more market pressure, thereby making more external regulatory controls unnecessary. Further, the argument is made that CON programs are not consistently administered, thereby subjecting health facilities to political influence.

The CON requirements for hospitals seeking expansion or modernization only minimally achieved the goal of curbing excess hospital capacity and equipment, if at all. First, hospitals appeared to respond to the controls by adding more equipment or other capital assets per bed. Second, the nonexistence of limits on the total number of projects that planning agencies could approve caused them not to make informed choices among alternative or competing projects. And third, the approval of a CON application frequently resulted in more services and jobs for the community, factors that were important to the community members of the planning agencies (Ubokudom 1997, p. 29). Therefore, for these and other reasons, costs continued to rise, necessitating additional interventions. It was out of this environment that managed care, a new health care delivery and financing paradigm, was launched.

Managed Care

None of the health care cost containment initiatives or innovations examined satisfactorily curbed the growth in expenditures because either the legislation setting up the programs did not involve far-reaching and effective cost containment measures, or health care providers minimized the programs' effectiveness by shifting their operations to the unregulated portions of the health care market, or both. As costs continued to rise, there were renewed calls for the enactment of a national health insurance program. Proponents of the nationalized health care approach argued that a single-payer system was the most effective approach to contain costs and provide care to the ever-increasing population of Americans without private health insurance. Opponents of national health insurance developed a counterargument that was based on at least three premises.

The first argument of the opponents of national health insurance was that the existing system was biased in favor of treating disease once it occurred, rather than preventing the occurrence of disease in the first place. Second, it was argued that if disease prevention became the primary focus of the health care system and health practitioners, hospitalization rates would be curtailed and costs controlled. Third, it was argued that new provider payment regimens, such as capitation, as well as disease or patient management, would encourage health practitioners and consumers to be cost conscious when prescribing and consuming health care services.

In the conservative political environment that prevailed during the Nixon administration, the argument for health promotion and disease prevention was more acceptable than the call for a national health insurance program. It was also believed that the disease management approach would generate very little opposition from the AMA and consumer groups. The understanding was that it would be very difficult for them to make any credible argument against health promotion and disease prevention. Therefore, the next federal effort to contain spiraling costs was the passage of the Health Maintenance Organization (HMO) Act of 1973. Events since the passage of the 1973 law culminated in today's managed care, utilization review, capitation payments, and disease and health management.

The History of Managed Care

Before the federal *HMO Act of 1973*, there were other kinds of prepaid or capitation arrangements in the United States. Before the advent of national health insurance in Europe, health services were normally provided by benevolent societies, guilds, unions, churches, or other associations that collected minimal premiums from their members and paid fixed amounts to physicians who agreed to care for those members. Payments usually consisted of an agreed upon amount per member per unit of time (Glaser 1970, p. 9). Similar arrangements existed in America in the nineteenth century. Company medical and labor union plans were mostly based on prepaid group practices that employed physicians (a staff model) or contracted with a physician group (a group model) to provide medical care to their members in exchange for a fixed payment.

The HMO terminology was developed in the late 1960s by Dr. Paul M. Ellwood, Jr., a Minneapolis, Minnesota, pediatric neurologist and policy entrepreneur. During his medical practice in Minnesota, Ellwood was concerned that the United States government was getting increasingly involved in the planning and funding of health care, as demonstrated by the passage of Medicare and Medicaid in 1965. This development was perceived as a disturbing trend toward socialized medicine. Therefore, Ellwood wanted to introduce the HMO as a better alternative to a socialized health system. The HMO alternative was expected to provide quality care and to control costs by preventing disease and maintaining good health in the population.

The idea of the federal government getting involved in HMO development and promotion was suggested to President Nixon by officials of the DHEW who had earlier been briefed by Dr. Ellwood about his health maintenance idea. The officials were convinced that the HMO idea would be an excellent alternative for the president who had been under intense pressure to support national health insurance legislation. Sold on the idea, President Nixon, in his State of the Union Address in January 1971, advocated "new programs to encourage preventive medicine by attacking the causes of disease and injury, and by providing incentives to physicians to keep people well rather than just to treat them when they are sick." After the usual Congressional back and forth, President Nixon signed the *HMO Act* (PL 93-222) on December 29, 1973.

In his signing statement, President Nixon stated that the HMO legislation would enable the federal government to help demonstrate the feasibility of the HMO concept over the next 5 years. The legislation was to provide initial federal development assistance for a limited number of development projects, with the hope that they would become self-sufficient within a fixed period of time. HMOs that received assistance under the law were to be required “to provide a comprehensive package of benefits, including essential preventive services, along with a list of supplemental benefits for which the enrollee could make an extra payment” (Woolley and Peters 2010, p. 1).

The Nixon HMO plans or experiments did not work out as anticipated because of physicians’ reluctance to embrace them. Similarly, most hospitals and doctors had no particular interest in developing HMOs because of benefit requirements, open enrollment, dual choice, limits on co-payments, and the requirement that premiums be based on community rating rather than experience rating (Rosoff 1975, p. 209). The lack of commitment by the medical industry to cooperate with HMOs led to their very slow development during the Nixon and Carter administrations. The well intentioned goals of health maintenance and promotion, as well as cost containment, did not turn out as intended.

In the 1980s, the Reagan administration focused on cutting federal spending, limiting benefits, and tightening the eligibility requirements for federal health care programs. For example, it was estimated that the Omnibus Budget Reconciliation Act (OBRA) of 1981 reduced federal Medicaid spending by more than \$4 billion from 1980 through 1984 (Davis et al. 1990, p. 73). OBRA-81 also encouraged states to devise new provider payment methods such as capitation, rate setting, prepayment, etc., in order to minimize their own expenditures. The imperative to contain costs rekindled great interest in a variety of delivery and payment methods collectively called managed care. For the most part, these innovations were designed to control health care costs.

Managed care plans use a variety of methods to monitor and control consumers’ health care utilization and providers’ prescription practices. Some of these approaches are discussed below.

Managed Care Cost Containment Methods

Miller and Luft (1994, p. 1512) wrote in 1994 that physician practice was what was managed in managed care. Perhaps, it would not be an overstatement to add that consumer health care seeking behavior is another variable managed care plans seek to manage. Since only about 10% of patients incur close to 70% of total health care costs (Berk and Monheit 2001, p. 9), managed care plans seek to monitor and control the utilization of medical services. They do so through a variety of methods, including: choice restriction, gatekeeping, case management, utilization review (UR), payment reforms, and practice profiling (Buchanan 1998, p. 617). We briefly discuss each of these cost control methods below.

Choice Restriction

Managed care plans may impose restrictions on the facilities and providers that will serve their enrollees. These restrictions led to the closed and open panel classification system discussed later under types of managed care plans. In addition, managed care plans develop a list of preferred medications called formularies and direct enrollees to plan-preferred pharmacies.

Gatekeeping

This cost control method is based on the understanding that managed care enrollees will need services other than primary care. Consequently, the enrollees choose or are assigned primary care physicians (PCPs) who coordinate all health care services they need or utilize. The PCPs direct or refer patients to secondary care providers, such as specialists, medical equipment suppliers, laboratories, etc. Therefore, the PCP serves as a gatekeeper, controlling patients' access to higher level services than primary care.

Case Management

While gatekeeping can be considered a form of case management, it is not adequate for patients who have complex medical problems, such as acquired immune deficiency syndrome (AIDS), multiple sclerosis (MS), head injuries, etc. Patients who suffer these complex problems need more secondary and tertiary care services than primary care. Therefore, an experienced and credentialed health care professional is needed to manage the totality of services required by patients with complex issues. Case managers continually review the appropriateness and effectiveness of the services provided their patients, to ensure that necessary changes are made in response to changes in the patients' conditions.

Utilization Review (UR)

UR attempts to evaluate medical services provided managed care enrollees for appropriateness and cost-effectiveness. Utilization management may be prospective, concurrent, or retrospective. Prospective UR determines the appropriateness of services proposed to be given, before they are actually delivered; concurrent UR managers monitor managed care enrollees receiving inpatient care to ensure that they are not kept longer than is necessary, and that the services they are given are appropriate

and necessary for their medical conditions; and retrospective UR involves assessing medical records after services have been provided to ensure that the services were appropriate, and that they were no overutilization or underutilization. Providers' health care utilization statistics may be compared to those of their peers.

Payment Reforms

The FFS payment system was one of the factors blamed for the cost inflation in the medical care market. As a result, it was felt that one of the ways to curtail expenditures was payment reforms. Toward this end, a PPS for Medicare patients based on DRGs was implemented in October 1983. At the outset, the DRG system divided the diagnostic conditions for which a patient could be admitted to the hospital into about 467 categories and set a fixed amount of payment for each category (Davis et al. 1990, p. 39). Additions and changes have since been made to the initial diagnostic categories.

Because the DRG system applied only to hospital services, the resource-based relative value scale (RBRVS) payment scheme for physician services under Medicare was implemented in 1992. The relative value scale (RVS) compares the time expended and the complexity of the services physicians provide Medicare beneficiaries, with adjustments made for service location. The RBRVS payment scheme has had the effect of increasing Medicare payments to primary care providers and reducing payments to specialists.

Various forms of the DRG and RBRVS payment schemes, such as capitation, are now used by private insurers to curtail their expenditures. Under capitation, the provider is paid a predetermined amount for each hospital or physician visit, or for each episode of illness. In other words, a cap is placed on the amount that is paid for each hospital or office visit, or for each episode of illness. If the services provided cost more than the allowed amount for that particular case, the provider takes a loss, or vice versa.

Practice Profiling

Under this cost containment approach, health providers' practice patterns are determined and compared to a known standard or norm, as previously discussed under retrospective UR. To ensure that profiling serves its objectives, the results of the profiling are provided to the providers evaluated. Profiling also allows managed care plans to identify the providers that meet the managed care plan's preferred practice patterns. Referrals are more likely to be made to these preferred providers than to those who the managed care profilers believe are overprescribing or overutilizing services.

Managed care plans differ in terms of the level of application, scope, and intensity of physician practice management features, such as provider selection, retention, information feedback methods, UR techniques, remuneration and risk-sharing methods, and medical practice organization (Davis et al. 1990; Miller and Luft 1994, p. 1512). In the next few pages, we identify different types of managed care plans. The classification presented is not exhaustive, as new innovations and changes outpace our ability to keep track of them.

Types of Managed Care Plans

We identify and analyze three kinds of managed care plans in this book: HMOs, preferred provider organizations (PPOs), and point of service (POS) plans. We begin with HMOs.

HMOs

Up until the 1980s, HMOs were the predominant form of managed care. To attract subscribers, the HMOs of the period offered more benefits and lower premiums than FFS plans (Zelman 1996, p. 2). However, both consumers and providers did not have serious interest in participating because of restrictions on the choice of physicians and the mode of practice and remunerations, respectively (Shi and Singh 2008, p. 342; Wilkerson et al. 1997, p. 3).

The first batch HMOs were either of the closed or open panel varieties. The open model allows the subscribers to receive services from both plan and nonplan physicians. Open panel or open access HMOs do not use gatekeepers, implying that there is no requirement for the patient to obtain a referral before seeing a specialist. However, the subscriber cost sharing, such as co-payments or coinsurance, may be higher for specialist care (Kongstvedt 2001, p. 40).

The closed panel HMOs, as the name suggests, limits subscribers to panel physicians. Subscribers are given a list of private practitioners in the community who have agreed to abide by the HMO's prescribing restrictions. The restrictions may involve a predetermined fee structure as well as detailed guidelines on the use of specialty services and hospitals. By limiting the subscriber's right to choose a physician, the HMO essentially assumes the responsibility of selecting competent physicians to serve on the panel.

There are about five HMO models—staff, group, network, independent practice association (IPA), and mixed—that differ based on the arrangements they make with their participating physicians. We examine them briefly below.

Staff model: Staff model HMOs directly employ full-time physicians who are not placed at financial risk (Ubokodom 1997, p. 71). The employer may add bonuses to the salaries of the employed physicians if it is deemed that the physicians are productive, and if the HMO's financial performance is good. The equipment and physi-

cal plant used for patient care are owned by the HMO, while the administrators direct the day-to-day functioning of the organization in accordance with the existing administrative and organizational constraints and goals.

Staff model HMOs must employ physicians in all the common specialties to serve their members' needs. Contracts may be established with some subspecialties that are not available or housed in the HMO's facilities, as well as with area hospitals for in-patient services (Shi and Singh 2008, p. 350). Laboratory and radiology services are frequently provided in the HMO's facilities. Since the practicing physicians are employees of the HMO, their practice behavior is subject to the direct control of the employer. As would be expected, utilization monitoring is easier under this arrangement. Viewed this way, the functioning of the staff model HMO resembles a closed panel type of arrangement.

Group model: The group practice HMO is a special type of closed panel arrangement in which the HMO either contracts with, or is owned by, a physician group practice that provides all the medical services. In other cases, the HMO may own the group practice as a separate corporation that is administratively tied to the HMO. HMO subscribers may make up the bulk of the practice's patients, or they may be only a fraction of the patient population. Whatever is the arrangement, the large number of patients that the HMO brings to the group practice gives it a fair amount of leverage on financial and utilization considerations.

The group practice, if it is not owned by the HMO, allows the HMO to avoid the large start-up costs or monies that would be needed to build facilities and establish a staff model arrangement. If it is a large group, it delivers a large number of physicians to the HMO with a single contract. However, if the HMO loses a contract with a large group practice, it will have difficulties meeting its obligations to enrollees (Shi and Singh 2008, p. 351).

Network model: Unlike the group model, the health benefit intermediary or insurance plan under the network model does not have an exclusive relationship with the medical group with which it is associated. The HMO contracts with more than one medical group practice. This minimizes its utilization control ability. Therefore, this model resembles an open panel arrangement.

Network enrollees may select their physicians from any of the groups the HMO contracts with. Each group receives a capitation fee that is based on the number of HMO enrollees receiving services from the group. The group is responsible for providing all physician services. The capitation amount it is paid is expected to cover the specialty services patients are referred to. If this arrangement is resisted, the HMO may contract with a panel of specialists, and the network physicians would be expected to refer patients to the specialty physicians the HMO contracts with (Wagner 1995, p. 24).

IPA: The IPA is a legal arrangement separate from the HMO. It contracts with solo and small group practices and sells the services of the contracted practitioners to the HMO. Consequently, IPAs usually have more participating physicians and more dispersed delivery sites (Ubokudom 1997, p. 72). By contracting with independent

practitioners and group practices and, thereafter, selling their services to the HMO, the IPA acts as the middleman between the contracting physicians and the HMO.

The IPA receives capitation payment for each HMO enrollee and determines whether to reimburse its physicians on a capitation basis or some other method, such as a portion of their customary fees plus bonuses if costs are minimized. It assumes financial risk for the operations and shares this risk with its contracting providers. The assumption of risk gives it the incentive to monitor the utilization and quality of services. The IPA may be established by a hospital, independent investors, community physicians, or the HMO may create an IPA and invite community physicians to participate in it (Shi and Singh 2008, p. 352). The IPA is an example of an open-panel HMO, where physicians may maintain their own offices and may also see non-HMO members.

Mixed model: As the name suggests, the mixed model HMO does not fit neatly into any of the four categories described above, but may involve some combination of the categories. For example, the HMO may employ its own physicians as well as contract with a single or multispecialty group practice.

PPOs

PPOs came into being in the late 1970s or early 1980s. They were set up by insurance companies to capture HMOs' growing market share. The first-generation PPOs were more concerned with provider reimbursement than utilization review. As a result, they did not use capitation payment methods. Rather, they negotiated discounted fees with providers in exchange for a steady caseload of HMO enrollees—enrollees were expected, but not required, to use the HMO's "preferred providers." However, enrollees could use physicians outside the preferred provider panel in exchange for higher deductibles and co-payments. The freedom to choose their physicians and hospitals was expected to make the PPO more attractive than closed-panel HMOs.

Because the first-generation PPOs were not much concerned with utilization review, they had limited success in controlling costs. Although unit costs fell, the volume of services provided their enrollees increased. More recently, PPOs have introduced prior authorization or retrospective utilization review, mandatory second opinions, and concurrent review for inpatient hospital care and high-cost outpatient services (Thorpe 1995, p. 294; Robinson 2002, p. W139). Most PPOs include financial incentives for the PCP to monitor utilization by setting specific targets for hospital admissions, total hospital days, and outpatient surgeries (Thorpe 1995, p. 294).

POS Plans

Point-of-service plans were developed to address consumer complaints about lack of choice of providers in the traditional HMOs. They combine features of HMOs

and traditional indemnity insurance plans or PPOs. At the point of service, enrollees can either use providers that are part of the network and pay minimal co-payments, or they can use out-of-network providers and pay substantial co-payments (Ubokudom 1997, p. 73). The network providers serve as gatekeepers and are reimbursed on a capitation basis, whereas the nonnetwork providers are paid on a FFS basis (The Next Generation 2007, p. 2). POS plans are sometimes called hybrid plans or open-ended HMOs (Shi and Singh 2008, p. 355).

HMOs were very successful and gained much publicity and popularity in the 1990s. By 1997, nearly three quarters of workers with health insurance received coverage through a HMO, a PPO, or a POS plan (Jensen et al. 1997, p. 125). Continuing the upward trend, the population enrolling in managed care plans increased from 27% in 1988 to about 95% in 2002. During the same period, enrollment in FFS plans declined from 70 to 5% (Next Generation 2007, p. 1; The Kaiser Family Foundation and Health Research and Educational Trust 2002, p. 68).

HMOs had the highest managed-care enrollment in 1997, followed by PPOs and POS plans, respectively. Over a few years, the PPO model gained market share from HMOs, reflecting consumer demands for fewer restrictions, and employer demands for more patient cost sharing. HMOs that could not or did not restrict their networks fared as well as PPOs. Competition centered on which health plans had the greatest market share and, therefore, could negotiate the greatest price discounts in return for larger patient caseloads, or which plans had the most attractive combination of customer service and administrative costs (Nichols et al. 2004, p. 14).

By 2009, nearly 20% of workers with health insurance received coverage through a HMO, 60% received coverage through a PPO, 10% received coverage through a POS plan, 8% received coverage through a high deductible health plan (HDHP), and only 1% received coverage through conventional plans (The Kaiser Family Foundation and Health Research and Educational Trust 2009, p. 62). Therefore, the tide had changed in favor of the less restrictive PPOs and against HMOs.

Consumer and Provider Concerns and the HMO Decline

In the late 1990s, concerns about rising health care costs were replaced by other concerns regarding the operation of the health care market. While there was agreement that managed care, most especially HMOs, had curtailed the rate of growth in health care expenditures, the means used to cut costs were suspect (Ubokudom 2003, p. 66).

Under the FFS payment scheme, physicians were accused of conflicts of interest by commission—having financial and other incentives to overprescribe services. Under managed care, especially HMOs, physicians were accused of conflicts of interest by omission—having financial and other incentives to underprescribe services (Emmanuel and Goldman 1998, p. 635). In addition, there was suspicion that the more restrictive managed care plans did not fully inform consumers about their operations and the decisions they made. Further, some managed care plans, espe-

cially HMOs, were accused of giving consumers little or no choice, or promoting market structures that were prone to biased risk selection (Moran 1997, p. 7).

In addition to consumers, health care providers also complained about the curtailment of their autonomy, the erosion of the fiduciary ethic, intrusions of external parties into the physician–patient relationship, and divided loyalty and the implementation of rules that limited the alternatives doctors could offer their patients (Macklin 1993, p. 1, 26; Gianelli 1996, p. 1; Woolhandler and Himmelstein 1995, p. 1706). In sum, both consumers and providers protested against managed care, especially HMOs, practices.

The dissatisfaction about the methods managed care plans used to contain inflationary expenditures were indicative of the difficulty of evaluating organizational effectiveness based on goal achievement (Ubokudom 2003, p. 67). Two types of information were necessary to evaluate managed care plan's effectiveness based on goal achievement. These were the extent of agreement about the value of the goals and the degree of certainty in how to achieve them.

Whereas there was broad agreement on the value or importance of health care cost containment, there was disagreement or uncertainty about the means used to contain costs. Some of the questions raised were: should services be reduced? should consumer choice be limited? should physicians' prescribing behavior be regulated? or should gag rules be established to limit the information physicians provided their patients? Disagreements and outright anger about the methods used to curtail expenditures led to calls for the enactment of patients' bill of rights to shelter consumers from unscrupulous health plans' activities.

According to research reports and publications, some 1,000 bills were introduced in state legislatures in the United States in 1996 to regulate managed care practices (Bodenheimer 1996, p. 1601). Between 1999 and 2000, the United States House of Representatives and the Senate passed different versions of a patient's bill of rights and set up a conference committee to reconcile the two bills. As the 2000 election approached, a reconciled version of the bill was not reported out of the conference committee. In the absence of legislation at the federal level to curtail managed care plans' excesses, consumers have come up with their own rule, so to speak. It says that when given a choice between health plans, consumers should choose the least restrictive plan. In my opinion, this unwritten rule is one of the causes for the decline of HMOs and the recent popularity of PPOs, POS plans and HDHPs.

For their own part, physicians have, over the past few years, been favorably disposed to physician equity models or physician equity alliances.

Physician-Equity Models

The term physician-equity model generally refers to an arrangement where the professional practice revenue stream of a physician practice or group of practices is divided into two parts: the part used to compensate the physicians working in the practice and the part used to cover administrative costs (O'Hare 1995, p. 20; Murdock 1997, p. 1). The portion of the revenue stream used for administrative

costs may be owned by a separate legal entity, composed either of physicians practicing in the group, or of outside investors. The arrangement involving physician ownership of the administrative revenue stream guarantees the participating physicians independence, power, and the opportunity to publicly trade the entity's stock. The physician equity model somehow resembles a physician-hospital organization (PHO), where a hospital and local physicians form an alliance. The intense monitoring of PHOs by federal antitrust lawyers appears to limit their growth (Sanderson et al. 2008, p. 64). The consumers' and providers' revolts have made managed care plans less able to contain health care costs as was the case when they were initially introduced.

The decline in managed care plans' ability to contain expenditure has caused employers and insurance carriers to continually rethink their cost containment strategies and devise other cost control practices. These additional cost control strategies are discussed below.

Other Cost Containment Practices

Increased Employee Cost Sharing

The ability of managed care plans to negotiate provider discounts diminished as providers, supported by their patients, successfully fought off managed care (Robinson 2002, p. W139; Enthoven 2003, pp. W3-237; Nichols et al. 2004, p. 15; Coulter 2006, p. 23). The result was a resurgence of high costs (Altman and Levitt 2002, p. W83). Therefore, employers decided to force employees to pay higher costs for their health benefits in order to give them the incentive to "comparison shop" for the best price or to consider the most appropriate use of services. As would be expected, between 1995 and 2005, workers' average monthly contribution to family coverage increased from \$129 to \$226. During the period, the average annual deductibles also increased substantially (The Kaiser Family Foundation and Health Research and Educational Trust 2005, p. 76).

The ultimate form of cost shifting to employees is dropping health insurance coverage altogether. As was discussed earlier in Chap. 2, the proportion of firms offering health benefits dropped from 69% in 2000 to 60% in 2005 (Collins et al. 2005, p. 6). Also, some employers eliminated health benefits for retired employees, thereby shifting costs either to the retired employees or to Medicare, or both (Blumenthal 2006, p. 196).

In addition to the shifting of costs to employees and government-sponsored insurance programs, employers are pursuing other measures designed to improve the performance of the health care system. Some of these measures include the setting up of the consumer-directed health plans (CDHPs) that have recently been gaining in popularity, paying for performance, disease management and health promotion. The remaining pages of this chapter are devoted to briefly describing and analyzing these new cost containment measures. First, we discuss the so-called CDHPs.

Consumer-Directed Health Plans

The terminology, CDHPs, is clever, and rhetorically and symbolically appealing. After all, who would quarrel with the idea of consumers directing the health plans that provide their medical services? The thinking is that consumer involvement in provider payment and selection would induce them (consumers) to make better and more economical choices. But do consumers sit on the Boards of these health plans? The answer is “No.” Their involvement with the plans stems from high cost sharing as well as the setting up of an account that can be used to meet out-of-pocket costs or saved for future health expenditures (Nichols et al. 2004, p. 16; Robinson 2005, p. 1199; Blumenthal 2006, p. 197; Coulter 2006, p. 26). Viewed in this manner, the CDHP focuses on the demand-side of the health care delivery system.

CDHPs, offsprings of HDHPs, were developed to minimize the impacts of the high deductibles consumers paid through HDHPs, thereby making the innovation more attractive to employers and employees. At least two features are said to distinguish CDHPs from HDHPs. First, CDHPs use tax-exempt funds to reduce the costs of deductibles to employees. Second, at least in theory, CDHPs provide employees with information about the costs and quality of health care services furnished by health providers (Blumenthal 2006, p. 197).

CDHPs currently feature three kinds of accounts that offer tax benefits to employees who enroll in them. The first of these is the health savings account (HSA), created by the *Medicare Modernization Act* of 2003. The funds in this account can be deposited by both the employee and employer and, once deposited, belong to the employee even if the employment with the employer who helped set up the account is terminated.

The second and third types of accounts featured by CDHPs are the health reimbursement account (HRA) and medical savings account (MSA). HRAs are similar to HSAs, but employers consider them more flexible. Under HRAs, employers agree to reimburse all or part of employees' out-of-pocket expenses up to a specified annual maximum, but do not actually deposit any monies into an account. The accounts are not portable and it is up to the employer to decide if any unused credit for a given year can be saved to be used in a subsequent year. The Internal Revenue Service (IRS) does not count HRA payments as income to the beneficiary.

MSAs were introduced in 1996 under the *Health Insurance Portability and Accountability Act* (HIPAA). At the time the HIPAA was passed, Congress made the MSA provision available only to firms with 50 or fewer employees and the self-employed. MSAs are portable, may accept payments from both employers and employees, and can only be used to pay for health care expenses up to a specified maximum (Blumenthal 2006, p. 197).

The criticisms of CDHPs are that they are likely to be more attractive to healthy employees (favorable risk selection) and to be very unlikely to have much impact in containing inflationary health care expenditures. Studies conducted in 2004 confirmed that those who enrolled in CDHPs had a history of lower health care expenditures than others (Tollen et al. 2004, p. 1167).

Paying for Performance

Under this approach, employers work with their insurance carriers to reward practitioners who offer both better quality and low cost care. The specific measures rewarded and the methodology used to determine the amount of reward do vary (Epstein et al. 2004, p. 406; Galvin et al. 2005, p. 228).

Pay for performance has potential advantages and disadvantages. One advantage is that it has the ability to correct a flaw in the FFS system which paid providers based on the quantity of services delivered regardless of the quality of the services. A likely disadvantage is that it may encourage favorable risk selection (Epstein et al. 2004, p. 406; Blumenthal 2006, p. 199).

Disease Management

The bulk of employers' medical costs are for employees with chronic conditions such as hypertension, diabetes, asthma, heart disease, etc. This chronic disease population is said to comprise about a third of the health beneficiary population but responsible for more than half of the overall costs of medical care (Coulter 2006, p. 29). Appropriate services for these individuals can result in significant cost savings and can improve both their productivity and quality of life. Program design tends to vary among insurers. Most vendors or insurers focus on specific chronic conditions such as diabetes, asthma, hypertension, and heart disease. However, other insurers take a health advocacy approach rather than focus on a specific diagnosis.

Health Promotion

The beneficiaries targeted by health promotion programs are currently healthy, incur modest medical expenses, and generally constitute about 15–20% of overall medical spending. They are targeted to reduce their chances of being diagnosed with a medical illness due to inactivity, obesity, tobacco consumption, or other behavioral factors that have the potential to cause illness (Coulter 2006, p. 30). Therefore, the primary focus of health promotion programs is the improvement of health-related behaviors.

An important element of health promotion is health screening in order to detect diseases before they become serious or catastrophic. Health screening is an important aspect of preventive health services. It is among the most cost-effective steps an employer can take to lower health benefit costs (Coffield et al. 2001, p. 1). Consequently, most employers have instituted worksite-based screening programs for their employees who are willing to take advantage of the opportunity.

We have gone to great lengths to discuss the various strategies that have been employed to achieve efficiency in the health care system. An important finding of the analyses in this chapter is that these cost containment and efficiency-seeking

measures vary as do insurance providers, employers, and health practitioners. In other words, each major employer, insurer, or physician group is doing their own thing, so to speak, without much coordination among the various actors.

One of the major differences between the United States' health care system and those of other industrialized countries, the lack of a central agency to administer the various innovations and payment systems, is apparent from the discussion in this chapter. While the rates of annual expenditure growth have declined, they are still about double the rate of general inflation. This implies that all the factors that drive costs have not been addressed.

The discussion in this chapter has not addressed the impact of technology on health care costs. Glied (2001, p. 961) observes that the factor that has had the greatest impact on insurance-related market failure and institutional response has been technological change in health care. She argues that technological improvements in the nature and quality of health care have made access to care more important and have driven increases in the cost of care. Similarly, Goddeeris (1984, p. 56) and Baumgardner (1991, p. 36) argue that expanded health insurance has interacted with the process of technological innovation and diffusion to introduce a new form of market failure, dynamic moral hazard, into the health care market. In other words, the existence of health insurance encourages the development and deployment of cost-increasing technologies. Developers and providers compete to attract patients by choosing technologies they believe would improve the quality of care, thereby giving them little incentive to develop or choose technologies that lower costs. Because of this indictment of technology as one of the factors exacerbating the failures in the health care market, the next chapter is devoted to examining the technological environment of the health care system.

Conclusion

Health policies affect and are affected by the economy. Similarly, the services providers produce and deliver have economic implications for the payers and consumers of care. Most recently, health professional services have accounted for the largest share of health care spending, followed by hospitals and pharmaceuticals, respectively. The total revenues raised to pay for health care from all sources equal the expenditures on health care or the total incomes of health care providers. Concerns for inflationary expenditures have led to the corporatization of American medicine. Since about 1970, the primary focus of the United States' health care policy-makers has been cost containment. Consequently, various health care providers, especially physicians, and consumers, are the prime targets of the continuously evolving cost minimizing or efficiency-seeking innovations in the health care system.

Note

The CMS have released the 2009 national health care expenditure data. The data underwent a comprehensive revision that included the incorporation of newly available source data, methodological and definitional changes, and benchmark estimates from the US Census Bureau's "quinquennial" economic census. These changes made it risky to attempt to incorporate the 2009 data in Table 4.1, and to try to make comparisons to past historical data. However, the 2009 data show that expenditures decelerated in 2009, increasing 4% between 2008 and 2009, compared to about 4.7% between 2007 and 2008. On average, there was a decline in the rate of growth of expenditures in all the expenditure categories between 2008 and 2009. Total expenditures reached \$2.5 trillion, which translated to \$8,086 per person or 17.6% of the GDP (CMS 2010).

Review Questions

1. Identify the relationships between economic issues and health policy.
2. Why are physicians usually blamed for rising health care costs?
3. How is today's health care market different from the markets described by Talcott Parsons, Kenneth Arrow, and Eliot Freidson?
4. Identify the various measures and approaches that have been employed to control health care costs since the early 1970s to the present time.
5. Why have US policy makers not used economic concerns and evaluations and a broader national system to solve the problems of the health care system as their counterparts in various European countries have done?
6. Define managed care and identify the various managed care plans and the approaches managed care utilizes to contain health care costs.
7. Why did HMOs lose their initial strong appeal even though they were successful in curtailing the rates of health care expenditure growth?
8. What are the advantages and disadvantages of increased corporate influence in American medicine?

References

- Altman, D.E., and L. Levitt. 2002. "The Sad History of Health Care Cost Containment as Told in One Chart." *Health Affairs*—Web Exclusive (23 January): W83–W84.
- Anonymous. 1973 January. "Professional Standards Review Organizations (PSRO's)." *California Medicine* 118(1): 39.
- Arrow, K.J. 1963. "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review* 53(3): 941–973.
- Battistella, R.M., J.W. Begun, and R.J. Buchanan. 1991. "The Political Economy of Health Services: A Review of Major Ideological Influences." In *Health Politics and Policy*, 2nd ed., eds. T.J. Litman and L.S. Robins. Albany, NY: Delmar, 66–92.

- Baumgardner, J. 1991. "The Interaction Between Forms of Insurance Contract and Types of Technological Change in Medical Care." *RAND Journal of Economics* 22(1): 36–53.
- Berk, M.L., and A.C. Monheit. 2001. "The Concentration of Health Expenditures Revisited." *Health Affairs* 20(2): 9–18.
- Blumenthal, D. 2006. "Employer-Sponsored Insurance—Riding the Health Care Tiger." *The New England Journal of Medicine* 355(2): 202.
- Bodenheimer, T.S. 1996. "The HMO Backlash—Righteous or Reactionary?" *The New England Journal of Medicine* 335(21): 1601–1604.
- Brook, R.H., R. Park, M.R. Chassin, D. Solomon, J. Keesey, and J. Koseoff. 1990. "Predicting the Appropriate Use of Carotid Endarterectomy, Upper Gastrointestinal Endoscopy, and Coronary Angiography." *New England Journal of Medicine* 323(17): 1173–1177.
- Buchanan, A. 1998. "Managed Care: Rationing Without Justice, but not Unjustly." *Journal of Health Politics, Policy and Law* 23(4) (Winter): 617–634.
- Chernew, M. 2001. "General Equilibrium and Marketability in the Health Care Industry." *Journal of Health Politics, Policy and Law* 26(5): 885–897.
- Coffield, A.B., M.V. Maciosek, M. McGinnis, J. R. Harris, M.B. Caldwell, S.M. Teutsch, D. Atkins, J.H. Richland, and A. Haddix. 2001. "Priorities Among Recommended Clinical Preventive Services." *American Journal of Preventive Medicine* 21(1): 1–9.
- Collins, S.R., K. Davis, and A. Ho. 2005. "A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to Employees." *Inquiry* 42(1): 6–15.
- Congressional Budget Office Testimony, June 27, 1979. "Statement of Robert D. Reischauer, Deputy Director, Congressional Budget Office." Retrieved June 6, 2010, from (<http://www.cbo.gov/doc.cfm?index=5226&type=o>).
- Coulter, C.H. 2006. "The Employer's Case for Health Management." *Benefits Quarterly* (First Quarter): 23–33.
- Davis, K., G.F. Anderson, D. Rowland, and E.P. Steinberg. 1990. *Health Care Cost Containment*. Baltimore, MD: Johns Hopkins.
- Development Data Group, The World Bank. 2008. Retrieved May 8, 2010, from (<http://earthtrends.wri.org/text/economics-business/variable-227.html>).
- Dye, T.R. 2008. *Understanding Public Policy*, 12th ed. Upper Saddle River, NJ: Pearson/Prentice Hall.
- Emmanuel, E.J., and L. Goldman. 1998. "Protecting Patient Welfare in Managed Care: Six Safeguards." *Journal of Health Politics, Policy and Law* 23(4): 635–659.
- Enthoven, A.C. 2003. "Employment-Based Health Insurance is Failing: Now What?" *Health Affairs—Web Exclusive*: W3-237–W3-249.
- Epstein, A.M., T.H. Lee, M.B. Hamel. 2004. "Paying Physicians for High Quality Care." *The New England Journal of Medicine* 350: 406–410.
- Ermann, D. 1988. "Hospital Utilization Review: Past Experience, Future Directions." *Journal of Health Politics, Policy and Law* 13(4): 683–704.
- Evans, R.G. 1997. "Sharing the Burden, Containing the Cost: Fundamental Conflicts in Health Care Finance." In *Health Politics and Policy*, 3rd ed., eds. T.J. Litman and L.S. Robins. Albany, NY: Delmar, 265–287.
- Freidson, E. 1970. *Professional Dominance: The Social Structure of Medical Care*. New York, NY: Atherton Press, Inc.
- Fuchs, V.R. 1974. *Who Shall Live? Health, Economics and Social Choices*. New York, NY: Basic Books.
- Galvin, R.S., S. Delbanco, A. Milstein, and G. Belden. 2005. "Has the Leap-frog Group Had an Impact on the Health Care Market?" *Health Affairs* 24(1): 228–233.
- Gianelli, D.M. 1996. "Bound and Gagged: AMA: Unethical Managed Care Rules Stifle Communication." *American Medical News* (February 5): 1, 26.
- Glaser, W.A. 1970. *Paying the Doctor*. Baltimore, MD: Johns Hopkins.
- Glied, S.A. 2001. "Health Insurance and Market Failure Since Arrow." *Journal of Health Politics, Policy and Law* 26(5): 957–965.
- Goddeeris, J.H. 1984. "Medical Insurance, Technological Change, and Welfare." *Economic Inquiry* 22: 56–67.

- InflationData.com 2010. "Historical U.S. Inflation Rate 1914-Present." Retrieved May 6, 2010, from http://inflationdata.com/inflation/Inflation_Rate/HistoricalInflation.aspx?dsInflation_current...
- Jensen, G.A., M.A. Morrisey, S. Gaffney, and D.K. Liston. 1997. "The New Dominance of Managed Care: Insurance Trends in the 1990s." *Health Affairs* 16(1):125–136.
- Kongstvedt, P.R. 2001. *The Managed Health Care Handbook*, 4th ed. Gaithersburg, MD: Aspen Publishers, Inc.
- Macklin, R. 1993. *Enemies of Patients*. New York, NY: Oxford University Press.
- Magleby, D.B., D.M. O'Brien, P.C. Light, J.M. Burns, J.W. Peltason, and T.E. Cronin. 2006. *Government by the People: National Version*, 21st ed. Upper Saddle River, NJ: Pearson/Prentice Hall.
- Manning, W.G., J.P. Newhouse, N. Duan, E.B. Keeler, A. Leibowitz, and M.S. Marquis. 1987. "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment." *The American Economic Review* 77(3): 251–277.
- McGuire, T.G. 2000. "Physician Agency." In *Handbook of Health Economics*, Volume 1, eds. A.J. Culyer and J.P. Newhouse. North Holland: Elsevier Science Publishers, 462–535.
- Miller, R. H., and H.S. Luft. 1994. "Managed Care Plan Performance Since 1980." *JAMA* 271(19) (May 18): 1512–1519.
- Moran, D.W. 1997. "Federal Regulation of Managed Care: An Impulse in Search of a Theory." *Health Affairs* 16(6): 7–21.
- Murdock, P. 1997. "Physician Equity Alliances." *Health Policy Newsletter* 10(1): Article 5. Retrieved October 25, 2011, from (<http://jdc.jefferson.edu/hpn/vol10/iss1/5>).
- National Conference of State Legislatures. 2010. "Certificate of Need: State Health Laws and Programs." Retrieved June 11, 2010, from (<http://www.ncsl.org/default.aspx?tabid=14373>).
- Neumann, P.J., and S.D. Sullivan. 2006. "Economic Evaluation in the U.S.: What is the Missing Link?" *Pharmacoeconomics* 2006: 24(11): 1163–1168.
- Newhouse, J.P. 1992. "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives* 6(3): 3–21.
- Nichols, L.M., P.B. Ginsburg, R.A. Berenson, J. Christianson, and R.E. Hurley. 2004. "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning." *Health Affairs* 23(2): 8–21.
- O'Hare, P.K. 1995. "Understanding the Physician-Equity Model." *Healthcare Financial Management* 49(7) (July): 20.
- Parsons, T. 1951. *The Social System*. Glencoe, IL: Free Press.
- Pauly, M.V. 1968. "The Economics of Moral Hazard." *American Economic Review* 58(3): 231–237.
- _____. 2001. "Forward: Kenneth Arrow and the Changing Economics of Health Care." *Journal of Health Politics, Policy and Law* 26(5): 829–834.
- Rettig, R.A. 1994. "Medical Innovation Duels Cost Containment." *Health Affairs* 13(3) (Summer): 7–27.
- Robinson, J.C. 2002. "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design." *Health Affairs—Web Exclusives*: W139–W154.
- _____. 2005. "Health Savings Accounts—The Ownership Society in Health Care." *The New England Journal of Medicine* (353): 1199–1202.
- Roemer, M.I. 1961. "Bed Supply and Hospital Utilization: A National Experiment." *Hospitals* 35(21): 36–42.
- Rosoff, A.J. 1975. "Phase Two of the Federal HMO Development Program: New Directions After a Shaky Start." *American Journal of Law and Medicine* 1(2) (Fall): 209–243.
- Rothschild, M., and J. Stiglitz. 1976. "Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information." *Quarterly Journal of Economics* 80: 629–649.
- Sanderson, B., B. Rice, and M. Fox. 2008. "Physician Integration is Back—and More Important than Ever." *Healthcare Financial Management* 62(12) (December): 64–71.
- Shi, L., and D.A. Singh. 2008. *Delivering Health Care in America: A Systems Approach*, 4th ed. Sudbury, MA: Jones and Bartlett Publishers.

- Silk, L.S. 1973. *Nixonomics*. New York, NY: Praeger.
- Starr, P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York, NY: Basic Books.
- The Henry Kaiser Family Foundation. 2008. "Kaiser State Health Facts." Retrieved May 2, 2010, from (<http://www.statehealthfacts.org/comparemaptable.jsp?ind=445,429,438,440,773,442&cat=8+print=1>).
- The Kaiser Family Foundation and Health Research and Educational Trust: Employer Health Benefits 2002 Annual Survey. Accessed June 18, 2010, at (<http://www.kff.org/insurane/7315/upload/7315.pdf>).
- _____. 2009 Annual Survey. Accessed June 18, 2010, at (<http://www.kff.org/insurance/7315/upload/7315.pdf>).
- _____. 2005 Annual Survey. Accessed June 18, 2010, at (<http://www.kff.org/insurance/7315/upload/735.pdf>).
- The Next Generation: An Introduction to Medicine* 2007. Retrieved June 16, 2010, at (http://www.nextgenmd.org/vol14-1/managed_care_organizations.html).
- Thorpe, K.E., 1995. "Health Care Cost Containment: Reflections and Future Directions." In Jonas's *Health Care Delivery in the United States*, 5th ed., ed. A Kovner. New York, NY: Springer Publishing Co., 294–321.
- Tollen, L.A., M.N. Ross, and S. Poor. 2004. "Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana Inc." *Health Services Research* 39: 1167–1188.
- Ubokudom, S.E. 1997. *Physician Participation in Medicaid Managed Care*. New York, NY: Garland Publishing, Inc.
- _____. 2003. "Managed Care and the Agitation for a Patients' Bill of Rights: A Historical and Theory-Based Analysis." *Journal of Public Affairs & Issues* 7(1): 57–76.
- United States Centers for Medicare & Medicaid Services (CMS). 2008a. "National Health Expenditure Web Tables." Retrieved February 8, 2010, from (<http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>).
- _____. 2008b. "National Health Expenditures Accounts: Definitions, Services, and Methods, 2008." Retrieved May 8, 2010, from (<http://www.cms.gov/NationalHealthExpendData/downloads/dsm-08.pdf>).
- _____. 2010. "National Health Expenditures 2009 Highlights." Retrieved November 10, 2010, from (<http://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf>).
- Wagner, E.R. 1995. "Types of Managed Care Organizations." In *Essentials of Managed Health Care*, ed. P.R. Kongstvedt. Gaithersburg, MD: Aspen Publishers, Inc., 24–34.
- Wennberg, J.E., B.A. Barnes, and M.A. Zubkoff. 1982. "Professional Uncertainty and the Problem of Supplier-Induced Demand." *Social Science & Medicine* 16: 811–824.
- _____. and A. Gittlesohn. 1982. "Variations in Medical Care Among Small Areas." *Scientific American* 246(4): 120–133.
- Wickizer, T.M. 1990. "The Effect of Utilization Review on Hospital Use and Expenditures: A Review of the Literature and an Update on Recent Findings." *Medical Care Research and Review* 47: 327–363.
- Wilkerson, J.D., K.J. Devers, and R.S. Given. 1997. "The Emerging Competitive Managed Care Marketplace." In *Competitive Managed Care: The Emerging Health Care System*, eds. J.D. Wilkerson, K.J. Devers, and R.S. Given. San Francisco, CA: Jossey-Bass Publishers, Inc., 3–29.
- Woolley, J.T., and G. Peters. "The American Presidency Project: 376—Statement on Signing the Health Maintenance Organization Act of 1973." Retrieved June 14, 2010, from (<http://www.presidency.ucsb.edu/ws/index.php?pid=4092>).
- Woolhandler, S., and D. Himmelstein. 1995. "Extreme Risk—The New Corporate Proposition for Physicians." *The New England Journal of Medicine* (21 December): 1706–1707.
- Zelman, W.A. 1996. *The Changing Health Care Marketplace*. San Francisco, CA: Jossey-Bass Publishers.

Chapter 5

Technological Influences

The previous chapter concluded with an indictment of medical technology as one of the primary factors responsible for health care cost inflation. Literature was briefly cited to show that technological improvements in the nature and quality of health care led to increases in the costs of care. It was also briefly mentioned that the existence of health insurance encouraged the development and diffusion of cost-increasing medical technologies. These findings, and the acknowledgment in Chap. 2 of the important role that technology plays in health care delivery and financing, suggest that we devote a chapter of the book to examine the influences of medical technologies on the health care delivery and policymaking processes. We begin by defining and giving some examples of medical technology, and by tracing the evolution of medical technology in the United States.

Following the lead of Riley and Brehm (1989, p. 21), we define medical technology broadly to include the drugs, devices, sophisticated machines and ultramodern facilities, computer-supported information systems, and medical and surgical procedures used in medical care, as well as the organizational and supportive systems within which health care is delivered. Medical technologies involve standardized physical objects and the traditional and designed social means and methods used to treat or care for patients. These technologies and some selected examples are presented below in Table 5.1.

Physical Technologies

Physical technologies, some examples of which are provided in Table 5.1, involve the standardized inanimate tools that aid in the provision of medical care. They tend to change rapidly and to create high expectations from both consumers and providers.

Most of the physical technologies shown in Table 5.1 are diagnostic tools, used in the initial appraisal of a patient's condition to determine what is wrong. However, some physical technologies, such as renal dialysis machines; lithotriptors; implantable cardioverter defibrillators and vaccines; liver and bone marrow transplants; and

Table 5.1 Physical, traditional and designed social technologies used for medical care

Types	Used for	Examples
Traditional social technologies	Social and financial support	Families
	First contact care	
	Health education	Schools
	Referral sources	
	Social support	Churches
Designed social technologies	Healing effects	
	Settings for care	Assisted living facilities
		Hospices
		Senior centers
		Continuing care retirement communities (CCRCs)
		Hospitals
		Clinical laboratories
		Child care centers
		Counseling centers
		Managed care
Physical technologies	Organizational delivery structure	Social health maintenance organizations (S/HMOs)
		Integrated delivery network
	Diagnosis	Magnetic resonance imaging (MRI)
		Computer axial tomography scanners
		Computerized electrocardiography
		Fetal monitors
		Stethoscopes
		Petri dishes and blood culture media
		Microscopes
	Illness management	Renal dialysis machines
		Pacemaker
	Lifesaving	Liver and bone marrow transplants
	Cure	Lithotriptors
		Artificial organs
	Cure and prevention	Prescription drugs
	Prevention	Implantable cardioverter defibrillators
		Vaccines
	System management	Computers

computers, organizational, and managerial systems, are used, respectively, to manage existing health conditions, for curative purposes, to prevent the occurrence of illnesses, for lifesaving, and as health system support tools.

Social Technologies

Social technologies are not inanimate tools, but those standardized social means and methods used to solve certain problems (Dubnick and Romzek 1991, p. 127). Social technologies involve standardized human behavior patterns. However, they are less

standardized than physical technologies. Social technologies can be classified into traditional and designed categories.

Traditional social technologies date back to the beginning of the human race. Some examples of traditional social technologies include families, schools, and churches. As the literature on the preindustrial period of the evolution of the health care system presented in Chap. 2 demonstrates, the family was the locus of health care delivery before it was replaced by designed social technologies, such as hospitals and nursing homes. And, based on the World Health Organization's definition of health as "a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO 1948), social technologies are still important parts of the health care system. The WHO definition emphasizes the importance of social, emotional, and financial support networks that social technologies provide. The maintenance of a strong social support system is known to be linked to good health conditions, longevity, productivity, and a pleasant and positive attitude (Shi and Singh 2008, p. 40; WHO 2010).

The recent emphasis on holistic health, which stresses the physical, mental, social and spiritual aspects of health, also underscores the importance of traditional social technologies for health and well-being. A growing body of literature stresses the healing effects of a person's religion and spirituality on morbidity and mortality (Levin 1994, p. 1475; Maugans 1996, p. 11; McCullough and Larson 1999, p. 126; McCullough et al. 2000, p. 211; Roberts et al. 1997, p. 166). Additionally, school-based health programs provide health education and serve as a point of care and referrals for children of low-income families. Further, before the growth of commercial health insurance, and especially during and shortly after the Great Depression, churches arranged for prepaid care for their members (Glaser 1970, p. 9; Ubokodom and Khubchandani 2010, p. 14).

As discussed in Chap. 2, urbanization, industrialization, and population mobility made people less reliant on traditional social technologies for their health care and other social needs. As a result, designed social technologies were invented to fill the vacuum. Some of them, such as medical equipment manufacturers, hospitals, academic health centers and clinical laboratories have accelerated the rate of growth of physical technologies. Others, such as managed care delivery systems, attempt to limit technological growth by placing more emphasis on health promotion, disease prevention, and coordination of care.

The Growth and Diffusion of Medical Technology

The survey of the postindustrial period (1850–1969) of the evolution of the health care system presented in Chap. 2 serves as the starting point for our discussion of the growth and diffusion of medical technology. As we noticed, the postindustrial period witnessed significant improvements in the methods of health care delivery. The period witnessed a complete revolutionization of medicine and increased use of medical technology. Doctors no longer relied solely on patients' description of

symptoms to diagnose and treat disease. Rather, they started using medical technologies to do their work. Some of the medical technologies invented early in the period included the thermometer, stethoscopes, microscopes, ophthalmoscope, laryngoscope, and x-ray. These devices allowed physicians to see and hear parts of their patients' bodies, such as lungs and hearts.

The utilization of technology in medical treatment has expanded tremendously since the early inventions detailed above, and especially since the end of World War II (WWII). The growth of medical technology since the end of WWII has exceeded all advances made since Rene Laennec invented the stethoscope in 1816. In other words, the growth of medical technology in the past 65 years has exceeded all advances made between 1816 and 1939 when WWII began (Gelijns et al. 2001, p. 913). This raises the question: what factors account for this rapid growth and diffusion of medical technology?

Factors Responsible for the Growth and Diffusion of Medical Technologies

The factors we identify as being responsible for the growth and diffusion of medical technologies, which are by no means exhaustive, are divided into three broad categories, namely, demand-side variables, supply-side factors, and government policy. We examine each of these categories in greater detail below.

Demand-Side Variables

By demand-side variables we imply factors that are related to consumers' health care seeking and utilization behavior, and provider payment mechanisms. These include the people's cultural beliefs and values, differences in patient characteristics, and the role of health insurance in minimizing consumers' out-of-pocket costs and fueling innovation.

Cultural Beliefs and Values

Americans have strong faith in the ability of physicians and the health care system to treat their ailments. They have a strong belief in the advancement of science and technology. They take pride in the scientific breakthroughs and innovations recorded in the country. They equate technology development with progress.

As was discussed in Chap. 2, the application of the scientific method to the field of medicine led to the reliance on the medical model that has mostly governed medical practice and training in the country. The medical model relies on extensive use of medical technology to diagnose and treat disease. This so-called technological imperative has spurred the growth in technological innovation and utilization in the country.

Patients are said to be making a stronger independent contribution to the choice of particular technologies. According to Gelijns et al. (2001, p. 922), direct-to-consumer advertising and the explosion of medical information on the Internet has led to substantial changes in the medical knowledge base of the general public. Therefore, some of the uncertainties that patients face about their illnesses and treatment have been minimized, thereby influencing patients' choices of their desirable treatment options. Where patients are better informed and face genuine choices, their preferences about treatment risks, costs, and benefits associated with each technology have assumed an important role in the technology selection process.

Differences in Patient Characteristics

In addition to cultural beliefs and values, the heterogeneity of patients is said to be related to differences or variations in the options or technologies employed for care. This heterogeneity may be due to multiple factors, such as genetic, environmental, behavioral, sex, race, and socioeconomic status differences. There is evidence that these characteristics of patients, other than the nature of their diseases, influence the care that they receive.

In particular, patients of different sex, race, and socioeconomic status have been shown to receive different intensities of care. For example, whites are said to be more likely to receive coronary artery surgery than blacks, and women are less likely than men to undergo this procedure. Also, it is noted that the same technology may have wide ranging eventual effects in treating different individuals with identical medical conditions (Wennecker and Epstein 1989, p. 253; Ayanian and Epstein 1991, p. 221; Gelijns et al. 2001, p. 920; Steingart et al. 1991, p. 226).

Role of Health Insurance in Fueling Innovation

In Chap. 2, we indicated that the development of health insurance began in the hospital industry during the Great Depression. Nonprofit and commercial insurance plans experienced tremendous growth when unions could negotiate health insurance coverage with their employers. The expansion of health insurance and the development of service-benefit plans, which paid providers generously and retrospectively for each service provided, led to high health care costs and moral hazard or the overutilization of services. Further, generous insurance coverage caused increases in spending for new technologies and services. The development of these new products and services puts pressure on insurers to cover their costs (Danzon and Pauly 2001, p. 86).

The rate of innovation is influenced by the availability and level of reimbursement set for new services. New procedures, services, and equipment proliferate when there is adequate reimbursement for them. According to Gelijns and Rosenberg (1994, p. 28), a generous level of reimbursement for percutaneous transluminal coronary angioplasty (PTCA) and a less generous level of reimbursement for cochlear implants under the Medicare prospective payment system led to more and

less utilization, respectively, of the two procedures. Also, greater reimbursement for specialty care has been implicated for the increase in specialists and the decrease in the number of generalists (Ubokudom and Khubchandani 2010, p. 13).

The cost increasing effects of health insurance noted above have led to substantial changes in the insurance market. The realization that insurance contributed to the overutilization of health services and procedures led to the development of both cost and technology minimizing systems such as managed care, utilization review, second opinions, and prospective payment. In addition, insurers are taking a more critical stance regarding the technologies that they will cover as part of a standard benefit package (Gelijns et al. 2001, p. 922). In other words, cost-effectiveness criteria are implicitly or explicitly being used by insurers to determine the technology and procedures they will cover and how much the reimbursement rate will be. The technologies and procedures that are adopted through this selection process are likely to flourish while those not chosen may wither or die.

Supply-Side Factors

Supply-side variables involve the factors that are associated with the production and delivery of health care services. They include physician characteristics and medical specialization, competition and the availability of resources, research and development (R&D) costs, and medical uncertainty and defensive medicine. We have not included new delivery systems and cost containment practices, such as managed care and utilization review, under supply-side factors because they were mentioned briefly in the previous section under the cost increasing effects of health insurance. In the following pages, we briefly examine each of the supply-side factors.

Physician Characteristics and Medical Specialization

Physicians differ in their styles of clinical practice due to their individual nature and medical training. Their personal characteristics result in some of them being more or less risk averse than others. A 1987 study found that physicians were similar to the general population in that they preferred certainty when facing a gain but would prefer to gamble when facing a loss. The research demonstrated that physicians who were more risk averse ordered more tests than those who were less risk averse (Nightingale 1987, p. 25).

Physicians' individual nature is probably one of several factors that influence their specialty choice and practice settings. Prior to WWII, approximately 80% of American physicians were general practitioners and the remaining 20% were specialists. The war encouraged specialization, thereby reversing the prevailing trend—in the years after the war, the above percentages were completely reversed (Torrens 1978, p. 3; Ubokudom 1997, p. 15). As we discussed in Chap. 4, patients want to be able to choose their physicians and where they will receive care. They resent the curtailment of their access to specialty care (Spann 2001, p. 584).

Physicians undergo their residency training programs in acute care hospitals, especially the ones that are affiliated with medical schools. Specialists also prefer to work in these settings where they are more likely to have the resources and equipment they need than in general hospitals. Specialists prefer to work in settings where the available resources and technology are similar to those they used during their residency training (Cohen 2004, p. 79). Physicians of different clinical specialties are known to use a different set of tests and interventions to treat the same disease (Di Salvo et al. 1996, p. 262; Lange and Hillis 1998, p. 1838). Similarly, some physician characteristics, such as race and ethnicity, are known to be associated with the types of patients they treat (Moy and Bartman 1995, p. 1515).

Competition and the Availability of Resources

In the final pages of Chap. 2, we identified the economic conditions that had to be met in a free and competitive market. We further stated that the health care market in the United States violated most of the assumptions of a free and competitive market, where patients shop around for the providers they consider to be the most effective and efficient. Rather, each part of the present health care system has a tendency to take an adversarial position, not a cooperative one (Porter and Teisberg 2006; Ginsburg 2005, p. 1512).

Health care providers do not compete on the bases of price and quality. Since patients tend to equate high quality with high technology, providers portray themselves as being superior to their competitors by acquiring and utilizing state-of-the-art technology. This type of competition has the effect of increasing costs and not necessarily improving quality (Glied 2001, p. 961).

Medical specialization, which is discussed in the previous subsection, has also generated competition based on advanced equipment and facilities. Spurred by the curtailment of their autonomy under managed care, many physicians and specialists joined together to open specialty hospitals and diagnostic facilities. In response, hospitals added new and competing service lines and equipment (Kher 2006, p. 64; Goddeeris 1984, p. 56; Pauly 2005, p. 1523; Baumgardner 1991, p. 36).

High technology is employed by medical centers as a tool for recruiting popular specialty physicians. In addition, medical centers and hospitals try to be full service providers, offering a full range of services, often of low volume. Also, physicians tend to send their patients to the hospitals where they have economic or professional interests, regardless of the quality in a certain procedure (Porter and Teisberg 2006). Self-referrals, or the appearance of them, led to the passage of the *Ethics in Patient Referrals Act* (Stark I) of 1989, which prohibits the referral of Medicare patients to laboratories, where the referring physician has an ownership or other economic interests. The provisions of this law were reinforced by the *Omnibus Budget Reconciliation Act of 1993* (OBRA-1993). These amendments, commonly referred to as Stark II, apply to both Medicare and Medicaid, and expand the type of services for which physician referrals are prohibited when there is a conflict of interest (Shi and Singh 2008, p. 171).

Research and Development Costs

Another important factor that spurs the continuing flow of medical technology in the United States involves the level of investments or expenditures in basic science and research. Private or commercial interests, such as pharmaceutical companies and medical equipment manufacturers, invest large amounts of money in research and development (R&D) because of strong consumer interest in, and generous private and government reimbursement for, many of the new products they produce (The Henry Kaiser Family Foundation 2007, p. 2; Weisbrod and LaMay 1999, p. 112; Gelijns et al. 2001, p. 913; Glied 2001, p. 957).

Weisbrod (1991, p. 523) reported in 1991 that about 35% of the 200 largest-selling prescription drugs were new each year. In 1999, the FDA approved some 5,000 new and modified devices (Gelijns et al. 2001, p. 914). Over the same time period, physician innovators and industry researchers were busy working on new clinical procedures, pharmaceuticals, and new equipment and devices. The innovations in health care are fueled by public, nonprofit, and private research initiatives.

An estimated \$139 billion was spent on US health research in 2009, an increase of approximately 25% from the 2005 expenditure of \$111 billion. The largest share of the 2009 expenditures was spent by Industry, comprising pharmaceutical, biotechnology, and medical technology R&D initiatives (\$74.3 billion, or 53%). Government spent about \$47 billion, or about 34% of total research expenditures from all sources, while the “other” category, comprising universities, state and local governments, philanthropic foundations, and independent research institutes, accounted for about \$18 billion, or about 13% of the total expenditures (Research!America 2010, p. 1, 2).

The above statistics point to the fact that the United States is both the largest market for new health care technologies and the most involved participant in the R&D that generate medical technologies (Weisbrod and LaMay 1999, p. 113). The projects and advances that research firms choose to invest in are influenced by the expectations they have about the likelihood that the advances will be widely adopted once developed, and by calculations of their expected profits from the investments.

Health care cost containment pressures have shifted incentives so that R&D now focus on major, groundbreaking innovations that are deemed important enough to guarantee profitable prices and large sales. Medical providers readily adopt these new technologies for prestige purposes, and to reduce the uncertainties inherent in medicine and, by extension, to reduce the fear of malpractice lawsuits.

Medical Uncertainty and Defensive Medicine

The role that physicians played in influencing the utilization of health care resources and, consequently, the cost of care, became apparent during the cost containment period beginning in the late 1970s and early 1980s. As we discussed in Chap. 4, research revealed substantial variations in physician practice patterns and resource use throughout the country. These variations, which were more pronounced for

some procedures than others, could not be explained by the characteristics of the population, such as age, sex, or race, or by the types and severity of the patients' illnesses (Wennberg et al. 1982, p. 811; Wennberg and Gittlesohn 1982, p. 120).

The most important factor that was implicated as being responsible for the variations in physician practice patterns was the degree of uncertainty about the best way to treat health problems. In other words, opinions vary among physicians about the proper means to treat the health conditions their patients present, and about the amount of resources that should be expended for treatment. Physicians may have the same goals for treating identical health problems, but the methods or means of achieving the goals may vary from one physician to the other.

Other studies have also found a link between geography or location of practice and resource utilization, including hospital use (Fisher et al. 1994, p. 989; Wennberg et al. 1987, p. 1185). These studies show cases of both overprovision and underprovision of necessary services. It is not very likely that physicians intentionally overutilize or underutilize health care resources in order to increase costs or compromise the quality of care. Rather, they are more likely to be influenced by their own belief systems and values, and by the incentives and influences in their task environments. The fear of malpractice lawsuits is one such environmental factor.

The fear of malpractice may induce physicians to order more tests or use more resources in order to minimize medical uncertainty and the likelihood of making a mistake and being sued. Therefore, the decision to use or not to use a particular procedure or device becomes a decision for both the physician and the patient, and depends not only on medical science, but also on the doctor's and patient's tolerance for three types of uncertainty, namely, input uncertainty (uncertainty that arises because the physician does not know everything about their patients and the factors that may be responsible for their ailments), process uncertainty (uncertainty that arises because not everything is known about the progression of disease, or uncertainty that may be due to the complexity of the care delivery setting), and outcome uncertainty (the preferred outcome of care may be uncertain) (Bohmer 2000, p. 6).

Most malpractice cases go undetected, unpunished, and uncompensated (McGuire 2000, p. 516; Localio et al. 1991, p. 245). On the other hand, research results show that doctors significantly overestimate the risk of being sued (Lawthers et al. 1992, p. 463). And, by their own admission, they often do more than is clinically appropriate in order to protect themselves against malpractice (Blendon et al. 1993, p. 194). In a more recent publication, Kessler and McClellan (1996, p. 353) reported that Medicare reforms, which were hypothesized to reduce fear of liability among doctors, led to a 5–9% reduction in medical expenditures.

Government Policy

The last category or factor that was mentioned as being responsible for the growth and diffusion of medical technologies is government policy. There is no doubt that government policies and activities have contributed to the growth and diffusion of

medical technology. In the following pages, we analyze the role of government as it relates to costs, safety, benefits, and risks of medical technology. The specific areas analyzed include government expenditures for biomedical research, the construction of health facilities, the curtailment of health facilities' expansion and modernization, and the regulation of drugs and medical devices and equipment. We spend little time on some of these issues that have already been discussed at great length in this chapter and in the preceding chapters. We begin with government expenditures for biomedical research.

Government Support for Biomedical Research

Government support for biomedical research to improve the health care system began during the postindustrial period of the evolution of the health care system presented in Chap. 2. The conditions prevalent during the preindustrial period were unacceptable and needed to change. To achieve the needed changes, government funds were appropriated to build, staff, and equip medical schools. Health departments also grew in numbers during the period and employed the available medical procedures to eradicate or curtail the infectious disease epidemics that were rampant during the preindustrial period.

New discoveries in the treatment of disease were commonplace during the postindustrial period. The existing public and private medical schools led the way in many of the advances of the period because of the reforms of medical education that were achieved with government support and acquiescence. These advancements led to the development of better surgical techniques, new sera for the treatment of pneumonia, and new diagnostic tests and treatment options for a variety of medical problems (Ubokudom 1997, p. 14). As medical science developed, so did the techniques and technologies used to treat diseases.

The National Institutes of Health (NIH) was responsible for \$35.5 billion, or 76% of the total 2009 federal government expenditures for biomedical research. The other federal agencies, including the National Science Foundation (NSF), Department of Energy (DOE), Agency for Health Care Research and Quality (AHRQ), etc., incurred the remaining 24% of the 2009 federal expenditures (Research!America 2002, p. 2). These federal expenditures do not include the investment tax breaks that private research firms get from the government. Federal direct and indirect or tax expenditures for research have led to new and costly advances and medical specialization.

The Construction of Health Facilities

In Chap. 2 we discussed the Truman administration's national health plan which included the expansion of hospitals, increased funding for public health and maternal and child health services, and more federal money for medical research and education. Congressional adoption of the part of the plan that focused on the expansion of

hospitals led to the passage of the *Hospital Survey and Construction Act* (Hill–Burton) of 1946. The Hill–Burton program provided federal grants for public and nonprofit hospital construction throughout the country.

The construction of health facilities through the Hill–Burton program not only created extra hospital capacity, but it also resulted in the training of more medical workers, including nurses and specialty physicians, and in the procurement of more medical devices for the newly constructed facilities. It was Congressional realization that Hill–Burton had resulted in increased technology and costs that informed the subsequent amendments to the law to require health planning.

Health Planning or Efforts to Curtail Health Facilities' Expansion

The Amendments to the Hill–Burton Law that were passed in 1964 and 1966, and passage of the *Health Planning and Resources Development Act of 1974*, were discussed at length in Chap. 4. Suffice it to note here that these activities were intended to mitigate the diffusion of medical technology. CON or government regulatory programs conflicted with the public's desire for high technology and market-based approaches to stem the tide of medical inflation. As I noted earlier, they were abandoned by the federal government. According to Zimmerman (2006, p. 42), almost all of the specialty hospitals that were begun since 1990 are located in states that have ineffective or no CON requirements.

Government Regulation of Drugs and Medical Devices

Government policy is also an important determinant of the drugs and medical devices that are available for use in the United States. The agency with primary responsibility for regulating drugs and devices is the Food and Drug Administration. Even though the AHRQ, the NIH, and the CDC also engage in some limited forms of technology assessment, our focus here is on the FDA.

The Food and Drug Administration

The FDA is housed in the United States Department of Health and Human Services (DHHS), one of the nation's federal executive departments. It is assigned the responsibility of protecting and promoting public health through the supervision and regulation of prescription and over-the-counter drugs or medications, foods, tobacco products, dietary supplements, vaccines, biopharmaceuticals, blood transfusions, medical devices, veterinary products, cosmetics, and electromagnetic radiation emitting devices (ERED) (FDA 2010).

The FDA also strives to advance the public health by helping to facilitate innovations that increase the effectiveness, safety, and affordability of medicines and foods, and by helping the public acquire accurate and scientific information they

need to make healthy choices, and to reduce tobacco consumption (FDA 2010). The agency also enforces other laws, such as Section 361 of the *Public Health Service Act* and its enabling regulations, many of which include sanitation requirements on interstate travel and control of diseases on products ranging from certain household pets to sperm donations for people needing reproductive assistance.

The FDA was established under the *Pure Food and Drug Act of 1906*. As was stated in Chap. 2, negative revelations and stories about the patent medicine industry led to the passage of the 1906 law and to the creation of the FDA to take action when consumers were harmed as a result of the marketing of impure and ineffective drugs. The charge given to the FDA was to react only after harm had been done, because it was expected that drug manufacturers would conduct safety tests before making their products available to the public. The ineffectiveness of the agency's reactionary posture and other disasters and focusing events led to numerous amendments designed to strengthen the legislation. Table 5.2 summarizes some of the important pieces of legislation and court rulings that have enabled the work of the FDA, and the targets of these laws and rulings.

Table 5.2 shows the progression of the regulatory authority of the FDA. Drugs must undergo a rigorous evaluation for safety, quality, and effectiveness before they can be sold. The FDA's review process has certainly advanced evidence-based medicine that has made available potent and efficacious medical technology. But anything that has advantages is also likely to have disadvantages. In other words, drugs and other medical technologies have intended and unintended consequences. Therefore, the next section is devoted to identifying the effects of medical technology.

The Effects of Medical Technology

The physical and social technologies presented in Table 5.1 have had profound effects on both the health of the people and the health care delivery system itself. These include the positive and negative effects of technologies on the scope and content of medical training and the practice of medicine, costs, quality of care and quality of life, access to care, and the ethical concerns raised by medical technologies. We elaborate on these issues briefly below.

Effects on Medical Training and Practice

Technology has had significant effects on the health care system. Specifically, technology has driven the scope and content of medical training. The emphasis on medical specialization in the country is one of the consequences of advances in medical technology.

For a long time, medical education in the United States placed great emphasis on organ systems and less emphasis on the whole body or holistic care. Similarly, there were no explicit government or private sector policies designed to influence physician supply and distribution. Rather, market forces determined the quantity

Table 5.2 Important enabling legislation or court rulings for the FDA

Year	Legislation or court ruling	Targets
1902	Biologics Control Act	Started serious regulation of anti-toxins after 13 children died in St. Louis, Missouri, and nine additional children died in New Jersey, due to contaminated vaccines
1906	Pure Food and Drug Act	Prohibited, under penalty of seizure of goods, the interstate transportation of contaminated or adulterated foods or drugs. Also banned “misbranding” of foods and drugs
1911	<i>United States v. Johnson</i> (1911) 221 US 488	The Supreme Court ruled that the misbranding provisions of the 1906 law did not apply to false curative and therapeutic efficacy statements
1912	Pure Food and Drug Act (Sherley) Amendments	Amended the 1906 law by adding “fake and fraudulent” claims of curative or therapeutic effect to the definition of misbranding
1938	Federal Food, Drug and Cosmetic Act	Mandated a premarket review of the safety of all new drugs, as well as banning false therapeutic claims in drug labeling. Did not require that the FDA prove fraudulent intent. Passed after the 1937 Elixir Sulfanilamide tragedy in which over 100 people died
1950	<i>Alberty Food Products Co. v. United States</i> (1950) (No. 12483)	The Ninth Circuit Court of Appeals found that drug manufacturers could not evade the “false therapeutic claims” provision of the Federal Food, Drug and Cosmetic Act of 1938 by simply omitting the intended use of a drug from the drug’s label
1951	Food, Drug, and Cosmetics Act Amendments	The “prescription-only” category of drugs was codified into law
1962	Food, Drug, and Cosmetics Act Amendments	Required “substantial evidence” of drug efficacy for a manufacturer’s claims
1976	Medical Device Regulation Act	Authorized premarket review of medical devices. Categorized medical devices into three classes
1984	Drug Price Competition and Patent Term Restoration Act (Hatch-Waxman Act)	Extended the patent exclusivity terms of new drugs and tied the extensions to the length of the FDA approval process for each individual drug. For generic drugs, a new approval process, the abbreviated new drug application (ANDA) mechanism, was added
1990	Safe Medical Devices Act	Mandated the reporting of serious or potentially serious device-related injuries, illness, or death of employees or patients
1992	Prescription Drug User Fee Act	Granted the FDA authority to collect fees from drug companies in order to increase resources to shorten the drug approval process
1997	Food and Drug Administration Modernization Act	Allowed expedited approvals of drugs for life threatening diseases and expanded preapproval access for patients with limited treatment options
2002	Medical Device User Fee and Modernization Act	Authorized the FDA to assess fees for the review of premarket medical device submissions. Similar to the Prescription Drug User Fee Act of 1992
2007	FDA Amendments Act of 2007	Reauthorized and expanded the Prescription Drug User Fee and the Medical Device User Fee and Modernization Acts
2009	Family Smoking Prevention and Tobacco Control Act	Allowed the FDA to make public the ingredients in cigarettes; banned misleading labels such as “low tar,” and banned marketing targeted at children. Also required new warning labels on cigarette cartons

and kinds of physicians that were trained. Additionally, specialists received greater recognition and pay than generalists. The result was that more physicians chose specialization and high technology tertiary care than primary care. While medical inflation has led to limited medical workforce planning, it will likely take a long time before the trend toward more specialization and high technology tertiary care can be reversed, if it can be reversed at all.

Advanced medical technologies have turned hospitals into capital-intensive institutions (Iglehart 1982, p. 69). The growth of alternative delivery procedures and systems, such as independent outpatient surgical and imaging facilities, physician order entries (POE) or the use of information systems for drug prescription and test ordering, telemedicine, laser surgery, incubators for low birth-weight babies, managed care, and new reproductive techniques, are the direct results of the rapid advances in medical technology going on in the country. All these devices result in the training of new categories of health workers and the procurement of new information management systems. This is probably why health sector jobs continue to grow during both good and bad economic times.

Technological advancements have led to turf battles among different medical specialties. These disputes create serious problems when they occur within a health care system. The disputes occur because many of the new devices and techniques are not clearly the domain of any one specialty. For example, in some hospitals general surgeons and gastroenterologists argue about who should be authorized to perform laparoscopic cholecystectomies (a surgical procedure that can be used to remove a patient's gallbladder through small incisions in the abdomen). Similarly, disputes are reported among obstetricians-gynecologists and radiologists about who should perform mammograms and pelvic ultrasounds, and among radiologists and gastroenterologists about who should perform gastrointestinal endoscopy. These disputes are likely to continue as technological advancements outpace the development of standards and guidelines about who is better equipped and trained to perform a particular procedure (Alexander et al. 2006, p. 277).

Effects on Medical Costs

Technological change is said to be the single most important factor driving medical inflation (Aaron 1991, p. 48; Schwartz 1987, p. 220; Schwartz and Mendelson 1991, p. 1037; Rettig 1994, p. 7; Gelijns and Rosenberg 1994, p. 28; Glied 2001, p. 961; Weisbrod 1991, p. 523; Goddeeris 1984, p. 56; Baumgardner 1991, p. 36). At least two factors help determine whether a particular new technology will increase or reduce total health expenditures (The Henry Kaiser Family Foundation 2007, p. 2). First, the impact of the technology on the cost of treating an individual patient is an important consideration. In other words, it must be ascertained whether the new technology is either a supplement or a partial or complete substitute for an existing procedure or protocol.

Second, the level of use that the new technology achieves is another important consideration. The important questions to consider here include whether the new technology is applied to a broader population, or whether it reduces utilization. For example, new technologies that are applicable to previously intractable illness, or that are used to diagnose new populations for existing treatment, or that extend existing treatments to new conditions, or that allow more focused and targeted treatment, fall under this second category of factors that help determine whether a particular new technology will increase or reduce total health expenditures (The Henry Kaiser Family Foundation 2007, p. 2).

According to Rettig (1994, p. 15) both technological innovation and cost containment, two desirable public policy goals, are likely to experience serious conflict. The way the nation deals with the conflict between these two desirable values will rest upon political choices about how best to accommodate them. In other words, it is in the interests of all parties to the medical innovation enterprise to find ways to cater for the two objectives of ensuring clinical benefit to patients within a given resource constraint and maintaining a continuing flow of highly valued medical innovations.

Effects on Quality of Care and Quality of Life

Both the quantity and quality of life in the United States are much better now than they were during the pre- and postindustrial periods of the evolution of the health care system presented in Chap. 2. In addition, as was discussed in Chap. 4, Americans have resisted restrictions on their choice of doctors and the particular settings where they will receive care. Americans enjoy longevity and better quality care than their ancestors, as well as the many freedoms the health care system offers.

The public's satisfaction with the health care system is determined by several factors; prominent among them are increased life expectancy and improved quality of life (Rossiter 2009, p. 7). In 1950, life expectancy at birth was about 68.2 years. In 2004, the average male and female life expectancy at birth was 77.8 years (75.2 years for males and 80.4 years for females). Similarly, in 2000, life expectancy at age 65 was 17.6 years; in 2006 it was 18.5 years (Arias 2007, p. 4). Increased life expectancy and improved quality of life are probably some of the reasons why people accept the high expenses associated with health care (Hall and Jones 2007, p. 39).

As Table 5.3 shows, the number of age-adjusted deaths per 100,000 population for some selected causes of death declined markedly from 1990 to 2006. Double digit declines in age-adjusted death rates were recorded for all causes of death, and for eight specific causes of death shown in the table during the period. Three specific causes of death (chronic lower respiratory disease, diabetes mellitus, and intentional injuries) showed significant increases during the period being reviewed. Although deaths due to chronic respiratory disease and diabetes mellitus showed increases between 1990 and 2006, both of them showed declines of 8.4 and 6.8 percentage points respectively, between 2000 and 2006. Similarly, although deaths due to

Table 5.3 1990, 2000, 2005, and 2006 age-adjusted death rates for selected causes of death per 100,000 population

Cause of death	1990	2000	2005	2006	% Change 1990–2006
All causes	938.7	869.0	798.8	776.5	(17.3)
Heart disease	321.8	257.6	211.1	200.2	(37.8)
Cancer	216.0	199.6	183.8	180.7	(16.3)
Cerebrovascular disease/stroke	65.3	60.9	46.6	43.6	(33.2)
Chronic lower respiratory disease	37.2	44.2	43.2	40.5	8.9
Influenza and pneumonia	36.8	23.7	19.8	17.8	(51.6)
Chronic liver disease/cirrhosis	11.1	9.5	9.0	8.8	(20.7)
Diabetes mellitus	20.7	25.0	24.6	23.3	12.3
HIV disease	10.2	5.2	4.2	4.0	(60.8)
Unintentional injuries	36.3	34.9	39.1	39.8	9.6
Suicide	12.5	10.4	10.9	10.9	(12.8)
Homicide	9.4	5.9	6.1	6.2	(34.0)

Source: National Center for Health Statistics, Centers for Disease Control and Prevention (2011); at <http://www.cdc.gov/nchs>

suicide and homicide showed declines between 1990 and 2006, both of them showed increases of 4.8 and 5.1 percentage points between 2000 and 2006.

I define quality health care as medical intervention that is administered at the right time, in the proper amount, to the proper person, in the proper setting. There are four parts to that definition. The right time implies that the intervention should be available when it is needed; the proper amount implies that there should be neither overprescription nor underprescription of services; the proper person implies that the patient should be diagnosed as definitely needing the intervention or treatment; and the proper setting implies that outpatient care, for example, must not be provided in an in-patient setting, and vice versa. Therefore, quality enhancing technologies are expected to provide better and quicker diagnoses, more complete cures, or risk reduction in a cost-effective manner (Shi and Singh 2008, p. 178).

There can be no doubt that medical technology has improved the quality of health services. Some very general examples that can be offered to support this assertion include the many techniques that used to be done in in-patient settings but are now done in outpatient settings, new cures and more accurate diagnostic techniques, minimized pains, and noninvasive surgical and less time-consuming procedures. Similarly, the declines in mortality rates shown in Table 5.3, and the treatment and better survival rates for preterm babies that could not be helped in the 1950s, are the result of advances in medical technology. Technological innovations, including the availability of special ventilators, incubators, artificial pulmonary surfactants to enhance infant lung development, neonatal intensive care, etc., have helped to decrease the mortality rates for low birth-weight babies (Cutler and McClellan 2001, p. 11).

Technology has spurred the development and use of electronic information systems to store patients' medical information. This innovation makes it easier to transmit medical information instantly to those who need it than the traditional paper filing system that was used prior to this time. It also allows for better coordination of care, quality measurement, and error minimization.

But even though electronic health records (EHRs) have the advantages discussed above, some of their drawbacks include the fact that they require substantial monetary investments that some small health organizations cannot afford, as well as confidentiality concerns or the likelihood of unauthorized persons accessing patients' confidential health records. These confidentiality concerns were addressed through provisions of the *Health Insurance Portability and Accountability Act* (HIPPA) of 1996 (PL 104–191), which made it illegal to access individually identifiable health information except for care delivery, facility operations, or reimbursement purposes. Accordingly, the law places strict controls on the transfer of individually identifiable information between health facilities, lays out procedures for the disclosure of personal information, requires the training of personnel who handle confidential health records, and stipulates criminal penalties for violations of the law (Clayton 2001, p. 312). Financial gains that accrue from the implementation of EHRs are said to be sufficient to recoup the initial investment expenditures (Miller et al. 2005, p. 1127).

Robert Sanders (2004, p. 5) writes that medical technology has had a long and noble history based on the need to solve medical problems. Throughout the seventeenth and eighteenth centuries, and even throughout most of the nineteenth century, technologies were viewed as tools used to support the intellectual diagnosis conducted by physicians. But by the turn of the nineteenth century and throughout the twentieth century, our extensive reliance on technology elevated it from a means to an end. In other words, technology no longer developed out of a need to solve a problem but, rather as a manifest destiny based on the belief that if it could be invented, it should be invented (Postman 1992).

The shift in the population's view of technology subsequently discouraged twentieth century physicians from continuing to develop the art of diagnosis through direct communication with patients, observations, questioning patients, history taking, and performing physical examinations. According to Jacob Needleman (1985), a physician, technology is now causing physicians to neglect or forget about the one-on-one interactions and relationships that were the hallmark of the early practice of medicine. In other words, technology has led to the depersonalization of care. As a result, some authors contend that the loss in human interaction and relationships far outweighs any loss that would result from not developing a particular technology (Inlander et al. 1988; Needleman 1985; Sanders 2004, p. 6). The loss in human physician–patient interaction and relationship is not necessarily a measure of good quality care.

Technology has, in many instances, resulted in the overuse of health services. The overuse of health services is defined as the provision of a service that conveys very little benefits relative to the costs of the technology. In other words, the risks of the service or procedure outweigh the benefits, yet the service is provided. These high-cost and low-benefit technologies raise serious concerns among health policy analysts, payers, and other stakeholders. Similarly, some technologies, labeled “wasteful technologies,” are unsafe, ineffective, and not cost-effective (Kalb 1990, p. 1109). Unsafe and ineffective technologies erode the quality of health care services. An example of the overuse of technology would be a caesarian section performed for reasons other than medical necessity. Technologies that are not cost-effective, but are widely used, can deplete society's finite resources, thereby reducing access to care for other consumers.

Effects on Access to Care

In an insurance-based health care financing system such as we have in the United States, the first and most important step to access is possession of public or private health insurance coverage. The second step is knowledge of the types of coverage the insurance policy provides, as well as knowledge of the services the insured needs. Recently, as we discussed briefly in Chap. 1, and as we discuss more fully in Chap. 7, there has been an increase in the number of Americans who lack health insurance, the first prerequisite for access to health care and other available medical technologies.

As a result of the numerous, predominantly private health insurance programs in the United States, waiting lists and times for primary and specialty care are not very common for a majority of the people. However, that cannot be said of the uninsured and underinsured. The uninsured have no chance whatsoever, while the underinsured are likely to experience underuse or underprovision of necessary, and especially elective, health services. Underuse or underprovision occurs when the benefits of an intervention outweigh the risks, yet the intervention is not provided. This is frequently due to high costs or inability to afford the services, a phenomenon called economic rationing.

The type of insurance coverage is an important factor in access to medical services and technology. According to previous studies, physicians are known to practice price and patient discrimination due to the type of insurance the patients carry and, by inference, due to the reimbursement rates they receive from the myriad insurance plans available in the country (Ubokodom 1997, p. 149; Barrilleaux and Miller 1992, p. 97; Fanning and de Alteriis 1993, p. 27; Zuckerman and Welch 1990, p. 39; Gabel and Rice 1985, p. 595; Wedig et al. 1989, p. 601; Cromwell and Mitchell 1984, p. 197; Fuchs 1978, p. 35; Fossett and Peterson 1989, p. 386).

New technologies have improved access to health care in rural and provider shortage areas of the country. For example, telemedicine and mobile equipment allow the delivery and transportation of medical services to the rural and physician-shortage areas of the country, and save the people in those areas the trouble of having to travel long distances to access services in the urban and suburban areas. Similarly, life-flight helicopters have been very effective in transporting seriously ill and emergent patients to tertiary institutions in urban centers. This service improves the response time for emergency call and increases the survival rates for patients experiencing trauma and other life-threatening medical issues.

Ethical Concerns Raised by Medical Technology

Both the overprovision and underprovision of health services and technology and other vexing issues have raised ethical and moral concerns about the health care system and the process of care. Similarly, the rapid development and diffusion of technologies that are not effective, cost-effective, or safe, or the diffusion of the

so-called wasteful technologies and their impacts on overall health care expenditures, have generated serious ethical concerns and dilemmas that must be addressed.

Unfortunately, there are no universally accepted answers to the ethical questions raised by medical technologies because citizens' political and religious beliefs, values, and ideologies differ, and there is no agreement as to when life begins and what constitutes quality of life. Disagreements also exist as to whether terminally ill patients should be able to decline or utilize life-saving technologies to prolong life, even if it is for a short period of time, or whether physicians should be allowed to administer treatments to terminate the life of persons who have no hope of recovery from life threatening conditions.

Bioethical issues have been debated since ancient times. Public attention was drawn to the use of human subjects in biomedical research and experiments as a result of revelations of Nazi atrocities conducted during WWII. The modern field of bioethics emerged as an academic discipline in the 1960s. By the 1970s, bioethics programs and centers, such as the Institute of Society, Ethics, and Life Sciences, founded in 1969 and now called the Hastings Center, and the Kennedy Institute of Ethics, established at Georgetown University in 1971, emerged.

In an attempt to find urgent solutions to ethical issues in medical care, James F. Childress and Tom Beauchamp published the first American textbook of bioethics, *Principles of Biomedical Ethics*, in 1977 (Parks and Wike 2010, p. 18). According to Childress and Beauchamp, the answers to bioethical problems can be quickly discovered by appealing to the four principles that are at the heart of the practice of good medicine. These are patient autonomy, justice, beneficence, and nonmaleficence (1994, p. 1).

The principle of patient autonomy is based on the understanding that individual persons have the right to make their own choices and develop their own life plan. The respect for autonomy negates the long history of paternalism, where physicians made choices for their patients without consulting them. It also ensures that patients or their surrogates consent to any treatment prescribed, and that their wishes are respected. Under the principle, providers cannot deny patients any treatment (Parks and Wike 2010, p. 19). Similarly, the patient or surrogate must be competent or be able to understand the consequences of his or her decision, and must be free from coercion or undue influence.

The justice principle requires that medical goods and services be distributed fairly, or that health care practitioners, and society at large, treat similar or equal cases similarly or equally. For example, two patients with the same medical need should not be treated differently (Childress and Beauchamp 1994, p. 329). Therefore, the justice principle raises questions about the rationing of care, be it price rationing, demand-side rationing, or rationing by ability to pay; or planned rationing, supply-side rationing, or nonprice rationing (deliberate attempts to limit the supply of health care services, especially those beyond the basic level of care).

The principle of beneficence is based on the understanding that the sole aim of medical care is to make people well again, to improve their lives or make them better, or to do good for patients. The principle of beneficence is one of the important factors that induced the paternalism in medical practice that has been discussed

earlier. It requires the practitioner to do what will further the patient's interest. The provider must prevent the infliction of needless pain, prevent killing, and must not incapacitate the patient. Under this principle, cost should not be a factor in deciding whether or not to administer necessary treatments, if other equally effective but less costly treatments are not available. This principle questions the underuse or underprovision of care, which we defined earlier as the denial of low risk and highly beneficial care, because of cost concerns.

Finally, the principle of nonmaleficence requires that practitioners should not do harm or take actions that would be against the patient's interests. While beneficence advocates the furtherance of the patient's interests, nonmaleficence cautions against doing what damages the patient's interest. If providers can no longer do good for their patients because their condition has worsened, then they should at least not harm, kill, incapacitate, or cause them needless pain. This principle can be met by doing nothing and simply allowing the illness to go through its natural progression (Parks and Wike 2010, p. 20; Childress and Beauchamp 1994, p. 194; Garrett et al. 1993, p. 54).

Since the early 1970s when the primary focus of the US health care policies shifted from improving the quality and quantity of care and providing access to care to cost containment or the desire for efficiency, the field of bioethics has become increasingly complex, and Childress' and Beauchamp's principles, while still profoundly popular and useful, no longer offer quick and straightforward answers to the ethical issues the health care system presents. By organizing and managing the utilization of medical services through managed care, caps on fees and patient referrals, compensating physicians for the frugal use of resources or penalizing them for perceived overprescriptions, and providing incentives for physicians to see fewer patients in clinics and to monitor the care provided by specialty providers, patient autonomy, justice, beneficence, and nonmaleficence are threatened. Therefore, new ethical concerns have emerged in addition to the old ones. These include, but are not limited to: questions about both the overutilization and underutilization of health services or rationing, controversies involving reproductive technologies, and life-sustaining or end-of-life decisions. In the next several pages, I briefly discuss these concerns and allow the reader to draw his or her conclusions about the merits or defects of the arguments presented.

Questions About Overutilization and Underutilization

The capitalist economic model and the individualistic political culture in the United States, which we discussed in Chap. 3, give rise to the predominance of the private insurance model in the country. Under this model, those who have the financial means can consume as much health care services as they want, while those who are unable to pay for needed services go without or depend on underfunded public programs to finance their care.

Americans do not appear to be much concerned about the economic, price, or demand-side rationing of care that is prevalent in the country. To the contrary, they

point to real or imaginary long waiting lines for elective procedures in Canada as the primary evils of planned, supply-side, or nonprice rationing. They argue, sometimes on ideological grounds, that if universal health care were so good, many Canadians would not be coming to the United States for medical treatment, compared with only the very few Americans that go to Canada for treatment. But, the most likely reason for any waiting lines in Canada is because everybody is covered there within the constraints of the available resources. The Canadian system seeks a balance between equity and efficiency, and appears to satisfy Childress' and Beauchamp's justice principle more than the United States' system. The Oregon Medicaid Priority List is modeled after the Canadian system.

Oregon's Medicaid Priority List

The Oregon Basic Health Services Program, otherwise known as the Oregon Plan, was initially developed in 1987 and passed by the state legislature in 1989. It raised Oregon's Medicaid eligibility up to 100% of the Federal Poverty Standard in an attempt to expand coverage in the state. Prior to the new plan, the state responded to its budget shortfalls by manipulating Medicaid eligibility standards. Under the new plan, by contrast, coverage was extended to everyone below the poverty line, but the range of services provided was limited.

The Oregon Plan attempted to ration care based on a priority list of services to which more individuals who could not afford private insurance would have access. The priority service list, developed through a communal process, contained about 300 items that would be covered under the plan. Since the list did not include all the services that are usually mandated by federal Medicaid guidelines, a waiver had to be sought from the Health Care Financing Administration (HCFA), the federal agency that was renamed the Centers for Medicare and Medicaid Services (CMS) by President George W. Bush. The waiver was granted in 1992.

Any health services that were not part of the 300 priority services covered under the Plan would not be paid for by Medicaid. However, those out-of-plan services could be provided if the patient was able and willing to pay for them out-of-pocket. Therefore, by limiting the number of services normally covered under Medicaid, Oregon would be able to extend coverage to those individuals who previously had no access to any services under the old Medicaid program. In other words, economic or price rationing was replaced by planned or supply-side rationing (Callahan 1991, p. 622; Thorne 1992, p. 24; Daniels 1992, p. 185).

The Oregon Plan had its critics. One such criticism concerned the scope of the program. It was argued that the rationing was limited to only the poor mothers and children in the Aid to Families with Dependent Children (AFDC) program, the least powerful group in society, while the aged, blind, and disabled were exempt from the priority system (Callahan 1991, p. 623). Further, it was argued that the targeted group constituted only about 30% of the Medicaid budget, resulting in an inequitable basis of sharing the Medicaid cost burden (Brown 1991, p. 35; Calkthan 1991, p. 80).

Second, it was argued that every group that was in a position to mount serious opposition to the plan was won over: the exemption of long-term care and other Medicaid services for the aged mollified the senior citizens and nursing home lobbies; the exemption of most psychiatric care mollified the mental health lobby; and providers were guaranteed both their “necessary” costs and immunity from professional liability should they decline to prescribe nonreimbursable services (Brown 1991, p. 35; Fox and Leichter 1991, p. 9).

Third, Oregon’s claim that fiscal imperatives drove it to ration care was said to be disingenuous. Data was presented to show that in fiscal year 1989, Oregon spent less than half the national average of state general funds used as state Medicaid matching shares; that it ranked forty-sixth of fifty states on Medicaid spending as a percentage of all state spending; and that the state did not make the effort to expand the traditional Medicaid program to more citizens, even though it had the resources to do so, having recently returned \$300 million in surplus funds to the state’s taxpayers.

The proponents of the Oregon Plan were equally vehement in their defense of the proposal. For example, they argued that what mattered was not whether the plan legitimized a two-tiered system, but whether the care provided under the new plan was decent, humane, and reasonably adequate for most, if not all, legitimate medical needs of the poor. If that standard could be met, the initiative could be judged reasonable and fair, even if the affluent had better coverage. Furthermore, supporters of the plan accused the critics of being obsessed with poor women and children and ignoring the larger goal of the program, which was to address the needs of the uninsured. Also, it was argued that services for the elderly were exempt not because of their political power, but because most of the services the elderly needed were social services that the index of cost-effectiveness was not designed to evaluate (Packwood 1990, p. 633).

Reproductive, Life-Sustaining, and End-of-Life Decisions

Many issues are interwoven in the discussion of controversies involving reproductive, life-sustaining, and end-of-life technologies. Therefore, it is difficult to discuss all of them with any degree of specificity here. Abortion, stem cell research, selective reduction of multiple embryos, sex selection, and in vitro fertilization (IVF) raise several important moral and ethical issues and questions that relate to the beginning of life. Similarly, the emergence of life-support technologies that are capable of keeping patients alive for an extended period of time, even when it is apparent that the patient does not enjoy a good quality of life, and the existence of technologies that may be used to instantly terminate life with little or no pain, raise ethical and legal concerns about who shall live, who shall die, and who shall make the decision as to whether the patient deserves to die or live (Parks and Wike 2010, p. 345; Cantor 1993). Therefore to simplify matters, I group the discussion here under two broad categories—the beginning of life and the end of life.

The Beginning of Life

The concerns about the beginning of life involve the potential death or destruction of human embryos or fetuses. The issues involve the moral status of embryos or fetuses and whether any status accorded them confers the same protection that is extended to legal and moral persons. While the Supreme Court decision in *Roe v. Wade* (1973) discussed in Chap. 3 still stands, it is not without serious controversies. Also, reproductive medical technologies have been introduced much faster than the legal system's ability to address the legal and moral questions they generate, resulting in still more controversies. For example, should a woman who is carrying multiple embryos use selective reduction procedures to limit the number of embryos? Does each of the embryos have an equal right to life? Should the pregnant woman risk her health, her life or the other embryos' lives by attempting to carry the multiple embryos to term? Who should make the decision—the woman, her husband, the state where she resides, her physician, or the legal system?

There is no agreement as to whether an embryo or fetus has the right to be treated as every other human being. Conservatives give full moral right to the embryo or fetus from the time of conception. Liberals, on the other hand, are only willing to confer this moral status after birth. These disagreements involve both moral beliefs and differences concerning the views people hold about what it means to be a person. The moral status of the embryo and the issue of personhood relate to the abortion debate, stem cell research, and the use of assisted reproductive technologies (ARTs), which often involve, as a side effect, the destruction of embryos or fetuses (Parks and Wike 2010, p. 349).

The End of Life

In order to begin a good and informed discussion of the ethical issues involving end-of-life decisions, it is important to differentiate between euthanasia and physician-assisted suicide. Euthanasia, or the so-called “good death,” involves physicians either taking or not taking actions that may cause the death of their patients. For example, at patients' requests, they may turn off or abandon life-sustaining technologies, such as respirators, or they may decline to start interventions that would normally be given, or they may even administer death causing treatments, such as lethal injections.

In the case of a physician-assisted suicide, the physician provides the patient with the means to terminate their own lives, such as prescribing lethal doses of toxic pharmaceuticals. In this case, the physician is only indirectly involved in the patient's death by prescribing the compound used to commit suicide. This assumes that the person did not know or would not have known of the prescribed compound without the assistance of the physician. Therefore, while the physician prescribes the life-ending treatment, the patients go off on their own with the prescribed treatment to effectively end their lives (Parks and Wike 2010, p. 671).

In addition to differentiating between euthanasia and physician-assisted suicide, the literature makes a distinction between active and passive euthanasia. Active and

passive euthanasia are differentiated, respectively, as killing or letting a patient die. In the case of active euthanasia, the physician takes direct action to end the patient's life. In the case of passive euthanasia, the physician omits or neglects to take the action that would be necessary to extend the patient's life, such as not making any attempts to resuscitate a dying patient. In other words, active euthanasia involves acts of commission, whereas passive euthanasia involves acts of omission.

By whatever names they are called, the taking of life or assisting in the taking or ending of life raises serious moral and legal questions. Such moral and legal questions include: can euthanasia and assisted-suicide be justified? Do we as individuals have the right to terminate our lives or to have a caregiver terminate our lives? How do we determine when life is no longer valuable or not worth living? Is a sick and suffering patient competent enough or in the right frame of mind to make end-of-life decisions? Similar to the case of human embryos, the answers to these questions involve moral beliefs and differences concerning our views about personhood.

Because of the emotional issues involved in attempting to answer the above questions, and especially because of the obvious differences in how people view personhood, the courts have, at various times, been invited to determine questions of life and death. Their decisions have not always been consistent and cannot be said to provide definitive answers to the legal and ethical questions raised above. Three short examples, the Karen Ann Quinlan, the Nancy Cruzan, and the Jack Kevorkian cases will be used to demonstrate the complexity of bioethical issues. The literature is replete with more such cases, and readers are encouraged to research and study them.

The Karen Ann Quinlan Case

The Karen Ann Quinlan case was the first to deal with the agony or dilemma of terminating life-sustaining treatment from a patient who was neither terminally ill nor really alive. The decision on whether to continue or withdraw life support was left to the legal system, and the decision of the New Jersey Supreme Court in this particular case set a precedent for a substantial number of right-to-die cases in the country.

In 1975, at age 21, Ms. Quinlan suffered cardiopulmonary arrest after ingesting an unsafe combination of alcohol and drugs. Thereafter, she went into a persistent vegetative state (PVS). Even though she no longer had any cognitive function, she was able to make noises, grimace, move her jaws, and maintain a normal blood pressure level. However, she was completely unaware of her surroundings or the presence of her relatives. She was put on a respirator from the time of her admission to the hospital.

The physicians who treated Quinlan refused her parents' request to remove her respirator and allow her to die. The rationale for the doctors' refusal to terminate life-sustaining treatment was that Quinlan did not meet the legal and professional definitions for brain death. Quinlan's father, Joseph, went to court to seek appointment as his daughter's guardian and to gain the right and power to discontinue her

life-sustaining treatment. Both requests were denied. The case was then appealed to the New Jersey Supreme Court (Quinlan, 70 N.J. 1976).

The appeal before the New Jersey Supreme Court was based on three constitutionally granted freedoms—the First Amendment’s right to religious freedom, the Eighth Amendment’s protection against cruel and unusual punishment, and the right to privacy which, although not specifically mentioned in the Constitution, was recognized by the US Supreme Court in *Griswold v. Connecticut* (1965) and *Roe v. Wade* (1973) (see Chap. 3), as an unstated element of several rights in the Bill of Rights (Shea et al. 2011, p. 168).

The New Jersey Supreme Court reasoned that the right to privacy was most relevant to the case. Accordingly, the Court argued that Ms. Quinlan’s right of privacy could be asserted on her behalf by her guardian under the circumstances. While the State of New Jersey had an interest in preserving life, the patient’s right to privacy outweighed the State’s interest to preserve life. Therefore, in March 1976, the New Jersey Supreme Court ruled that, if the hospital ethics committee agreed that Quinlan would not recover from irreversible coma, her respirator could be removed. Further, the Court granted legal immunity from civil and criminal prosecution for all those involved in making the decision to end Quinlan’s life-sustaining treatment. Incidentally, after Quinlan’s respirator was removed, she was able to breathe on her own because her cerebral cortex was only moderately damaged (Kinney et al. 1994, p. 1469). She remained in a PVS until she died of multiple opportunistic infections on June 11, 1985 (Library Index 2010a; Quinlan and Quinlan 1977).

The Nancy Cruzan Case

The case of 25-year-old Nancy Cruzan began in the State of Missouri court system, reached the US Supreme Court, and returned to the Missouri court system where it was finally resolved. The case highlights the numerous ethical and medical uncertainties surrounding the discussion or debate about the point, if there is any such point, where quality of life is so diminished that it is not worth living (Center for Biomedical Ethics and Humanities, University of Virginia 2010).

Nancy Cruzan lost control of her car in Missouri on January 11, 1983, and was found lying face-down in a ditch by a state trooper. She was in cardiac and respiratory arrest, but emergency responders were able to revive her. A neurosurgeon later estimated that she suffered anoxia or deprivation of oxygen for 12–14 minutes. Cruzan’s case was first heard by a Missouri trial court which reasoned that after 6 minutes of oxygen deprivation, the brain generally suffered permanent damage. Accordingly, the court gave her parents, Joyce and Lester Cruzan, the right to terminate artificial nutrition and hydration. However, the state and Cruzan’s court-appointed legal guardian appealed to the Missouri Supreme Court (Nancy Beth Cruzan 1988, *By Coguardians, Lester L. Cruzan, Jr., and Joyce Cruzan v. Robert Harmon*). Although Ms. Cruzan’s court-appointed guardian felt that it was in her best interest to stop artificial feeding

and hydration, he, nonetheless felt that he had to take the case to the state supreme court because that was the first case of that nature in the State of Missouri.

The Missouri Supreme Court ruled in favor of the State of Missouri's interest in preserving life. It argued that while the recognized right to privacy would be applicable in this case, thereby allowing Cruzan to refuse medical treatment, the US Supreme Court decisions in *Roe v. Wade* and *Griswold v. Connecticut* did not extend to the withdrawal of food and water.

On appeal, the US Supreme Court held that there was no clear and convincing evidence that Ms. Cruzan would, if she was conscious, want her life-sustaining treatment to be discontinued. The Court further held that if the decision to continue life support was erroneous, possible new advances in medical technology or new evidence of the patient's intent could correct the error. However, an erroneous decision to discontinue artificial feeding could not be corrected because the result of that decision—death—was irreversible.

The Cruzan case was retried again in Missouri after the Cruzan family lawyer, Bill Colby, found some technicalities that would allow the case to be retried in the State. On December 14, 1990, a Missouri Circuit Court ruled that new evidence presented by Nancy Cruzan's friends constituted "clear and convincing" evidence that she would not want to continue to exist in a PVS. Therefore, the Court permitted the disconnection of her artificial feeding. Within 2 hours of the court ruling, artificial feeding was discontinued and Cruzan died on December 26, 1990, almost 7 years after her automobile accident (Library Index [2010b](#); Colby [2003](#); Nancy Beth Cruzan [1990](#)).

The Dr. Jack Kevorkian Case

Dr. Jack Kevorkian, who died recently, was a right-to-die activist and pathologist. He was best known for publicly campaigning and championing a terminal patient's right to die by way of physician-assisted suicide (Betzold [1993](#)). He claimed to have assisted at least 130 patients end their lives. In each of the cases, it was alleged that the patients themselves took the final action which caused their deaths. The role of the pathologist was to assist only by attaching the patient to a euthanasia device the pathologist called a "Thanatron" or death machine. The patient was responsible for pushing a button on the death device to release the drugs or chemicals that caused death. Other patients were assisted by a device that employed a gas mask fed by a canister of carbon monoxide which the doctor named "Mercitron" or mercy machine.

Dr. Kevorkian was tried several times in Oakland County, Michigan, for assisting patients take their lives. The juries would not convict him because he always had evidence that the patients freely chose to die and were solely responsible for pushing the button on the death machine. However, this situation changed on November 22, 1988, when Kevorkian allowed the CBS News Documentary, *60 Minutes*, to air a videotape he made of him engaging in active euthanasia. In this instance, Kevorkian personally administered a lethal injection that killed Thomas Youk, a patient who

was in the final stages of amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease. Based on this documented evidence, Michigan authorities were able to convict Kevorkian of second degree homicide (MSNBC 2007).

Much has changed since the end-of-life controversies first surfaced. The federal government passed the *Uniform Rights of the Terminally Ill Act* in 1985, and amended it in 1989, to require that all persons entering a hospital in the United States be told about living wills. Since then, most states have passed similar laws governing advance directives, durable powers of attorney, and health care proxies. Also, the States of Oregon, Montana, and Washington have laws legalizing physician-assisted suicides under specified conditions.

In sum, our discussion so far has highlighted the pervasiveness of medical technologies in the United States, the factors that influence their development and growth, and the effects of these technologies on medical costs, access to care, quality of care and quality of life, and the ethical concerns raised by medical technologies. Given their pervasive nature, the use and implementation of medical technology are increasingly mediated by a widening group of health policy-makers, including health product and equipment manufacturers, clinicians, patients, hospital administrators, health care payers, and political leaders. These actors increasingly rely on technology assessment to support decisions about whether or how to implement technology, whether to allow it on the market, to acquire it, to pay for its use, to determine its direct and indirect consequences, and to delineate the ethical issues related to the use of the technology (Sacchini et al. 2009, p. 453; Goodman 2004, p. 9; Saarni et al. 2008, p. 617; ten Have 1995, p. 13).

Technology Assessment (TA)

Because between 25 and 33% of the United States health care expenditures are for services that provide only minimal benefits (Brook and Lohr 1986, p. 68), technology assessment was first employed in the Congress around 1967. This initial focus was on environmental issues and developments in the physical sciences. Later, attention focused on medical technologies and led to the establishment of the Congressional Office of Technology Assessment (OTA) in 1972. The primary thrust of the OTA was on evaluations of the efficiency and safety of medical technologies.

As was discussed in Chap. 4, while other industrialized countries have openly incorporated cost-effectiveness, cost benefit, and ethical dimensions into their technology assessment processes, US policy-makers and private health care payers have been reluctant to use economic concerns and evaluations openly and explicitly to determine what technologies to cover, and how to pay for them (Neumann and Sullivan 2006, p. 1163). The incorporation of ethical concerns into technology assessment has been equally difficult and slow for reasons that are soon to be discussed. First, we deal with evaluations of efficacy, safety, cost-effectiveness, and cost-benefits of medical technology.

Efficacy and Effectiveness

While some authors make no distinction between efficacy and effectiveness (Shi and Singh 2008, p. 183), for technical reasons, I identify more closely with those authors who distinguish between the two concepts. Therefore, this book defines efficacy as health benefits under ideal or experimental conditions (Wan 1995, p. 145; Banta 1995, p. 406). This definition acknowledges that the experimental or ideal context may not produce the same results as the natural or real-life environment. For example, it is possible for the technology to show more promising results in the laboratory than it does when tried on humans or other intended targets. Therefore, efficacy is the benefit claims that a drug or equipment manufacturer makes. Effectiveness, on the other hand, is a measure of the benefits of the medical device or equipment under average or community conditions, or the benefits the device or equipment actually produces, as opposed to what it was expected to produce. The difference between efficacy and effectiveness is the actual usefulness or quality of the medical device.

There are some important factors to consider when measuring the benefits of a medical procedure or technology. First, the reliability or ability of the procedure to deliver accurate results must be ascertained. Second, its diagnostic accuracy must be determined. Some of the questions to consider under this second factor involve whether the technology permits accurate diagnosis, its therapeutic impact or the other forms of treatment it replaces, and the likelihood that a different procedure would result in a better diagnosis. And third, it must be determined whether the application of the technology results in improved health.

Safety

Safety measurements are designed to minimize harm to the patients who receive the medical intervention or treatment. Since most technologies or procedures are not completely and totally free of negative side effects, to declare a technology safe implies that the benefits the technology conveys outweigh the negative side effects.

Cost-Effectiveness

This is a measure of the parity between the benefits and costs of a medical procedure. It determines the additional or marginal benefits that can be gained by applying the technology, compared to the additional or marginal costs incurred. When a technology or procedure is judged to be cost-effective, the implication is that its benefits

outweigh its costs, and vice versa. Viewed in this manner, a technology or procedure may be beneficial but not cost-effective. The optimum point of health resource inputs is where the benefits and costs are the same.

Localities or jurisdictions that use cost-effectiveness analysis to make reimbursement decisions are unlikely to pay for technologies that are not considered cost-effective. In such jurisdictions, those technologies that are judged as not cost-effective are unlikely to survive; and even if they survive, they are unlikely to proliferate. Both the costs and benefits of the technology do not necessarily have to be expressed in dollar terms. Other measures, such as resource inputs and health outcomes, may be used to measure costs and benefits, respectively.

Cost-Benefit

This procedure compares the costs and benefits of a medical procedure in monetary terms (Wan 1995, p. 152). Cost-benefit analysis in health care is controversial because of the difficulty or lack of agreement on how to measure the value of human life. The so-called quality-adjusted life year (QALY) is more commonly used to quantify the value of human life. As was discussed earlier in this chapter, Cutler and McClellan (2001, p. 11) used QALY, which is assigned a value of \$100,000 for each year of high quality life, to compare the costs and benefits of technological change for the treatment of heart attacks, low birth-weight babies, depression, cataracts, and breast cancer.

The Incorporation of Ethical Concerns into TA

The incorporation of ethics into a medical technology assessment process is important for several reasons (Saarni et al. 2008, p. 617). First, the discussion in this chapter clearly demonstrates that the provision of medical technology may, and frequently does, have moral consequences. Therefore, it is advisable to add ethical analysis to the assessment of technology. Second, the values that certain technologies embody may challenge widely held moral principles or societal norms that should be addressed by TA. And third, TA is value-laden.

Although desirable, the incorporation of ethics into TA is difficult because, technologies are often perceived to be ethically neutral and value-free, the only questions that are thought to be relevant are technical and economic in nature, there are methodological difficulties to integrating ethical issues into TA, and there are few and limited TA personnel and resources (Sacchini et al. 2009, p. 455). Efforts must be made to overcome these difficulties and to incorporate ethical considerations into TA.

Conclusion

Medical technologies include the drugs, devices, sophisticated machines and ultra-modern facilities, computer-supported information systems, and the medical and surgical procedures used in medical care. They also include the organizational and supportive systems within which health care is delivered. The growth and diffusion of medical technologies are made possible by several factors, including the people's cultural beliefs and values, differences in patients' characteristics, the availability of health insurance, physician characteristics and medical specialization, competition among health providers and the availability of resources, research and development costs, medical uncertainty and defensive medicine, and by the numerous government policies involving medical technology. Technologies affect the organization of the health care system, medical costs, access to care and the quality of life of the people, and health care outcomes. Similarly, the application of medical technology frequently involves ethical and moral issues.

The growth and diffusion of technology affect other aspects of life in the country. These include the air we breathe, the food we eat, the generation of radioactive substances and toxic chemicals, and the existence of illicit drugs, safety hazards, and natural and man-made safety hazards. Therefore, since technology impacts the physical environment, and since the physical environment in turn impacts our health and the health care policymaking process, the next chapter examines the physical environment of the health care policymaking system.

Review Questions

1. Define medical technology and explain how they are employed for health care delivery.
2. What demand-side and supply-side variables account for the growth and diffusion of medical technologies?
3. Why are there significant variations in physician practice patterns and resource use in the country?
4. In what ways has the Hospital Survey and Construction Act of 1946 contributed to the growth of medical technology and high health care costs?
5. Trace the history of the development of the regulatory authority of the FDA and identify the agency's role in the growth and diffusion of medical technologies.
6. What are the positive and negative effects of medical technology?
7. What ethical concerns have the growth and diffusion of medical technologies caused for health care policy-makers and the population at large?
8. Why did the State of Oregon promote a two-tiered health care system and what are the criticisms of the model?
9. Are the criticisms of the Oregon two-tiered system justified? Why or why not?
10. Identify the controversies associated with the beginning of life and end-of-life medical decisions. Who should make these decisions?

11. What are the advantages and disadvantages of involving the judiciary in end-of-life decisions?
12. What is technology assessment and how is it accomplished?

References

- Aaron, H.J. 1991. *Services and Unstable Condition: Financing America's Health Care*. Washington, DC: The Brookings Institution.
- Alberty Food Products Co. v. United States*, 185F.2d321 (9th Cir. 1950).
- Alexander, J.A., T.G. Rundall, T.J. Hoff, and L.L. Morlock. 2006. "Power and Politics." In *Health Care Management: Organization Design and Behavior*, 5th ed., eds. S.M. Shortell and A.D. Kaluzny. Clifton Park, NY: Delmar-Cengage Learning, 276–310.
- Arias, E. 2007. "United States Life Tables, 2004." *National Vital Statistics Reports* 56(9). Hyattsville, MD: National Center for Health Statistics, 1–40.
- Ayanian, J.Z., and A.M. Epstein. 1991. "Differences in the Use of Procedures Between Women and Men Hospitalized for Coronary Heart Disease." *The New England Journal of Medicine* 325(4) (July 25): 221–225.
- Banta, H.D. 1995. "Technology Assessment in Health Care." In *Jonas's Health Care Delivery in the United States*, 5th ed., ed. A. Kovner. NY: Springer Publishing Co., 401–421.
- Barrilleaux, C.J., and M.E. Miller. 1992. "Decisions Without Consequences: Cost Control and Access in State Medicaid Programs." *Journal of Health Politics, Policy and Law* 17(1): 97–118.
- Baumgardner, J. 1991. "The Interaction Between Forms of Insurance Contract and Types of Technological Change in Medical Care." *Rand Journal of Economics* 22(1): 36–53.
- Betzold, M. 1993. *Appointment with Doctor Death*. Troy, MI: Momentum Books.
- Blendon, R.J., K. Donelan, R. Leitman, A. Epstein, J.C. Cantor, A.B. Cohen, I. Morrison, T. Moloney, and K. Koeck. 1993. "Health Lessons Learned from Physicians in Three Nations." *Health Affairs* 12(3) (Fall): 194–203.
- Bohmer, R.M.J. 2000. "Changing Physician Behavior." Harvard Business School Case Study 9-699-124 (Revised March 22, 2000): 1–28.
- Brook, R.H., and K.N. Lohr. 1986. "Will We Need to Ration Effective Health Care?" *Issues in Science and Technology* 3(1) (Fall): 68–77.
- Brown, L.D. 1991. "The National Politics of Oregon's Rationing Plan." *Health Affairs* 10(2) (Summer): 28–51.
- Calkthan, D. 1991. "Commentary: Ethics and Priority Setting in Oregon." *Health Affairs* 10(2) (Summer): 78–87.
- _____. 1991. "Evaluating the Oregon Priority Plan." *Journal of the American Geriatrics Society* 39(6): 622–623.
- Cantor, N.L. 1993. *Advance Directives and the Pursuit of Death With Dignity*. Indianapolis, IN: Indiana University Press.
- Center for Biomedical Ethics, University of Virginia. 2010. "The Legacy of Nancy Cruzan—29 September 2004." Retrieved November 14, 2010, from <http://www.healthsystem.virginia.edu/internet/him/nancycruzan.cfm>.
- Childress, J.F. and Beauchamp, T.L. 1994. *Principles of Biomedical Ethics*, 4th ed., NY: Oxford University Press.
- Clayton, P.D. 2001. "Confidentiality and Medical Information." *Annals of Emergency Medicine* 38(3): 312–316.
- Cohen, A.B. 2004. "The Diffusion of New Medical Technology." In *Technology in American Health-Care: Policy Directions for Effective Evaluation and Management*, eds. A.B. Cohen and R.S. Hanft. Ann Arbor, MI: The University of Michigan Press, 79–104.
- Colby, W.H. 2003. *Long Goodbye: The Deaths of Nancy Cruzan*, 5th printing ed. Carlsbad, CA: Hay House, Inc.

- Cromwell, J., and J.B. Mitchell. 1984. "An Economic Model of Large Medicaid Practices." *Health Services Research* 19(2) (June): 197–216.
- Cutler, D.M., and M. McClellan. 2001. "Is Technological Change in Medicine Worth It?" *Health Affairs* 20(5) (September/October): 11–29.
- Daniels, N. 1992. "Justice and Healthcare Rationing: Lessons from Oregon." In *Rationing America's Medical Care: The Oregon Plan and Beyond*, eds. M.A. Strosberg, J.M. Wiener, R. Baker, and A. Fein. Washington, DC: The Brookings Institution, 185–194.
- Danzon, P.M., and M.V. Pauly. 2001. "Insurance and New Technology: From Hospital to Drugstore." *Health Affairs* 20(5): 86–100.
- Di Salvo, T.G., S. D. Paul, D. Lloyd-Jones, A.J.C. Smith, G. Villarreal-Levy, V. Bamezai, S.I. Hussain, K.A. Eagle, and P.T. O'Gara. 1996. "Care of Acute Myocardial Infarction by Noninvasive and Invasive Cardiologists: Procedure Use, Cost and Outcome." *Journal of the American College of Cardiology* 27(2): 262–269.
- Dubnick, M.J., and B.S. Romzek. 1991. *American Public Administration: Politics and the Management of Expectations*. New York, NY: Macmillan.
- Fanning, T., and M. de Alteriis. 1993. "The Limits of Marginal Economic Incentives in the Medicaid Program: Concerns and Cautions." *Journal of Health Politics, Policy and Law* 18(1) (Spring): 27–42.
- Fisher, E.S., J.E. Wennberg, T.A. Stukel, and S.M. Sharp. 1994. "Hospital Readmission Rates for Cohorts of Medicare Beneficiaries in Boston and New Haven." *The New England Journal of Medicine* 331 (October 13): 989–995.
- Food and Drug Administration (FDA). 2010. "About FDA: Centers and Offices." Retrieved November 1, 2010, from <http://www.fda.gov/aboutFDA/Centersoffices/default.htm>.
- Fossett, J., and J. Peterson. 1989. "Physician Supply and Medicaid Participation: The Causes of Market Failure." *Medical Care* 27(4) (April): 386–396.
- Fox, D.M., and H.M. Leichter. 1991. "Rationing Care in Oregon: The New Accountability." *Health Affairs* 10(2) (Summer): 7–27.
- Fuchs, V. R. 1978. "The Supply of Surgeons and the Demand for Operations." *Journal of Human Resources* 13 (Supplement): 35–56.
- Gabel, J.R., and T.H. Rice. 1985. "Reducing Public Expenditures for Physician Services: The Price of Paying Less." *Journal of Health Politics, Policy and Law* 9(4) (Winter): 595–609.
- Garrett, T.M., H.M. Baillie, and R.M. Garrett. 1993. *Health Care Ethics: Principles and Problems*, 2nd ed. Englewood Cliffs, NJ: Prentice Hall.
- Gelijns, A.C., J.G. Zivin, and R.R. Nelson. 2001. "Uncertainty and Technological Change in Medicine." *Journal of Health Politics, Policy and Law* 26(5): 913–924.
- Gelijns, A., and N. Rosenberg. 1994. "The Dynamics of Technological Change in Medicine." *Health Affairs* 13(3) (Summer): 28–46.
- Ginsburg, P.B. 2005. "Competition in Health Care: Its Evolution Over the Past Decade." *Health Affairs* 24(6): 1512–1522. DOI: 10.1377/hlthaff.24.6.1512.
- Glaser, W.A. 1970. *Paying the Doctor*. Baltimore, MD: Johns Hopkins.
- Glied, S.A. 2001. "Health Insurance and Market Failure Since Arrow." *Journal of Health Politics, Policy and Law* 26(5): 957–965.
- Goddeeris, J.H. 1984. "Medical Insurance, Technological Change, and Welfare." *Economic Inquiry* 22: 56–67.
- Goodman, C.S. 2004. "HTA 101: Introduction to Health Technology Assessment". Falls Church, VA: The Lewin Group, Retrieved November 14, 2010, from <http://www.nlm.nih.gov/nichsra/hta101/hta101.pdf>.
- Griswold v. Connecticut*, 381 U.S. 479 (1965).
- Hall, R.E., and C.I. Jones. 2007. "The Value of Life and the Rise in Health Spending." *Quarterly Journal of Economics* 122(1) (February): 39–72.
- Iglehart, J.K. 1982. "The Cost and Regulation of Medical Technology: Future Policy Directions." In *Technology and the Future of Health Care*, ed., J.B. McKinlay. Cambridge, MA: MIT Press, 69–103.

- Inlander, C.B., L.S. Levin, and E. Weiner. 1988. *Medicine on Trial: The Appalling Story of Ineptitude, Malfeasance, Neglect, and Arrogance*. New York, NY: Prentice Hall.
- Kalb, P.E. 1990. "Controlling Health Care Costs by Controlling Technology: A Private Contractual Approach." *Yale Law Journal* 99(4) (March): 1109–1126.
- Kessler, D., and M. McClellan. 1996. "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics* 111(2) (May): 353–390.
- Kher, U. 2006. "The Hospital Wars." *Time* 168(24) (December 11): 64–68.
- Kinney, H.C., J. Korein, A. Panigrahy, P. Dikkes, and R. Goode. 1994. "Neuropathological Findings in the Brain of Karen Ann Quinlan—The Role of the Thalamus in the Persistent Vegetative State." *The New England Journal of Medicine* 330(21): 1469–1475.
- Lange, R.A., and L.D. Hillis. 1998. "Editorial: The Use and Overuse of Angiography and Revascularization for Acute Coronary Syndrome." *The New England Journal of Medicine* 338(25): 1838–1839.
- Lawthers, A.G., A.R. Localio, N.M. Laird, S. Lipsitz, L. Hebert, and T.A. Brennan. 1992. "Physicians' Perceptions of the Risk of Being Sued." *Journal of Health Politics, Policy and Law* 17(3) (Fall): 463–482.
- Levin, J.S. 1994. "Religion and Health: Is There an Association, Is it Valid, and Is it Causal?" *Social Science and Medicine* 38(11): 1475–1482.
- Library Index. 2010a. "Court and the End of Life—The Right to Privacy: Karen Ann Quinlan." Retrieved November 14, 2010, from <http://www.libraryindex.com/pages/582/Court-End-Life-Right-Privacy-Karen-A...>
- . 2010b. "Court and the End of Life—The Case of Nancy Cruzan." Retrieved November 14, 2010, from <http://www.libraryindex.com/pages/590/Court-End-Life-Case-Nancy-Cruzan.html>.
- Localio, A.R., A.N. Lawthers, T.A. Brennan, N.M. Laird, L.E. Hebert, L.M. Peterson, J.P. Newhouse, P.C. Weiler, and H.H. Hiatt. 1991. "Relation Between Malpractice Claims and Adverse Events Due to Negligence: Result of the Harvard Medical Practice Study III." *The New England Journal of Medicine* 325(4): 245–251.
- Maugans, T.A. 1996. "The Spiritual History." *Archives of Family Medicine* 5(1): 11–16.
- McCullough, M.E., W.T. Hoyt, D.B. Larson, H.G. Koenig, and C. Thorsen. 2000. "Religious Involvement and Mortality: A Meta-Analytic Review." *Health Psychology* 19(3): 211–222.
- and D.B. Larson. 1999. "Religion and Depression: A Review of the Literature." *Twin Research* 2: 126–136.
- McGuire, T.G. 2000. "Physician Agency." In *Handbook of Health Economics*, Volume 1, eds. A.J. Culyer and J.P. Newhouse. North Holland: Elsevier Science Publishers, 462–535.
- Miller, R.H., C. West, T.M. Brown, I. Sim, and C. Ganchoff. 2005. "The Value of Electronic Health Records in Solo or Small Group Practices." *Health Affairs* 24(5): 1127–1137.
- Moy, E., and B.A. Bartman. 1995. "Physician Race and Care of Minority and Medically-Indigent Patients." *JAMA* 273(19): 1515–1520.
- MSNBC.com News Services. 2007. "Kevorkian Released from Prison After 8 Years : Promises not to Help Anyone Commit Suicide; Says will work for Legalization." Retrieved November 15, 2010, from <http://www.msnbc.msn.com/id/18974940/>.
- Nancy Beth Cruzan, By Co-guardians, Lester L. Cruzan, Jr., and Joyce Cruzan v. Robert Harmon, 760 S.W. 2d 408 [Mo. banc 1988].
- Nancy Beth Cruzan, by her Parents and Co-Guardians, Lester L. Cruzan et ux. v. Director, Missouri Department of Health et al., 497 U.S. 261, 1990.
- National Center for Health Statistics, Centers for Disease Control and Prevention. 2011. "1990, 2000, 2005, and 2006 Age-adjusted Death Rates for Selected Causes of Death Per 100,000 Population." Retrieved May 10, 2011, from <http://www.cdc.gov/nchs>.
- Needleman, J. 1985. *The Way of the Physician*. San Francisco, CA: Harper and Row.
- Neumann, P.J., and S.D. Sullivan. 2006. "Economic Evaluation in the U.S.: What is the Missing Link?" *Pharmacoeconomics* 24(11): 1163–1168.
- Nightingale, S.D. 1987. "Risk Preference and Test Selection." *Journal of General Internal Medicine* 2(1): 25–28. DOI: 10.1007/BF02596246.

- Packwood, B. 1990. "National Policy Prospectives: Oregon's Bold Idea." *Academic Medicine* 65(10) (October): 632–633.
- Parks, J.A., and V.S. Wike. 2010. *Bioethics in a Changing World*. Upper Saddle River, NJ: Prentice Hall.
- Pauly, M.V. 2005. "Competition and New Technology." *Health Affairs* 24(6) (November/December): 1523–1535.
- Porter, M.E., and E.O. Teisberg. 2006. *Redefining Health Care: Creating Value-Based Competition on Results*. Boston, MA: Harvard Business Press.
- Postman, N. 1992. *Technopoly: The Surrender of Culture to Technology*. New York, NY: Vintage Books.
- Quinlan, J., and J.D. Quinlan. 1977. *Karen Ann: The Quinlans Tell Their Story*. NY: Bantam Books.
- Quinlan, 70 N.J. 10, 355 A. 2d 647, 1976.
- Research!America 2010. "2009 U.S. Investment in Health Research: ARRA Saves Research from Decline." Retrieved November 1, 2010, from <http://www.researchamerica.org/uploads/health-dollar09.pdf>.
- Rettig, R.A. 1994. "Medical Innovation Duels Cost Containment." *Health Affairs* 13(3) (Summer): 7–27.
- Riley, J.G., and H.P. Brehm. 1989. "Technological Innovations and Their Impact on Care Delivery." In *Health Care, Technology, and the Competitive Environment*, eds. H.P. Brehm and R.M. Mullner. NY: Praeger, 21–39.
- Roberts, J.A., D. Brown, T. Elkins, and D.B. Larson. 1997. "Factors influencing the View of Patients with Gynecologic Cancer about End-of-Life Decisions." *American Journal of Obstetrics and Gynecology* 176(1): 166–172.
- Roe v. Wade*, 410 U.S. 113 (1973).
- Rossiter, L. 2009. "Rising Costs for Health Care: Implications for Public Policy—A Report Prepared for the National Federation of Independent Business Research Foundation." The Schroeder Center for Healthcare Policy, College of William & Mary, 1–97. Retrieved November 1, 2010, from <http://www.nfib.com/Portals/o/PDF/healthcare/healthcare-costs-200904.pdf>.
- Saarni, S.I., B. Hofmann, K. Lampe, D. Luhmann, M. Makela, M. Valasco-Garrido, and I. Autti-Ramo. 2008. "Ethical Analysis to Improve Decision-Making on Health Technologies." *Bulletin of the World Health Organization* 86(8): 617–623.
- Sacchini, D., A. Virdis, P. Refolo, M. Pennacchini, I.C. de Paula. 2009. "Health Technology Assessment (HTA): Ethical Aspects." *Medical, Health Care and Philosophy* 12 (9 June): 453–457.
- Sanders, R.L. 2004. "Medical Technology: A Critical Perspective." *The Internet Journal of Medical Technology* 2(1): 1–13. Retrieved September 11, 2010, from http://www.ispub.com/journal/the_internet_journal_of_medical_technology/volume_2_nu...
- Schwartz, W.B. 1987. "The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief." *JAMA* 257(2): 220–224.
- _____, and D.N. Mendelson. 1991. "Hospital cost Containment in the 1980s: Hard Lessons Learned and Prospects for the 1990s." *The New England Journal of Medicine* 324(15):1037–1042.
- Shea, D., J. Green, and C. Smith. 2011. *Living Democracy: Brief Edition*, 2nd ed., Boston, MA: Longman/Pearson.
- Shi, L., and D.A. Singh. 2008. *Delivering Health Care in America: A Systems Approach*, 4th ed. Sudbury, MA: Jones and Bartlett.
- Spann, S.J. 2001. "The Future of Family Medicine: Clinical Practice." *Journal of Family Practice* 50(7): 584–585.
- Steingart, R.M., M. Packer, P. Hamm, M.E. Coglianese, B. Gersh, E.M. Geltman, J. Sollano, S. Katz, L. Moye, L.L. Basta, S.J. Lewis, S.S. Gottlieb, V. Bernstein, P. McEwan, K. Jacobson, E.J. Brown, M.L. Kukin, N.E. Kantrowitz, and M.A. Pfeffer. 1991. "Sex Differences in the Management of Coronary Artery Disease." *The New England Journal of Medicine* 325(4) (July 25): 226–230.
- The Henry J. Kaiser Family Foundation. 2007. "Snapshots: Health Care Costs—How Changes in Medical Technology Affect Health Care Costs (March 2007)." Retrieved October 11, 2010, from <http://www.kff.org/insurance/snapshot/chcm0308070th.cfm>.

- ten Have, H.A.M.J. 1995. "Medical Technology Assessment and Ethics: Ambivalent Relations." *Hastings Center Report* 25(5) (Sep.-Oct.): 13–19.
- Thorne, J.I. 1992. "The Oregon Plan Approach to Comprehensive and Rational Healthcare." In *Rationing America's Medical Care: The Oregon Plan and Beyond*, eds. M.A. Strosberg, J.M. Wiener, R. Baker, and A. Fein. Washington, DC: The Brookings Institution, 24–36.
- Torrens, P.R. 1978. *The American Health Care System: Issues and Problems*. St. Louis, MO: The C.V. Mosby Co.
- Ubokudom, S.E., and J. Khubchandani. 2010. "The Ecology of Health Policymaking and Reform in the United States of America," *World Medical and Health Policy* 2(1): Article 19, DOI: 10.2202/1948-4682.1010. Available at: <http://www.psocommons.org/wmhp/vol2/iss1/art19>.
- _____. 1997. *Physician Participation in Medicaid Managed Care*. New York and London: Garland Publishing, Inc.
- United States v. Johnson* 221 U.S. 488 (1911).
- Wan, T.T.H. 1995. *Analysis and Evaluation of Health Care Systems: An Integrated Approach to Managerial Decision Making*. Baltimore, MD: Health Professions Press.
- Wedig, G., J.B. Mitchell, and J. Cromwell. 1989. "Can Price Controls Induce Optimal Physician Behavior?" *Journal of Health Politics, Policy and Law* 14(3) (Fall): 601–620.
- Weisbrod, B.A., and C.L. LaMay. 1999. "Mixed Signals: Public Policy and the Future of Health Care R&D." *Health Affairs* 18(2) (March–April): 112–125.
- _____. 1991. "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment." *Journal of Economic Literature* 29(2): 523–555.
- Wennberg, J.E., B.A. Barnes, and M.A. Zubkoff. 1982. "Professional Uncertainty and the Problem of Supplier-Induced Demand." *Social Science and Medicine* 16:811–824.
- _____, J.L. Freeman, and W.J. Culp. 1987. "Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?" *Lancet* 1(8543) (May 23): 1185–1189.
- _____, and A. Gittlesohn. 1982. "Variations in Medical Care Among Small Areas." *Scientific American* 246(4): 120–133.
- Wennecker, M.B., and A.M. Epstein. 1989. "Racial Inequalities in the Use of Procedures for Patients with Ischemic Heart Disease in Massachusetts." *JAMA* 261(2): 253–257.
- World Health Organization (WHO). 1948. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
- _____. 2010. "The World Health Report—Health Systems Financing: The Path to Universal Coverage." Retrieved November 20, 2010, from http://www.who.int/whr/2010/whr10_en.pdf.
- Zimmerman, E. 2006. "The Implications of Reimbursement Changes for Specialty Hospitals." *Health Care Financial Management* 60(7): 42–45.
- Zuckerman, S., and W.P. Welch. 1990. "A Geographic Index of Physician Practice Costs." *Journal of Health Economics* 9(1) (June): 36–69.

Chapter 6

Physical, Social and Cultural, and Global Influences

In Chap. 5, we examined the technological environment of the health care policymaking system. Specifically, we examined the classification, evolution, and diffusion of medical technology; the effects of medical technology on medical training and the practice of medicine; effects on medical costs, quality of care, and quality of life; effects on access to care; the ethical concerns raised by medical technology; and the practice of technology assessment. We concluded the chapter by observing that the growth of technology, as well as other human endeavors, affects other important aspects of our lives, most notably, the air we breathe, the food we eat, the generation of radioactive by-products and toxic chemicals, the manufacture of illicit drugs, and the generation of natural and man-made hazards. In other words, in addition to their effects on the health care system, technology and other human activities affect many other aspects of our lives that are associated with health.

Briefly, we concluded Chap. 5 by observing that since technology also impacts our physical, social, cultural, and global environments, it was advisable to devote the next chapter of the book to examining these additional issues. Therefore, our goal for this chapter is to delineate, to the best of our ability, the impacts of physical, social, cultural, and global factors on health and health policymaking. This exercise will help us to more fully understand and appreciate the demographic health data that are presented in the next chapter. Essentially, therefore, this chapter is an attempt to broaden the concept of health policy to include areas that, for a long time, were not usually considered when thinking about health, such as education, income, occupation, recreation, living arrangements, and housing (Williams and Jackson 2005, p. 325). According to Isaacs and Schroeder (2004, p. 1141), “investments in social and economic policy made upstream can pay health dividends downstream.” We begin the pursuit of our goals for this chapter by defining health.

The Definition of Health

We can define health under the medical, or more specifically, the biomedical, and wellness models of health care delivery and financing. These two models differ in terms of the scope of the factors they identify as contributing to health and wellness. As will be demonstrated below, health policymaking under each of these models would involve the allocation of different amounts and levels of resources to the health care system, as well as different combinations of medical technologies employed to provide care. Therefore, in defining health, stakeholders are likely to employ the definition that gives them the most advantage or best achieves their cherished goals.

The Medical Model

The medical model has primarily informed the concepts of health and health care delivery and policymaking in the United States. Under the medical model, health is defined as the nonoccurrence of disease or illness. This definition implies that a person in optimum health is free of symptoms and does not require medical treatment.

The treatment of disease and illness under the medical model primarily involves the diagnostic, curative, life-saving, and illness management physical technologies, as well as some of the designed social technologies presented in Table 5.1 of Chap. 5. Preventive, health education and promotion, social support systems, and some of the designed social technologies listed in Table 5.1, such as assisted living facilities, senior centers, continuing care retirement communities, and child care centers, which are primarily concerned with health maintenance, are secondary under the medical model. As we noted in Chap. 4, some of these technologies were not part of the regular medical system until the quest for cost containment led to their invention and incorporation into the health care delivery system.

The Wellness Model

The WHO's definition of health as "a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO 1948), is primarily based on the wellness model. In this definition, emphasis is put on the fact that health is not merely the absence of disease, but also involves a social dimension. Therefore, it also emphasizes the social and financial support systems identified in Table 5.1 of Chap. 5. This definition of health, as involving the combination of physical, mental, and social well-being led to the concept of the "Health Triangle."

The Health Triangle left out the spiritual dimension of health, which has recently gained significant attention in the literature due to a growing interest in the notion of holistic health. Holistic health stresses the importance of all the things that make a person whole and complete. In addition to the three dimensions of the Health Triangle,

it incorporates a fourth factor, the spiritual dimension of health. It is now argued that these four factors are necessary for optimal health. For example, some of the research cited in Chap. 5 point to the healing effects of religion and spirituality on morbidity and mortality (Levin 1994, p. 1475; Maugans 1996, p. 11; McCullough and Larson 1999, p. 126; McCullough et al. 2000, p. 211; Roberts et al. 1997, p. 166).

The four factors stressed by the advocates of holistic health—physical, social, mental, and spiritual—involve some environmental components, personal habits, and living conditions that can increase the likelihood of developing a particular disease or negative health condition (Banta and Jonas 1995, p. 14). In other words, the notion of holistic health also includes the control and reduction of both internal and external risk factors for both disease and negative health conditions.

Because diseases and negative health outcomes are seldom caused by a single factor, the tripartite model or the so-called Epidemiology Triangle has been used to explain disease occurrence, particularly communicable diseases (Timmreck 1994, p. 2). The tripartite model involves three elements—the host, an agent, and the environment.

The host is the person or organism that becomes diseased. Some factors associated with the host include genetic disposition, level of immunity, and personal habits and lifestyles. But for the host to become diseased, an agent—a bacterium, a virus, tobacco smoke, contaminated or adulterated food, unbalanced diet, radiation, unclean water and air—must be present. However, the presence of the agent does not guarantee the occurrence of disease. The physical, social, cultural, economic, and global nature of the environment where the host lives serves as a mediating or moderating factor that can either enhance or impede the likelihood of the host becoming diseased.

The brief discussion of health and disease undertaken above leads to the main focus of this chapter, which is the discussion of the physical, social and cultural, and global environments of the US health care policymaking process. The discussion proceeds by looking at the association between these environmental factors and health, and by extension, the influences of the environmental factors on health care policymaking in the country. Put differently, we begin by examining our understanding of the determinants of health, and how that understanding shapes health policymaking.

The Determinants of Health

The prominent British public health scholar, Thomas McKeown, was a powerful and forceful critic of the mid-twentieth century medical profession's emphasis of curative and scientific medicine. In his famous book, *The Role of Medicine: Dream, Mirage, or Nemesis*, McKeown emphasized the importance of economic growth, rising living standards, and improved nutrition as the primary sources of the historical improvements in the health of the people of the developed nations. Although McKeown's analysis was profoundly insightful, it was faulted for failing to emphasize the redistributive social philosophy and practical politics that prevailed at the time

of his analysis (Szreter 2002, p. 723). Subsequent studies revealed that the cessation of the large-scale redistribution of income and wealth from the very rich to the poorest in society had adverse effects on the health of the population. For example, when unhealthy behaviors and lifestyles were held as constant as possible, studies showed that people of lower socioeconomic status were more likely to die prematurely than were people of higher socioeconomic status (Isaacs and Schroeder 2004, p. 1138; Smith et al. 1996, p. 486; Davey Smith et al. 1994, p. 131).

The relationship between physical, social and cultural, and global environmental factors and health status is very well documented. In a letter to the Editor of the *JAMA*, Winkelstein (1993, p. 2504) argues that curative medical care, or those practices that are used for the care and rehabilitation of the sick, which involve most of the physical and designed social technologies listed in Table 5.1 of the previous chapter, is not the same as health care. Medical care, as he defines it, makes only modest contributions to the health status of the population.

On the contrary, the health status of the population is largely determined by a different set of factors that involve important physical, social, and economic components. These include preventive medicine, genetic predisposition, social and economic circumstances, environmental conditions, lifestyles and behaviors, and medical care (McKeown 1976; Kannel et al. 1991; Belloc and Breslow 1972, p. 409; Bunker et al. 1989; Bunker et al. 1995, p. 305; Marmot et al. 1991, p. 1387; Bell and Standish 2005, p. 339; McGinnis et al. 2002, p. 78; Wilkinson 1996, p. 1504). We briefly examine each of the identified determinants of health below.

Preventive Medicine

Preventive medicine seeks to minimize the occurrence of illness and disease. Unlike the medical model that is reactive and seeks to contain disease and ill-health after they have occurred, preventive medicine is proactive and seeks to minimize the likelihood of the occurrence of disease and ill-health.

Generally, there are three areas or types of preventive measures, namely: primary prevention, secondary prevention, and tertiary prevention. Primary prevention seeks to stop or minimize the development of disease or ill-health before it occurs. Primary prevention may involve counseling against smoking, in order to prevent the development of chronic emphysema or chronic obstructive pulmonary disease (COPD) and lung cancer. Other primary interventions may include the promotion of an active lifestyle or exercise program, in order to minimize the likelihood of excess body fat and heart disease; driver education and mandatory seatbelt and motorcycle helmet laws, in order to reduce motor vehicle accidents and accidental head injuries; vaccinations for various forms of diseases and illnesses, such as measles and rubella, which can minimize the occurrence of early childhood diseases and mortality; and water purification and sewage treatment programs that can minimize the occurrence of typhoid, cholera, and other waterborne diseases.

Secondary prevention involves the early detection and treatment of disease. Health screenings and periodic and regular health examinations, such as hypertension

screenings, mammograms, and PAP smears, serve as examples of secondary prevention measures. These examples fall under the broad category of health promotion discussed in Chap. 4. The beneficiaries of these programs are currently healthy people who are targeted to improve their health-related behaviors in order to minimize their chances of developing catastrophic and expensive illnesses. As was discussed in Chap. 4, secondary prevention measures are some of the most cost-effective steps employers take to lower their health benefit costs (Coffield et al. 2001, p. 1).

Tertiary prevention measures involve steps taken to reduce the complications of diseases or illnesses, or to prevent further illnesses. They involve rehabilitative practices and the monitoring of the process of health care delivery. The infection control practices in hospitals and other improvements in the methods of health care delivery discussed in Chap. 2, under the postindustrial period of the evolution of the health care system, which are intended to reduce the occurrences of nosocomial infections and iatrogenic illnesses, are practical examples of tertiary prevention measures. Other examples include patient education, nutrition counseling, and behavior modification programs that seek to prevent the recurrence of disease and illness (Timmreck 1994, p. 17).

Since the mid-1970s in the United States, there have been significant reductions in heart disease, stroke, personal injury, and non-tobacco-related death rates (McGinnis and Foege 1993, p. 2207; Banta and Jonas 1995, p. 20). Similarly, the data presented in Table 5.3 of Chap. 5 show significant declines in death rates related to heart disease, cancer, stroke, influenza and pneumonia, chronic liver disease or cirrhosis, human immunodeficiency virus (HIV) disease, suicide and homicides, from 1990 to 2006. These particular declines appear to be the result of preventive health measures, such as early screening, detection and treatment of hypertension, the provision and utilization of pneumonia and influenza vaccinations, moderate alcohol intake or abstinence, safe sex practices, suicide prevention and anger management programs, increased use of seatbelts and reductions in driving-under-the-influence episodes, smoking cessation, and the lowering of dietary fat and cholesterol. If, at least, some of the declines in mortality discussed above are due to preventive measures, the preventive strategy has yielded significant gains in health. Perhaps, it is this recognition of the importance of preventive services that led to the establishment of the US Preventive Services Task Force (USPSTF) in 1984.

The USPSTF

Most likely, it was the recognition of the crucial role that preventive medicine plays in enhancing population health that led to the convening of the USPSTF in 1984 by the US Public Health Service. The Task Force is a leading independent panel of nationally recognized nonfederal experts in prevention and evidence-based medicine. Programmatic responsibility for the Task Force was transferred to the Agency for Health Care Research and Quality (AHRQ) in 1995 (USPSTF Procedure Manual 2011).

The USPSTF is assigned the responsibility of making evidence-based recommendations that address primary and secondary preventive services targeting conditions that represent a substantial burden in the country, and that are provided

in primary care delivery settings or made available through primary care referrals. The Task Force's recommendations are intended to improve clinical practice and promote the public health. Tertiary prevention measures are outside the scope of the USPSTF. Even though the main audience for Task Force recommendations is the primary care provider, the recommendations are also used to guide programmatic, funding, and reimbursement decisions by policy-makers, managed care organizations, public and private payers, quality improvement organizations, research institutions, and consumers.

Beginning at the end of May 2007, the USPSTF changed the grades it assigns to its recommendations. It assigns one of five possible letter grades, A, B, C, D, or I, to each of its recommendations, including "suggestions for practice" associated with each grade. The agency also defines the levels of certainty regarding the net benefit of each of its recommendations. The Task Force's 2009 reduction of the grade given for evidence quality from "B" to "C" for routine mammograms in women under the age of 50 years generated significant controversy among health professionals and politicians (Kinsman 2009).

In addition to the 2009 mammography recommendations stated above, the USPSTF has recently recommended against screening for testicular cancer in adolescent or adult males (Grade D recommendation) (USPSTF 2011, p. 483). It has also concluded that there was insufficient evidence to assess the balance of benefits and harms of screening for bladder cancer in asymptomatic adults (Moyer 2011, p. 246), and that prostate-specific antigen (PSA) screening was associated with psychological harms, while its potential benefits remained uncertain (Lin et al. 2008, p. 192). Table 6.1 shows the approach adopted by the agency in June 2007, to rank its recommendations.

Genetic Disposition

Health is dependent upon biological factors. Our predispositions to health or disease begin to take shape at the moment of conception. These predispositions are embedded in our genetic code. The genetic code guides the development of the proteins that determine our phenotypes (sizes, shapes, personalities, hair color, etc.) and genotypes or those aspects of our genetic codes that we cannot see, such as the biologic limit of our life expectancies (McGinnis et al. 2002, p. 80; Khoury et al. 1993; Bell and Standish 2005, p. 339; Starfield 1973, p. 132; Blum 1981; Centers for Disease Control and Prevention (CDC) 1979).

Genetic factors predispose individuals to certain diseases. But although an individual may have a strong likelihood of developing a particular disease, this propensity to develop the disease is significantly enhanced by environmental factors. For example, some studies demonstrate that there is a genetic basis for alcoholism (Reich 1988).

But a person who has never taken a drink will not become an alcoholic. Some triggers, in this case, the availability and consumption of alcohol, are necessary for the individual to progress from being genetically predisposed to alcoholism to actually

Table 6.1 US Preventive Services Task Force (USPSTF) grade definitions and suggestions for practice associated with each grade

Grade	Definition	Suggestions for practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial	Offer or provide this service
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial	Offer or provide this service
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small	Offer or provide this service only if other considerations support the offering or providing of the service in an individual patient
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no benefit or that the harms outweigh the benefits	Discourage the use of this service
I	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence of poor quality is lacking, or is conflicting, and the balance of benefits and harms cannot be determined	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms

Source: Agency for Health Care Research and Quality, *Guide to clinical preventive services*, 2010–2011

Appendix A: How the US Preventive Services Task Force Grades Its Recommendations; at <http://www.ahrq.gov/clinic/pocketgd1011/gcp10app.htm>

drinking and becoming an alcoholic. Similarly, those who develop lung cancer from smoking cigarettes, or those who develop cancer due to genetic mutations caused by environmental contaminants, may well have genetic predispositions for the diseases (Berkman and Breslow 1983; Burnett 1971; Banta and Jonas 1995, p. 18; Davis and Webster 2002, p. 13). These examples suggest that the interaction between genetic factors and the environment in producing a particular disease is complex. While people have little or no control over their genetic makeups, the lifestyles and behaviors they freely choose and the surroundings where they live can have significant influences on the likelihood of developing a particular disease to which they are genetically predisposed.

To further the discussion of the influence of genetics on health, McGinnis et al. (2002, p. 80) cite studies which show that although only about 2% of deaths in the United States may be attributed to purely genetic diseases, about 60% of late-onset disorders, such as diabetes, cardiovascular disease, and cancer, have some genetic component. For example, the BRCA1 gene accounts for only between 5 and 10% of breast cancers in the United States; only about 10% of colon cancers may be explained by genes, and only about 5% of elevated serum cholesterol levels may be explained by familial hyperlipidemia. Similarly, studies of identical twins focusing

on the occurrence of schizophrenia, and other twin studies examining the occurrence of dementia in older people, have found that about half of each might be explained by genetic factors. Further, while about two-thirds of the risk of obesity might be genetic, the risk is expressed only with exposure to controllable lifestyle factors (Baird 1994, p. 133; Muller 2000, p. 7; Panjukanta et al. 1998, p. 369; Kendler 1983, p. 1413; Rowe and Kahn 1998).

Social and Economic Circumstances

The Institute of Medicine (IOM) (2003, p. 20) reported that Americans in 2003, compared with those who lived in 1900, were healthier, lived longer, and enjoyed lives that were less likely to be marked by injuries, ill health, or premature death. But the gains in health reported by the IOM were not shared equally among the population of the United States. At the moment, as was also the case in 2003, gains in health status are not shared fairly or equally by all Americans. Americans with a good education, those who hold high-paying jobs, and those who live in serene and comfortable neighborhoods live longer and healthier lives than those with lower levels of education and income, and those who live in crime infested, overcrowded, and less comfortable and cohesive urban areas (Isaacs and Schroeder 2004, p. 1137; Bell and Standish 2005, p. 339; Lantz et al. 1998, p. 1703; Navarro 2009, p. 423; Satcher 2010, p. 6; Williams 1990, p. 81; Metzler 2007, p. 1; Kilbourne et al. 2006, p. 2113; Berkman and Lochner 2002, p. 291).

There are several pathways through which social and economic circumstances affect health. Those with good educational achievements are more likely to attain higher socioeconomic status than the poorly educated (Angel et al. 2006; Barr 2008; Bartley 1994; Mirowsky and Ross 1986, p. 23). People of lower socioeconomic status die earlier and are more susceptible to undesirable life events than people on higher socioeconomic levels, a pattern that holds true in a progressive fashion from the poorest to the richest (McLeod and Kessler 1990, p. 162; Adler et al. 1993, p. 3140; Adler and Newman 2002, p. 60; Guralnik et al. 1993, p. 110; McDonough et al. 1997, p. 1476). This trend also holds whether one looks at education or occupation (National Center for Health Statistics 1998, p. 3; Kaplan and Keil 1993, p. 1973). These differences are said to be due to the fact that people of higher socioeconomic status have healthier behaviors and lifestyles than those of lower socioeconomic status. People of higher socioeconomic status are less likely to smoke, and are far more likely to eat healthier foods and to engage in leisure-time physical exercise (National Center for Health Statistics 2002, p. 198; Pratt et al. 1999, p. S526; Giles-Corti and Donovan 2002, p. 601). According to Isaacs and Schroeder (2004, p. 1138), as a result of “a sedentary lifestyle and unhealthy eating habits, obesity and the diseases it fosters now characterize lower-class life.”

Poor eating habits and a sedentary lifestyle alone do not explain the differences in health between high and low socioeconomic people. Rather, another explanation for the differentials lies in the distribution of income or the income gradient between

the low and high socioeconomic groups. In a study of white Americans using 1980 census data, undertaken by Smith et al. (1996, p. 486), men earning less than \$10,000 per year were 1.5 times as likely to die prematurely as were those earning \$34,000 or more. A similar study of British civil servants conducted about 2 years before the American study showed that when smoking and other risk factors were controlled for, those who were in the lowest employment category were more than twice as likely to die prematurely of cardiovascular disease as were those in the highest employment category (Davey Smith et al. 1994, p. 131). The findings of these studies have led to the theory that inequitable distribution of income and wealth, or the so-called income and wealth gradient, causes poor health (Sen 1992, p. 102, 1999, p. 87; Daniels et al. 2000; Deaton 2002, p. 13).

As noted above, the relationship between health and income is referred to as a gradient. This terminology emphasizes the gradual relationship between the two variables. Health improvements are directly related to improvements in income throughout the income distribution, and poverty has more than a “threshold” effect on health (Deaton 2002, p. 14). The US National Longitudinal Mortality Study (NLMS) published by the National Institutes of Health (NIH) (1992) showed that the proportional relationship between income and mortality was the same at all income levels, implying that the absolute reduction in mortality for each dollar of income was much larger at the bottom of the income distribution than at the top.

Apart from income, mortality is also known to decline with wealth, rank, and with social status (Marmot et al. 1984, p. 1003, 1991, p. 1387). Similarly, studies also show marked differences in life expectancy by race and by geography or people’s places of residence. For example, there is a 20-year gap in life expectancy between white men who live in the healthiest counties or localities and black men who live in the unhealthiest counties (Murray et al. 1998, p. 1; Gittelsohn 1982, p. 133; Marmot 2006, p. 1304; Kawachi and Berkman 2003).

The brief discussion in this section points to the effects of numerous, and possibly interrelated, social and economic factors on health. Income might affect health just as health might affect income; the distribution of income and wealth might affect health. Similarly, education, race, minority status, geography, employment, housing, discrimination and social isolation, nutrition, lifestyle, stress, health practices, and coping skills might affect health. It does not appear to matter very much which of the above factors is stressed, especially since they are more likely to be interdependent than independent.

Disease risks exist, most often, along a continuum (Rose 1994). Risks are rarely dichotomous. According to Berkman and Lochner (2002, p. 2291), there is no clear division between risk and no risk with regard to, for example, levels of blood pressure, cholesterol, alcohol or tobacco use, physical activity, diet and weight, etc. This gradient of risk also exists for many social and environmental conditions, such as socioeconomic status, social isolation, occupational and environmental exposure, and air quality. Put differently, the numerous studies on the determinants of health that we are unable to fully summarize individually here for lack of space, point to the fact that even though the human and material resources at our disposal, the foods we eat, our levels of education, the houses we live in, the quality of the environments

where we live and work, to name but a few, affect every person's health, the effects may vary in direction and scope from person to person, depending on the differences in their unique circumstances.

Environmental Conditions

Improvement in environmental conditions is an important goal of the US government, as can be inferred from the emphasis on environmental quality outlined in *Healthy People 2010*. That document clearly states that factors in the physical and social environment play major roles in the health of individuals and communities.

The physical environment is operationalized to include the air, water, and soil through which exposure to chemical, biological, and physical agents may occur. The physical environment can harm individual and community health, especially when individuals and communities are exposed to toxic substances, irritants, infectious agents, and physical hazards in homes, schools, and work sites. The physical environment can also promote good health, for example, by providing clean and safe places for people to work, exercise, and play (*Healthy People 2010*, p. 19). Therefore, the physical environment is perhaps one of the most important factors that should be considered when classifying the health status of an individual (Wikipedia 2010).

Environmental factors, such as air and water quality, exposure to pesticides and toxic waste, and housing conditions, have major effects on health and human development. For example, substandard air and water quality have been directly associated with diseases such as cancer, asthma, certain birth defects, and some neurological disorders (Grant Makers in Health 2010, p. 165). Similarly, many forms of cancer are associated with dioxin, polychlorinated biphenyls (PCBs), and mercury (Friis 2007). Also, airborne particulate matter, tobacco smoke, and ground-level ozone, have been known to cause asthma attacks in children. Exposure to lead, which can be found in peeling paint or in the soil and air in many poor communities, has been associated with impaired cognitive and behavioral development and low birth weight among children born to exposed mothers, and is also known to cause kidney damage (Friis 2007).

In recognition of the danger of environmental contamination, Bell and Standish (2005, p. 339) urge communities to act on their behalf to make changes in the policies that affect their physical, social, and economic environments. They state, plausibly, that "policy, place, and community" matter. Combined, policy and community can alter or ameliorate the underlying forces that lie at the heart of the determinants of health. For example, they argue that policy determines the behaviors or things that are allowed, encouraged, discouraged, and prohibited. Policy also determines whether industrial facilities will be sited near residential neighborhoods, how industrial facilities treat their neighbors; how dense neighborhoods will be; what materials can be used to build houses; who will live in a neighborhood; whether businesses can locate in a neighborhood; and whether there are tax or other incentives available for locating in a neighborhood (Bell and Standish 2005, p. 340).

In the developed communities or countries, environmental epidemiologists are concerned about such things as gene–environment interactions, environment–environment interactions, particulate air pollution, nitrogen dioxide, ground-level ozone, environmental tobacco smoke, radiation, lead, video display terminals, cellular telephones, and persistent organic pollutants (POPs) that act as endocrine disruptors. Exposure to these downstream or proximate environmental vectors (exposures that are closely related in time and space to the ill-effects they cause) affect both health and well-being (Encyclopedia of Public Health 2010).

In the developing communities, the primary environmental determinants of health are said to involve biological agents in the air, water, and soil that account for most deaths. For example, diarrheal diseases acquired from contaminated food or water, malaria, intestinal parasitic infections, respiratory diseases caused by biological and chemical agents in both indoor and outdoor air, wreak havoc in the developing countries. These environmental hazards take a far greater toll on human life and suffering in absolute terms compared to those environmental vectors of concern in the developed countries (Encyclopedia of Public Health 2010).

The above environmental vectors that cause havoc in the developing countries also abound in the poor localities of the United States and other developed countries. Wealthy people are more likely to live in better homes and locations where they are less exposed to environmental risks than poor people (Friis 2007; McLeod and Kessler 1990, p. 162; Giles-Corti and Donovan 2002, p. 601; Shi and Singh 2008, p. 51; Grant Makers in Health 2010, p. 165). For example, although the rates of asthma have been rising in the country, the disease affects low-income people disproportionately. Whereas the national prevalence rate of childhood and adult asthma is put at about 7%, some African-American communities report about 25% of children suffering from asthma. Also, Puerto Rican children are reported to have the highest prevalence of active asthma of any US ethnic or racial group. In California, Latino children are reported to be hospitalized for asthma at a rate that is 10% greater than that of white children. Obviously, environmental hazards are some of the reasons for these disparities (*Healthy People* 2010; Joint Center for Political and Economic Studies and PolicyLink 2004, p. 6; Flores et al. 2002, p. 82).

Despite the gains in environmental quality since the advent of the environmental movement in the 1970s, mainstream environmental policies neglected the problems identified in low-income communities because the inhabitants of those areas lacked the political and economic resources to press for environmental justice. However, since its start around 1982, the environmental justice movement has resulted in the cleanup of hazardous waste sites, the redevelopment of brown-fields, the shutdown of incinerators, and the establishment of parks and conservation areas in low-income communities.

Additionally, in low-income communities, local pollution problems are being addressed, cleaner and more accessible means of public transportation are made available, and wild lands and unique habitats are being protected (Faber and McCarthy 2001). These changes are due to interest group pressure, the recognition of the externalities associated with environmental degradation, and the value of a clean environment to the health and well-being of all persons, rich and poor.

Lifestyle and Behaviors

McGinnis et al. (2002, p. 82) contend that behavior choices constitute the single most important domain of influence over health prospects in the United States. Lifestyle and behaviors involve many dimensions, including dietary choices, engagement in physical activity, sexual behavior and recreation, including the choice to smoke and to ingest alcohol, the wearing of motor vehicle seatbelts and motorcycle helmets, and other responsible behavior when operating motor vehicles. Because lifestyle and behavioral factors are under the control of individuals, the public is very likely to define lifestyle and behavioral health problems as being self-induced.

The choices we make with regard to the many dimensions of lifestyle and behavior enumerated above have significant impacts on personal and population health. For example, dietary factors have been associated with coronary heart disease and stroke; colon, breast, and prostate cancers; and diabetes (US Department of Health and Human Services 1988). Similarly, a sedentary lifestyle has been associated with increased risk for heart disease, osteoporosis, dementia, diabetes, and colon cancer (US Department of Health and Human Services 1996). Furthermore, research shows that diets rich in fruits and vegetables, low-fat dairy foods with reduced saturated and total fat, and low sodium diets can lower blood pressure (Appel et al. 1997, p. 1117; Svetkey et al. 1994, p. 285; Sacks et al. 2001, p. 3).

The primary differences between how we perceive behavioral change now from much earlier perceptions is the great awareness that individual behavior occurs in a social context (Berkman and Lochner 2002, p. 292), be it the place of work or abode, the family, the place of worship, the peer group, the school system, the stage of development, etc. For example, the results from the 2001 National Youth Risk Behavior Survey (YRBS) demonstrated that numerous high school students engaged in behaviors that increased their chances of dying from motor vehicle crashes, other unintentional injuries, homicide, and suicide. Specifically, the survey results showed that 14.1% of those surveyed had rarely or never worn a seatbelt during the 30 days preceding the survey; 30.7% had ridden with a driver who had been drinking alcohol; 17.4% had carried a weapon during the 30 days preceding the survey; 47.1% had drunk alcohol during the 30 days preceding the survey; 23.9% had used marijuana during the 30 days preceding the survey; and 8.8% had attempted suicide during the 12 months preceding the survey (Grunbaum et al. 2002, p. 313).

The authors of the YRBS concluded that “priority health-risk behaviors, which contribute to the leading causes of mortality and morbidity among youths and adults, are often established during youth, extend into adulthood, are interrelated, and are preventable.” The examination of the main causes of death in the United States, which we shall shortly discuss in the next section of this chapter, will shed further light on behavioral risk factors. Meanwhile, suffice it to say that lifestyle and behavioral factors constitute some of the important determinants of health that health policy must seek to address.

Medical Care

Even though it is agreed that the contribution of medical care to improved health is not as pronounced as the other factors just examined, curative medical care—those practices, technologies, and organizations that society and the medical profession use to cure and rehabilitate the sick—is nonetheless a key determinant of health (Blum 1981; CDC 1979). The Centers for Disease Control and Prevention (CDC) estimate that only about 10% of premature deaths in the United States can be attributed to inadequate access to medical care, while the remaining 90% can be accounted for by individual lifestyle and behaviors (50%), genetic profiles (20%), and social and environmental conditions (20%) (CDC 1979).

The reason why medical care is the least important determinant of health is because it is reactive, not proactive—it waits for disease and illness to occur before intervening, so to speak. In other words, while individual and population health are somehow associated with having access to curative care, access to preventive services is of greater significance. Therefore, health can improve significantly, and the prevalence of disease can decline dramatically, without effective medical care, due to the other determinants of health (Sigerist 1970, p. 46; McKeown 1976, p. 93; Banta and Jonas 1995, p. 19). This knowledge is very likely the reason why Williams and Jackson (2005, p. 325) and Isaacs and Schroeder (2004, p. 1141) advocate the broadening of the concept of health policy to include the other determinants of health that were not usually seriously considered when discussing health policy. This knowledge, too, is the primary reason for this chapter of the book.

We can elaborate further on the importance and relevance of the determinants of health by linking them to the ten leading causes of death in the United States. Where possible, the analysis will link the incidences of mortality reported in the country that are associated with each, some, or combinations of the determinants of health. Table 6.2 shows the ten leading causes of death in the United States for 2006 and 2007.

The Ten Leading Causes of Death in the United States, 2006–2007

We present, below, the ten leading causes of death in the country for 2006 and 2007 in order to attempt to link some of them to treatable or preventable behaviors and exposures. In other words, we shall attempt to show that most of the deaths can be associated with factors that mainly fall under the social, economic, environmental, and lifestyle and behavioral determinants of health that we have just discussed.

Most of the ten leading causes of death presented above are nongenetic and can be prevented or treated. Diseases of the heart, cancers, cerebrovascular diseases or strokes, chronic lower respiratory diseases, unintentional injuries, diabetes, influenza and pneumonia, and infection- and high blood pressure-induced nephritis can be curtailed, prevented, or treated. For example, cigarette smoking is linked with an increased

Table 6.2 Leading causes of death in the United States, 2006 and 2007

Causes of death	Rank	2007		2006	
		Deaths	% of Total deaths	Deaths	% of Total deaths
<i>All causes</i>	–	2,423,712	100	2,426,264	100
Disease of heart	1	616,067	25.4	631,636	26.0
Malignant neoplasms	2	562,875	23.2	559,888	23.1
Cerebrovascular disease (stroke)	3	135,952	5.6	137,119	5.7
Chronic lower respiratory disease	4	127,924	5.3	124,583	5.1
Accidents (unintentional injuries)	5	123,706	5.1	121,599	5.0
Alzheimer’s disease	6	74,632	3.1	72,432	3.0
Diabetes mellitus	7	71,382	2.9	72,449	3.0
Influenza and pneumonia	8	52,717	2.2	56,326	2.3
Nephritis, nephrotic syndrome and nephrosis	9	46,448	1.9	45,344	1.9
Septicemia	10	34,828	1.4	34,234	1.4

Source: Heron, M. (2011)

risk of heart disease, chronic lower respiratory disease, and cancer; obesity is a major health risk for diabetes, hypertension, coronary heart disease, and some forms of cancer; alcohol causes a wide variety of accidents and injuries, increases the risks for high blood pressure, irregularities of the heart, and stroke; flu vaccines can minimize influenza deaths; and seeking treatment for infections can prevent septicemia.

Additionally, although there is a genetic basis for nephrosis and nephrotic syndrome, the conditions can occur as a result of infection (such as strep throat, hepatitis, or mononucleosis), use of certain drugs, and diabetes. Furthermore, although age and family history are important risk factors for Alzheimer’s disease, longstanding high blood pressure and a history of head trauma are suspected risk factors for the disease as well (Institute of Medicine (US) Committee on Health and Behavior 2001; The Robert Wood Johnson Foundation 2004; MedlinePlus 2011; Womenshealth.gov. 2011; PubMed Health 2011a, b). Most of these conclusions are consistent with the results of previous studies on the actual causes of death in the United States.

McGinnis and Foege (1993, p. 2207) identified and quantified the major external or nongenetic factors that contributed to deaths in the United States in 1990. Deaths associated with socioeconomic factors and access to medical care, although important contributors to the total deaths recorded in the country, were not included in the study because of the difficulty quantifying them independent of the other factors reported in the study. About 10 years after the McGinnis and Foege study, Mokdad et al. (2004, p. 1238) used a similar methodology to quantify the nongenetic factors that contributed to deaths in 2000.

The results of the two studies cited above showed that about half of all deaths that occurred in the United States in both 1990 and 2000 could also be attributed to a small number of largely controllable behaviors and exposures, including tobacco, diet and activity patterns, alcohol, microbial and toxic agents, firearms, sexual behavior, motor vehicle accidents, and illicit drug use.

The results of the causes of death studies reported by McGinnis and Foege and Mokdad and his colleagues are consistent with the findings of the 2001 National YRBS cited earlier in this chapter. The survey results showed that in the United States, 70.6% of all deaths among youth and young adults aged 10–24 years were due only to four causes: motor vehicle crashes, other unintentional injuries, homicide, and suicide. The deaths attributable to these causes among the identified population group were 31.4, 12, 15.3, and 11.9%, respectively (Grunbaum et al. 2002, p. 313).

Furthermore, substantial morbidity and social problems were said to result from the approximately 870,000 pregnancies that occurred each year among women 15–19 years (Ventura et al. 2001, p. 1), and from the estimated million cases of sexually transmitted diseases (STDs) that occurred each year among persons 10–19 years (Institute of Medicine 1997; Eng and Butler 1997).

Similar to the studies on the actual causes of death in the United States in 1990 and 2000, the YRBS also found that the leading causes of mortality and morbidity among all age groups in the country were related to behaviors that contributed to unintentional injuries and violence, tobacco use, alcohol and other drug use, sexual behaviors that contributed to unintended pregnancies and STDs, including HIV infection, unhealthy dietary behaviors, and sedentary lifestyles.

In 2010, almost 10 years after the 2001 YRBS discussed above, the CDC quantified the death rates among teenagers aged 12–19 years between 1999 and 2006. Not surprisingly, the ten leading causes of death for the teenage population remained constant throughout the period. They were as follows: accidents or unintentional injuries, 48% of deaths; homicides, 13% of teenage deaths; suicide, 11%; cancer, 6%; and heart disease, 3%. Further analysis showed that motor vehicle accidents accounted for almost three quarters (73%) of all deaths from unintentional injury; and that non-Hispanic black males had the highest death rate among all teenagers, with homicide being the leading cause of death for them (Minino 2010).

The determinants of health that have occupied our attention up to this point are not only affected by the broad national and personal factors we have identified but are also affected by broad global or international factors (Shi and Singh 2008, p. 53). Therefore, the rest of this chapter is devoted to examining the influences of global factors on the health care system and the health policymaking process.

Global Factors and Health

Foreign policies involve the political relationships between countries and the outside world. Foreign policy development generally concerns the protection of a country's national interests, usually defined in terms of security, economic prosperity, and ideological goals (Lee et al. 2007, p. 208). Increased globalization has led to the broadening of foreign policy concerns to include health. Conversely, it is now recognized that international trade and finance, migration and population mobility, environmental change or global warming, the emerging and reemerging infectious disease paradigms, natural disasters, and global insecurity or terrorism have clear

and observable consequences for human health (Kassalow 2001; McInnes and Lee 2006, p. 5; Lee et al. 2007, p. 208; Katz and Singer 2007, p. 223; Campbell-Lendrum et al. 2007, p. 235; Fidler 2007, p. 243; MacPherson et al. 2007, p. 200; Labonte et al. 2009). We shall briefly examine how these components of globalization—international trade, population mobility, infectious diseases, global warming or climate change, and natural disasters and terrorism—affect countries' health care and policymaking systems generally, and the United States' health care and policymaking systems in particular. We begin with international trade.

International Trade and Finance

The principal agents of global international trade and finance include such international agencies as the World Bank, the International Monetary Fund (IMF), and the World Trade Organization (WTO). It has been reported that the market-biased or efficiency-oriented austerity policies these organizations promote or sponsor have resulted in reduced expenditures for social programs in developing countries, thereby impairing population health and slowing the advances in literacy, fertility reduction, and improved reproductive health of the women of the developing countries (Kinnon 1998, p. 397; Gray 1998; Watts 1997).

Some specific examples of international trade and finance policies include the following: trade liberalization or the lowering of tariffs and other barriers to imports that has led to the doubling of the value of world trade from 24% of world GDP in 1960 to 48% in 2003 (World Bank 2006); the reorganization of production and service provision across multiple national borders by multinational or transnational corporations, such as outsourcing or the pursuit of integration into global value chains, resulting in a global labor market (World Bank 1995, p. 2007; Woodall 2006); the conditions attached to World Bank and IMF loans, and to the rescheduling of loan payments, including structural adjustment programs (SAPs); financial liberalization, which exposes national economies to the uncertainties created by large and volatile short-term capital flows; the significant growth in the world's urban population caused by transnational economic integration; the promotion of export-oriented agricultural development that does not consider the social and environmental consequences of such actions, which result from the pressures on governments around the world to increase export earnings (Stonich and Bailey 2000, p. 23); and the promotion and reinforcement of a market-oriented concept of health sector reform that strongly favors private provision and financing (Petchesky 2003; Koivusalo and Mackintosh 2005, p. 3).

Critics of the above international trade and finance policies argue that it is not at all clear that globalization leads to substantial poverty reduction. They point to the large-scale and extreme unequal distribution of wealth and income in the countries that have been identified as "globalizers" witnessing rapidly growing economies. It is argued that even a little redistribution of income through progressive taxation and targeted social programs would go farther in terms of poverty reduction than many

years of solid economic growth (Jubany and Meltzer 2004; Paes de Barros et al. 2002; de Ferranti et al. 2004).

Further, it is argued that as countries compete for foreign direct investment and outsourced production, the need to appear business-friendly may limit their ability to adopt and implement labor standards, occupational safety and health regulations, and other redistributive programs (Cornia 2005); global integration of production may cause a sharp decline in the wages of, and demand for, low-skilled workers; large amounts of debt limit the ability of many developing and developed countries to meet other human needs related to health, education, water, public safety, sanitation, nutrition, etc.; globalization may lead to an intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away, and vice versa (Giddens 1990, p. 64); much of the urbanization caused by international finance and trade policies occurs in countries that have limited resources to provide urban infrastructures; and the emphasis on private financing and provision of health care leads to large-scale underinsurance and uninsurance in both the developed and developing countries (Labonte and Schrecker 2007, p. 6).

Globalization and the quest for exports are also blamed for increased smoking and tobacco-related mortality in the developing countries (Murray and Lopez 1997, p. 1498). Also noteworthy is the escalation in the sale of weapons, much of it facilitated by Western governments. The wars that have raged on and off in sub-Saharan Africa, Latin America, and Asia are tragic examples of the ill effects of aggressive weapon sales to these places (McMichael and Beaglehole 2000, p. 497).

Although the adverse effects of globalization discussed above tend to affect developing countries more than the United States, there are significant adverse consequences of globalization for the United States as well. Some of these include the perpetuation and exacerbation of the gap between the rich and the poor, a large public debt profile that puts significant pressure on social and other safety net policies and programs, the prevalence of uninsurance and underinsurance, job insecurity and reduced wages, the collapse of large manufacturing businesses, increased availability and demand for illicit drugs, and the emergence of new infectious diseases that spread more easily due to increased migration and population mobility (Ubokudom and Khubchandani 2010, p. 20). For example, American labor unions complain that the North American Free Trade Agreement (NAFTA) with Canada, Mexico, and the United States, which came into force on January 1, 1994, has led to the loss of American jobs. Job loss causes stress, loss of income and the financial means to pay for medical care.

Infectious Disease Epidemics

From the onset, health issues were not at the heart or margins of foreign policy theory or practice for two reasons. First, the protection and promotion of population health did not factor into world leaders' calculations of what "competition in anarchy"

(the condition from which foreign policy dynamics flow) required of their countries, nor was health for all seriously (as opposed to rhetorically) considered a pathway to a better world. Second, those who were engaged in public health did not participate significantly in discussions of foreign policy (Fidler 2007, p. 243). Therefore, there were only small and nonsubstantial linkages between health and foreign policy (Harris 2004, p. 171).

Actions linking health issues or problems with foreign policy have been strongest when the potential impact on economic prosperity, national security, the environment, and development is severe. This has resulted in attention to health threats that are acute and severe, those that are projected to result in mass casualties, and those that are believed to be geographically widespread. In contrast, long-term health risks, or health risks that cause minor health problems, affect a limited number of people, or are not geographically widespread, attract little attention in relation to foreign policy. In other words, acute epidemic infections and major public health emergencies, such as natural or human-induced disasters, bioterrorism, and chemical and radiation accidents, have received significant attention (Fidler 2007, p. 243; Lee et al. 2007, p. 208; Katz and Singer 2007, p. 233).

A few specific examples of “attention-receiving” public health problems include the previously unknown human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) which appeared in the United States in the early 1980s; the hantavirus, believed to have originated in Korea; eastern equine encephalitis, which is found in the eastern and north-central United States, Canada, parts of Central and South America, and the Caribbean Islands; Western equine encephalitis, which occurs primarily in the Western and Central United States, Canada, and parts of South America; the polio virus that is believed to have originated in India in 2005; the spread of Severe Acute Respiratory Syndrome (SARS) from China in 2003; and the 2009 outbreak of the deadly H1N1-Swine Flu-influenza believed to have originated in Mexico (CDC 2009; Shi and Singh 2008, p. 578; Friis 2007, p. 87).

In summary, many health problems, particularly infectious diseases, are widely recognized as global concerns that cross national and international boundaries. Consequently, countries frequently include in their foreign policies strategies on these diseases that have the potential to threaten their domestic interests. This is likely to lead to higher prioritization, more attention, greater political support, and more funding. For example, in the United States, projections of the impact of HIV/AIDS on the workforces of many countries, and the prevalence of HIV among military personnel in several regions of the world, contributed to the determination that HIV/AIDS was a security issue.

Similarly, awareness of the havoc caused by previous influenza pandemics and the economic impact of the small and short outbreak of SARS led to serious preparations by the WHO and its member states for the next influenza pandemic (Katz and Singer 2007, p. 234). This understanding has led to many international agreements covering health and the environment, including the Agreement on Sanitary and Phytosanitary Measures, the International Standards Organization’s classification system for food labeling, the UN Framework Convention on Climate Change, and the Kyoto Protocol, to name a few.

Global Warming or Climate Change

Data from the National Aeronautics Space Administration (NASA) show that the Earth's surface has warmed by about 0.66°C between January and November 2010. That period was reported to be the warmest January–November in the NASA Goddard Institute for Space Studies (GISS) analysis, which covers 131 years. The period was only a few hundredths of a degree warmer than 2005, so it is possible that the final GISS results for the full year, 2010, would be warmer or in the same range as 2005. Further, the available data also show that the Earth's surface has warmed by more than 0.8°C over the past century and by about 0.6°C in the past 3 decades (NASA 2010). Therefore, contrary to frequent assertions that global warming has slowed in the past decade, global warming has proceeded in the decade that ended in 2010 just as fast as it did in the prior 2 decades (NASA 2010).

The health hazards posed by climate change and global warming are inequitable, diverse, global, and probably irreversible over human time scales (Patz et al. 2005, p. 310; Campbell-Lendrum et al. 2007, p. 235). They include increased risks of extreme weather, such as floods and storms, fatal heat waves, long-term drought conditions in many areas of the world, surface water pollution and groundwater contamination, the melting of glaciers that supply freshwater to large population centers, salination of sources of agricultural and drinking water, increased rates of water extraction that may precipitate declines in supply, and creating a conducive environment for the global killers that are very sensitive to climatic conditions, such as malaria, diarrhea, and protein-energy malnutrition (Campbell-Lendrum et al. 2007, p. 235; Friis 2007, p. 3). As we noted under the actual causes of death, these three global killers cause many deaths in the United States; they are also said to account for about three million deaths worldwide each year (WHO 2004).

Population Mobility

The relationship between migration, population mobility, and health is receiving renewed attention due to the emerging and reemerging infectious diseases that were discussed previously in this section. The health of both legal and illegal migrants to any country are affected by the determinants of health discussed earlier in this chapter, as well as by the risks that are present in their country of origin or that arise from the migration process itself (MacPherson and Gushulak 2001, p. 390). This is very true of the United States where a significant portion of the annual population growth is due to migration.

The effects of population mobility and migration on the country's health care system and the provision of health services are reported daily in the pages of newspapers. First, there is likely to be increased demand for services due to population growth, whether that growth is due to increased fertility rates or migration. For example, the exponential growth in Medicaid expenditures in states that border Mexico are said to be due to the increased demand for medical services by illegal

immigrants as well as by the medical needs of an aging population. Second, officials of the states that share boundaries with Mexico complain about increased violent crimes committed by illegal immigrants, crimes that take a heavy toll on population health and health care expenditures. Third, increased migration compels more health services planning, infrastructure maintenance, development and training of a diverse medical workforce to cater for the increasingly diverse population, and the establishment of public health programs for health promotion, health protection, and disease prevention (MacPherson et al. 2007, p. 200; Cohen et al. 2002, p. 90). And, fourth, the opinion pages of newspapers carry citizens' letters that attribute the success of previous terrorist campaigns to the nearly open border policy the United States maintained prior to September 11, 2001 (9/11). Since the 9/11 attacks, border security and entry visa requirements have been tightened. Border control measures are now centered on inspecting and excluding goods, vessels, and people that pose serious health or terrorist threats to the United States. Other countries have similar measures.

Natural Disasters and Terrorism

The world has changed. Indeed, the world has changed significantly. While most people are actively planning on how to make their lives better, a few others are actively planning on how to destroy lives and settle political and ideological differences through acts of violence. No place and people are immune from the threats of violence, terrorism, and natural disasters. In the past 9 or 10 years, the United States has experienced disasters that have led to a rethinking of how to keep the population safe.

The terrorist attacks in the United States on September 11, 2001, an unsuccessful attempt to initiate an anthrax epidemic in October 2001, and the devastation caused by Hurricane Katrina of the 2005 Atlantic hurricane season led to significant loss of lives and property and revealed deficiencies in the public health and emergency response systems in the country. Because of both underfunding and understaffing, and perhaps because the changes that have taken place in the world were not anticipated, the public health system was unable to develop or implement a comprehensive program of preparedness, prevention, response, and recovery (US General Accounting Office 2003). Following the disasters, state, local, and federal public health agencies began to identify weaknesses in the nation's public health infrastructure and to reevaluate existing disaster response plans (Baker and Koplan 2002, p. 15).

The shortcomings revealed in the nation's disaster response plans elevated public health to an important national instrument for anticipating and dealing with terrorism, infectious disease outbreaks, and natural disasters. The guidance on responses to chemical, biological, radiological, nuclear, and explosive threats provided by the CDC, and by other national organizations and Universities, helped individual state governments to develop statewide policies that took their unique concerns into account (Ziskin and Harris 2007, p. 1584; Shah 2006, p. 1414; Gebbie and Turnock 2006, p. 923).

Public health plans to deal with terrorist threats, infectious diseases, and natural disasters now involve public health agencies at the federal, state, and local levels of government; other government and private agencies, such as the Departments of Justice and Defense; the Food and Drug Administration; private, public, and non-profit hospitals, clinics, and nursing homes; private and public practitioners, such as nurses and physicians; blood supply organizations, such as the American Red Cross; police and fire departments; and individuals and groups throughout the country. As would be expected, expenditures for government public health activities, while still low relative to expenditures for medical care, rose from \$47 billion in 2001 to about \$69.4 billion in 2008, an increase of 47.6% from 2001 (Centers for Medicare and Medicaid Services (CMS) 2010). It remains to be seen if this enthusiasm for public health, demonstrated by increased funding since 2001, can be sustained.

The law that is used as the basis for most of the new emergency preparedness measures is the Homeland Security Act of 2002. In addition to the strengthening of the public health infrastructure, the law also called for improved inspections of food products entering the United States. It calls for better measures to contain attacks on food and water supplies, to protect vital infrastructures, such as nuclear facilities, and to track biological materials anywhere in the country. Further, the provisions of the law have been used to justify tough and controversial interrogation techniques, such as waterboarding. Similarly, Presidential Executive Order 13295, signed by George W. Bush on April 4, 2003, authorizes the apprehension, detention, or conditional release of individuals with suspected communicable diseases, such as SARS, cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, and viral hemorrhagic fevers such as Ebola (The Free Dictionary 2008).

In summation, international trade and finance, infectious disease epidemics, global warming and climate change, population mobility, and natural disasters and terrorism significantly affect the United States health care delivery and policymaking systems. In addition, medical technology and US health care professionals and consumers are also affected by global factors. For example, because the United States is widely believed to be the world leader in the development and utilization of high-technology medical protocols, foreign dignitaries come here for specialty care. Also, nurses and foreign medical school graduates (FMGs) move to the United States to acquire licenses to practice in the country. This so-called brain drain causes shortages of medical practitioners in the developing countries and alleviates some of the shortages in the health professional shortage areas of the United States.

Furthermore, telemedicine allows US physicians to transmit radiological images to other countries where they are analyzed at lower costs. On the other hand, US consulting pathologists and radiologists provide their services to other parts of the world. Also, advanced medical equipment and supplies that are abandoned here a few years after deployment are shipped to the developing and less technology-intensive developed countries at low costs. The high costs paid by US consumers are used to subsidize the low costs paid by the developing countries (Ubokudom and Khubchandani 2010, p. 21).

Conclusion

This chapter has identified the impacts of physical, social, cultural, and global factors on health and health policymaking. Health can be defined under the medical or wellness models. The health status of the US population, or the population of any other country for that matter, is largely determined by factors that have important physical, social, and economic dimensions. These include preventive medicine, genetic disposition, social and economic circumstances, environmental conditions, lifestyles and behaviors, and medical care. These determinants of health are associated, in various degrees, with the real or actual causes of death in the country. Research demonstrates that most of the deaths in the country are attributable to a small number of largely controllable behaviors and exposures, or due to factors that fall under the preventive, social, economic, environmental, and lifestyle and behavioral determinants of health. These determinants of health are not only affected by the broad national and personal factors identified in the chapter, they are also affected by global or international factors, including trade and finance, outbreaks of infectious diseases, climate change, natural disasters, and the threats of terrorism and population mobility.

But even though most of the deaths in the country are the result of social, cultural, economic, environmental, and global factors, medical care is also an important determinant of health that cannot be ignored. An insurance card is one of the important factors that influence access to medical services. Consequently, the next chapter examines demographic factors, most especially Americans' ability to access medical services, and the disparities in health among segments of the population.

Review Questions

1. What are the likely policy implications of defining health under the medical and wellness models?
2. Why have the US health policies relied extensively on the medical model and what are the implications?
3. What is holistic health and what factors does the concept embody?
4. Identify the major determinants of health.
5. What are the differences between medical care and health care, and what should be the prudent implications of these differences for health care policy and delivery?
6. Define and give examples of primary, secondary, and tertiary prevention measures.
7. What are the functions of the USPSTF and how does the agency go about performing these functions?
8. What are the different pathways through which social and economic circumstances affect health?

9. What are the physical environmental factors that affect health and what attempts are made to mitigate the effects of these factors?
10. What are the most likely causes of death in the United States and how much influence has this knowledge had on the formulation of the nation's health care policies?

References

- Adler, N.E., W.T. Boyce, M.A. Chesney, S. Folkman, and S.L. Syme. 1993. "Socioeconomic Inequalities in Health: No Easy Solution." *JAMA* 269(24): 3140–3145.
- _____, and K. Newman. 2002. "Socioeconomic Disparities in Health: Pathways and Policies." *Health Affairs* 21(2) (March/April): 60–76.
- Angel, R., L. Lein, and J. Henrici. 2006. *Poor Families in America's Health Care Crisis*. New York, NY: Cambridge University Press.
- Appel, L.J., T.J. Moore, E. Obarzanek, W.M. Vollmer, L.P. Svetkey, F.M. Sacks, G.A. Bray, T.M. Vogt, J.A. Cutler, M.M. Windhauser, P. Lin, and N. Karanja. 1997. "A Clinical Trial of the Effects of Dietary Patterns on Blood Pressure." *The New England Journal of Medicine* 336(16) (April 17): 1117–1124.
- Baird, P.A. 1994. "The Role of Genetics in Population Health." In *Why are Some People Healthy and Others Not?*, eds. R.G. Evans, M.L. Barer, and T.R. Marmor. New York, NY: Aldine de Gruyter, 133–159.
- Baker, E.L., and J.P. Koplan. 2002. "Strengthening the Nation's Public Health Infrastructure: Historic Challenge, Unprecedented Opportunity." *Health Affairs* 21(6): 15–27.
- Banta, David H., and S. Jonas. 1995. "Health and Health Care." In Jonas's *Health Care Delivery in the United States*, 5th ed., ed. A. Kovner. NY: Springer Publishing Co., 11–33.
- Barr, D.A. 2008. *Health Disparities in the United States: Social Class, Race, Ethnicity and Health*. Baltimore, MD: The Johns Hopkins University Press.
- Bartley, M. 1994. "Unemployment and Ill Health: Understanding the Relationship." *Journal of Epidemiology and Community Health* 48(4) (August): 333–337.
- Bell, J., and M. Standish. 2005. "Communities and Health Policy: A Pathway for Change." *Health Affairs* 24(2): 339–342. DOI: 10.1377/hlthaff.24.2.339.
- Belloc, N.B., and L. Breslow. 1972. "Relationship of Physical Health Status and Health Problems." *Preventive Medicine* 1(1): 409–421.
- Berkman, L.F., and L. Breslow. 1983. *Health and Ways of Living: The Alameda County Study*. New York, NY: Oxford University Press.
- _____, and K.A. Lochner. 2002. "Social Determinants of Health: Meeting at a Crossroads." *Health Affairs* 21(2) (March/April): 291–293.
- Blum, H.L. 1981. *Planning for Health*, 2nd ed., New York, NY: Human Sciences Press.
- Bunker, J.P., D.S. Gomby, and B.H. Kehrner, eds. 1989. *Pathways to Health: The Role of Social Factors*. Menlo Park, CA: The Henry Kaiser Family Foundation.
- _____, H.S. Frazier, and F. Mosteller. 1995. "The Role of Medical Care in Determining Health: Creating an Inventory of Benefits." In *Society and Health*, eds. B.C. Amick, S. Levine, A.R. Tarlov, and D.C. Walsh. New York, NY: Oxford University Press, 305–341.
- Burnett, M. 1971. *Genes, Dreams, and Realities*. New York, NY: Basic Books.
- Campbell-Lendrum, D., C. Corvalan, and M. Neira, 2007. "Global Climate Change: Implications for International Public Health Policy." *Bulletin of the World Health Organization* 85(3) (March): 235–237.
- Centers for Disease Control and Prevention (CDC). 1979. *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. Washington, DC: Public Health Service, U.S. Department of Health and Human Services.

- _____. 2009. "Key Facts About Swine Influenza." Retrieved May 20, 2009, from http://www.cdc.gov/h1n1flu/key_facts.htm.
- Centers for Medicare and Medicaid Services (CMS). 2010. "National Health Expenditure Projections 2009-2019." Retrieved November 10, 2010, from http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections_2009_to_2019.pdf.
- Coffield, A.B., M.V. Maciosek, M. McGinnis, J.R. Harris, N.B. Caldwell, S.M. Teutsch, D. Atkins, J.H. Richland, and A. Haddix. 2001. "Priorities Among Recommended Clinical Preventive Services." *American Journal of Preventive Medicine* 21(1): 1-9.
- Cohen, J.J., B.A. Gabriel, and C. Terrell. 2002. "The Case for Diversity in the Health Care Workforce." *Health Affairs* 21(5): 90-102.
- Cornia, G.A. 2005. *Policy Reform and Income Distribution*, ST/ESA/2005/DWP/3. New York, NY: United Nations Department of Economics and Social Affairs.
- Daniels, N., B. Kennedy, and I. Kawachi. 2000. *Is Inequality Bad for Our Health?* Boston, MA: Beacon Press.
- Davey Smith, G., D. Blane, and M. Bartley. 1994. "Explanations for Socioeconomic Differentials in Mortality: Evidence from Britain and Elsewhere." *European Journal of Public Health* 4(2): 131-144.
- Davis, D.L., and P.S. Webster. 2002. "The Social Context of Science: Cancer and the Environment." *The Annals of the American Academy of Political and Social Science* 584(1) (November): 13-34.
- Deaton, A. 2002. "Policy Implications of the Gradient of Health and Wealth." *Health Affairs* 21(2) (March/April): 13-30.
- de Ferranti, D., G. Perry, F.H. Ferreira, and M. Walton. 2004. *Inequality in Latin America & the Caribbean: Breaking with History?* Washington, DC: The World Bank.
- Encyclopedia of Public Health*. 2010. Environmental Determinants of Health." Retrieved January 2, 2011, from <http://www.enotes.com/public-health-encyclopedia/environmental-determinants-health>.
- Eng, T.R., and W.T. Butler, eds. 1997. *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. Washington, DC: National Academy Press.
- Faber, D.R., and D. McCarthy. 2001. *Green of Another Color: Building Effective Partnerships Between Foundations and the Environmental Justice Movement*. Washington, DC: Aspen Institute.
- Fidler, D.P. 2007. "Reflections On the Revolution in Health and Foreign Policy." *Bulletin of the World Health Organization* 85(3) (March): 243-244.
- Flores, G., E. Fuentes-Afflick, O. Barbot, O. Carter-Pokras, L. Chaudio, M. Lara, J. McLaurin, L. Pachter, F.J. Ramos-Gomez, F. Mendoza, R.B. Valdez, A.M. Villarruel, R.E. Zambrana, R. Greenberg, and M. Weitzman. 2002. "The Health of Latino Children: Urgent Priorities, Unanswered Questions, and a Research Agenda." *JAMA* 288(1) (July 3): 82-90.
- Friis, R.H. 2007. *Essentials of Environmental Health*. Sudbury, MA: Jones and Bartlett Publishers.
- Gebbie, K.M., and B.J. Turnock. 2006. "The Public Health Workforce, 2006: New Challenges." *Health Affairs* 25(4) (July/August): 923-933. DOI: 10.1377/hlthaff.25.4.923.
- Giddens, A. 1990. *The Consequences of Modernity*. Stanford, CA: Stanford University Press.
- Giles-Corti, B., and R.J. Donovan. 2002. "Socioeconomic Status Differences in Recreational Physical Activity Levels and Real and Perceived Access to a Supportive Physical Environment." *Preventive Medicine* 35: 601-611. DOI: 10.1006/pmed.2002.1115.
- Gittelsohn, A.M. 1982. "On the Distribution of Underlying Causes of Death." *American Journal of Public Health* 72(2): 133-140.
- Grant Makers in Health. 2010. "Social Determinants of Health." Retrieved December 10, 2010, from http://www.gih.org/usr_doc/knowledge_to_action_-_social_determinants_of_health.pdf.
- Gray, J. 1998. *False Dawn: The Delusions of Global Capitalism*. London, England: Granta.
- Grunbaum, J.A., L. Kann, S.A. Kinchen, B. Williams, J.C. Ross, R. Lowry, and L. Kolbe. 2002. "Youth Risk Behavior Surveillance—United States, 2001." *Journal of School Health* 72(8) (October): 313-328.

- Guralnik, J.M., K.C. Land, D. Blazer, G.G. Fillenbaum, and L.G. Branch. 1993. "Educational Status and Active Life Expectancy Among Older Blacks and Whites." *The New England Journal of Medicine* 329 (July 8): 110–116.
- Harris, S. 2004. "Marrying Foreign Policy and Health: Feasible or Doomed to Fail?" *Medical Journal of Australia* 180(4): 171–173.
- Healthy People 2010: Understanding and Improving Health*, United States Department of Health and Human Services (USDHHS). Retrieved January 2, 2011, from <http://www.health.gov/healthypeople>.
- Heron, M. 2011. "Deaths: Leading Causes for 2007." *National Vital Statistics Reports* 59(8). Hyattsville, MD: National Center for Health Statistics, 1–96.
- Homeland Security Act of 2002, Public Law 107-296 (H.R. 5005), November 25, 2002.
- Institute of Medicine. 2003. *The Future of the Public's Health in the 21st Century*. Washington, DC: National Academy Press, 20.
- Institute of Medicine, Committee on Prevention and Control of Sexually Transmitted Diseases. 1997.
- Institute of Medicine (US) Committee on Health and Behavior: Research, Practice, and Policy. Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences. (2001): Washington, DC: National Academies Press, 1–27. Retrieved November 20, 2011, from <http://www.ncbi.nlm.nih.gov/books/NBK43744/?report=printable>.
- Isaacs, S.L., and S.A. Schroeder. 2004. "Class—The Ignored Determinant of the Nation's Health." *The New England Journal of Medicine* 351(11): 1137–1142.
- Joint Center for Political and Economic Studies and PolicyLink. 2004. "Breathing Easier: Community-based Strategies to Prevent Asthma," 1–9. Retrieved January 10, 2011, from <http://www.jointcenter.org/hpi/sites/allfiles/JointCenter-Asthma.pdf>.
- Jubany, F., and J. Meltzer. 2004. *The Achilles' Heel of Latin America: The State of the Debate on Inequality*, FPP 04-5. Ottawa, Canada. Canadian Foundation for the Americas (FOCAL).
- Kannel, W.B., L.A. Cupples, R. Ramaswami, J. Stokes, III, B.E. Kreger, and M. Higgins. 1991. "Regional Obesity and Risk of Cardiovascular Disease: The Framingham Study." *Journal of Clinical Epidemiology* 44(2): 183–190.
- Kaplan, G.A., and J.E. Keil. 1993. "Socioeconomic Factors and Cardiovascular Disease: A Review of the Literature." *Circulation* 88(4): 1973–1998.
- Kassalow, J.S. 2001. *Why Health Is Important to U.S. Foreign Policy*. Washington, DC: Council on Foreign Relations/Milbank Memorial Fund. Retrieved January 27, 2011, from http://www.cfr.org/publication/8315/why_health_is_important_to_us_foreign_policy.html.
- Katz, R., and D.A. Singer. 2007. "Health and Security in Foreign Policy." *Bulletin of the World Health Organization* 85(3) (March): 233–234.
- Kawachi, I., and L.F. Berkman, eds. 2003. *Neighborhoods and Health*. New York, NY: Oxford University Press.
- Kendler, K.S. 1983. "Overview: A Current Perspective on Twin Studies of Schizophrenia." *American Journal of Psychiatry* 140 (November): 1413–1425.
- Khoury, M.J., T.H. Beaty, and B.H. Cohen. 1993. *Fundamentals of Genetic Epidemiology*. New York, NY: Oxford University Press.
- Kilbourne, A.M., G. Switzer, K. Hyman, M. Crowley-Matoka, and M.J. Fine. 2006. "Advancing Health Disparities Research Within the Health Care System: A Conceptual Framework." *American Journal of Public Health* 96(12) (December): 2113–2121.
- Kinnon, C.M. 1998. "World Trade: Bringing Health Into the Picture." *World Health Forum* 19:397–406.
- Kinsman, D. 2009. "Statement on the Politicization of Evidence-Based Clinical Research." Retrieved January 2, 2011, from <http://www.medicalnewstoday.com/articles/172101.php>.
- Koivusalo, M., and M. Mackintosh. 2005. "Health Systems and Commercialization: In Search of Good Sense." In *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*, eds. M. Mackintosh and K.M. Basingstoke. Houndmills, England: Palgrave Macmillan, 3–21.

- Labonte, R., T. Schrecker, C. Packer, and V. Runnels, eds. 2009. *Globalization and Health: Pathways, Evidence and Policy*. New York, NY: Routledge.
- _____. 2007. "Globalization and the Social Determinants of Health: The Role of the Global Marketplace (part 2 of 3)." *Globalization and Health* 2007 3 (19 June): 6. DOI: 10.1186/1744-860-3-6. Retrieved November 29, 2010, from <http://www.globalizationandhealth.com/content/3/1/6>.
- Lantz, P.M., J. House, J.M. Lepkowski, D.R. Williams, R.P. Mero, and J. Chen. 1998. "Socioeconomic Factors, Health Behaviors, and Mortality: Results from a Nationally Representative Prospective Study of U.S. Adults." *JAMA* 279(21) (June 3): 1703–1708.
- Lee, K., A. Ingram, K. Lock, and C. McInnes. 2007. "Bridging Health and Foreign Policy: The Role of Health Impact Assessments." *Bulletin of the World Health Organization* 85(3) (March): 207–211.
- Levin, J.S. 1994. "Religion and Health: Is There an Association, Is it Valid, and Is it Causal?" *Social Science and Medicine* 38(11): 1475–1482.
- Lin, K., R. Lipsitz, T. Miller, and S. Janakiraman. 2008. "Benefits and Harms of Prostate-Specific Antigen Screening for Prostate Cancer: An Evidence Update for the U.S. Preventive Services Task Force." *Annals of Internal Medicine* 149(3): 192–199.
- MacPherson, D.W., B.D. Gushulak, and L. Macdonald. 2007. "Health and Foreign Policy: Influences of Migration and Population Mobility." *Bulletin of the World Health Organization* 85(3) (March): 200–206.
- _____. 2001. "Human Mobility and Population Health: New Approaches in a Globalizing World." *Perspectives in Biology and Medicine* 44(3) (Summer): 390–401.
- Marmot, M.G., S. Stansfield, C. Patel, F. North, J. Head, I. White, E. Brunner, A. Feeney, and G. Davey Smith. 1991. "Health Inequalities Among British Civil Servants: The Whitehall II Study." *Lancet* 337 (8758) (July 6): 1387–1393.
- _____, M.J. Shipley, and G. Rose. 1984. "Inequalities in Death-Specific Explanations of a General Pattern?" *Lancet* 1 (8384) (5 May): 1003–1006.
- _____. 2006. "Status Syndrome: A Challenge to Medicine." *JAMA* 295(11) (March 15): 1304–1307.
- Maugans, T.A. 1996. "The SPIRITual History." *Archives of Family Medicine* 5(1): 11–16.
- McCullough, M.E., and D.B. Larson. 1999. "Religion and Depression: A Review of the Literature." *Twin Research* 2: 126–136.
- _____, W.T. Hoyt, D.B. Larson, H.G. Koenig, and C. Thorsen. 2000. "Religious Involvement and Mortality: A Meta-Analytic Review." *Health Psychology* 19(3): 211–222.
- McDonough, P., G.J. Duncan, D.R. Williams, and J. House. 1997. "Income Dynamics and Adult Mortality in the United States, 1972 Through 1989." *American Journal of Public Health* 87(9): 1476–1483.
- McGinnis, J.M., P. Williams-Russo, and J.K. Knickman. 2002. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs* 21(2) (March/April): 78–93.
- _____, and W. H. Foege. 1993. "Actual Causes of Death in the United States." *JAMA* 270(18) (November 10): 2207–2212.
- McInnes, C., and K. Lee. 2006. "Health, Foreign Policy and Security." Review of *International Studies* 32(01): 5–23.
- McKeown, T. 1976. *The Role of Medicine: Dream, Mirage, or Nemesis?* London, England: Nuffield Provincial Hospitals Trust.
- McLeod, J.D., and R.C. Kessler. 1990. "Socioeconomic Status Differences in Vulnerability to Undesirable Life Events." *Journal of Health and Social Behavior* 31 (June): 162–172.
- McMichael, A.J., and R. Beaglehole. 2000. "The Changing Global Context of Public Health." *The Lancet* 356 (9228) (August 5): 495–499.
- MedlinePlus. 2011. "Septicemia." Retrieved November 20, 2011, from <http://www.nlm.nih.gov/medlineplus/ency/article/001355.htm>
- Metzler, M. 2007. "Social Determinants of Health: What, How, Why, and Now." *Public Health Research, Practice, and Policy* 4(4) (October): 1–4.
- Mirowsky, J., and C.E. Ross. 1986. "Social Patterns of Distress." *Annual Review of Sociology* 12: 23–45.

- Minino, A.M. 2010. "Mortality Among Teenagers Aged 12-19 years: United States, 1999-2006." Hyattsville, MD (NCHS Data Brief, No. 37), 1-8.
- Mokdad, A.H., J.S. Marks, D.F. Stroup, and J.L. Gerberding. 2004. "Actual Causes of Death in the United States, 2000." *JAMA* 291(10) (March 10): 1238-1245.
- Moyer, V.A. on behalf of the U.S. Preventive Services Task Force. 2011. "Screening for Bladder Cancer: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 155(4): 246-251.
- Muller, H. 2000. "Hereditary Colorectal Cancer: From Bedside to Bench and Back." *Annals of Oncology* 11(4) (Suppl., October): 7.
- Murray, C.J.L., C.M. Michaud, M.T. McKenna, and J.S. Marks. 1998. *U.S. Patterns of Mortality by County and Race: 1965-94*. Cambridge, MA: Harvard Center for Population and Development Studies, 1-97.
- _____, and A.D. Lopez. 1997. "Alternative Projections of Mortality and Disability by Cause 1990-2020: Global Burden of Disease Study." *The Lancet* 349 (May 24): 1498-1504.
- National Aeronautics and Space Administration (NASA), Goddard Institute for Space Studies. 2010. "GISS Surface Temperature Analysis: 2010 Global Temperature and Europe's Frigid Air." Retrieved January 17, 2011, from <http://data.giss.nasa.gov/gistemp/2010november/>.
- National Center for Health Statistics. 1998. "Health, United States: With Socioeconomic Status and Health Chart." Hyattsville, MD (DHHS Publication No. (PHS) 98-1232), 1-464.
- _____. 2002. "Health, United States: With Chartbook on Trends in the Health of Americans." Hyattsville, MD (DHHS Publication No. (PHS) 2002-1232), 1-430.
- National Institutes of Health. 1992. *A Mortality Study of 1.3 Million Persons by Demographic, Social, and Economic Factors: 1979-1985 Follow-up: U.S. National Longitudinal Mortality Study*, eds., E. Rogot, et al. Bethesda, MD.
- Navarro, V. 2009. "What We Mean by Social Determinants of Health." *International Journal of Health Services* 39(3): 423-441. DOI: 10.2190/HS.39.3.a.
- Paes de Barros, R., D. Contreras, J.C. Feres, F.H.G. Ferreira, E. Ganuza, E. Hansen, P.G. Leite, L.F. Lopez-Calva, X. Mancero, F. Medina, et al. 2002. *Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean*. Santiago, Chile: United Nations Economic Commission for Latin America and the Caribbean.
- Panjukanta, P., I. Nuotio, J.D. Terwilliger, K.V.K. Porkka, K. Ylitalo, Pihlajamaki, et al., 1998. "Letter: Linkage of Familial Combined Hyperlipidaemia to Chromosome 1q21-q23." *Nature Genetics* (18) (April): 369-373.
- Patz, J.A., D. Campbell-Landrum, T. Holloway, and J.A. Foley. 2005. "Impact of Regional Climate Change on Human Health." *Nature* 438(17) (November): 310-317. DOI: 10.1038/nature04188.
- Petchesky, R.P. 2003. *Global Prescriptions: Gendering Health and Human Rights*. London, England: Zed Books.
- Pratt, M., C.A. Macera, and C. Blanton. 1999. "Levels of Physical Activity and Inactivity in Children and Adults in the United States: Current Evidence and Research Issues." *Medicine & Science In Sports & Exercise* 31(11) (Supplement): S526-S533.
- PubMed Health. 2011a. "Nephrotic Syndrome: Nephrosis." Retrieved November 22, 2011, from <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001520/>.
- _____. "Alzheimer's Disease; Senile Dementia-Alzheimer's Type (SDAT); SDAT." Retrieved November 22, 2011, from <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001767/>.
- Reich, T. 1988. "Biologic-Marker Studies in Alcoholism." *The New England Journal of Medicine* 318 (January 21): 180-182.
- Roberts, J.A., D. Brown, T. Elkins, and D.B. Larson. 1997. "Factors Influencing the View of Patients with Gynecologic Cancer About End-of-Life Decisions." *American Journal of Obstetrics and Gynecology* 176(1): 166-172.
- Rose, G. 1994. *The Strategy of Preventive Medicine*. New York, NY: Oxford University Press.
- Rowe, J.W., and R.L. Kahn. 1998. *Successful Aging*. New York, NY: Pantheon Books.
- Sacks, F.M., L.P. Svetkey, W.M. Vollmer, L.J. Appel, G.A. Bray, D. Harsha, E. Obarzanek, P.R. Conlin, E.R. Miller III, D.G. Simons-Morton, N. Karanja, and P. Lin. 2001. "Effects on

- Blood Pressure of Reduced Dietary Sodium and the Dietary Approaches to Stop Hypertension (DASH) Diet." *The New England Journal of Medicine* 344(1) (January 4): 3–10.
- Satcher, D. 2010. "Commentary: Include a Social Determinants of Health Approach to Reduce Health Inequities." *Public Health Reports* 125 (Supplement 4): 6–7.
- Sen, A. 1992. *Inequality Reexamined*. Oxford, England: Oxford University Press.
- _____. 1999. *Development as Freedom*. New York, NY: Alfred A. Knopf.
- Shah, M.N. 2006. "The Formation of the Emergency Medical Services." *American Journal of Public Health* 96(3) (March): 414–423.
- Shi, L., and D.A. Singh. 2008. *Delivering Health Care in America: A Systems Approach*, 4th ed. Sudbury, MA: Jones and Bartlett Publishers.
- Sigerist, H. 1970. *Medicine and Human Welfare*. College Park, MD: McGrath Publishing Co.
- Smith, G.D., J.D. Neaton, D. Wentworth, R. Stamler, and J. Stamler. 1996. "Socioeconomic Differentials in Mortality Risk Among Men Screened for the Multiple Risk Factor Intervention Trial: I. White Men." *American Journal of Public Health* 86(4) (April): 486–496.
- Stonich, S.C., and C. Bailey. 2000. "Resisting the Blue Revolution: Contending Coalitions Surrounding Industrial Shrimp Farming." *Human Organization* 59: 23–36.
- Starfield, B. 1973. "Health Services Research: A Working Model." *The New England Journal of Medicine* 289(2): 132–136.
- Svetkey, L.P., D. Simmons-Morton, W.M. Vollmer, L.J. Appel, P.R. Conlin, D.H. Ryan, J. Ard, M. Kennedy, for the DASH Research Group. 1994. "Effects of Dietary Patterns on Blood Pressure: Subgroup Analysis of the Dietary Approaches to Stop Hypertension (DASH) Clinical Trial." *Archives of Internal Medicine* 159 (February 8): 285–293.
- Szreter, S. 2002. "Rethinking McKeown: The Relationship Between Public Health and Social Change." *American Journal of Public Health* 92(5): 722–725.
- The Free Dictionary. 2008. "Severe Acute Respiratory Syndrome (SARS)." Retrieved January 22, 2011, from [http://medical-dictionary.thefreedictionary.com/Severe+Acute+Respiratory+Syndrome+\(S....](http://medical-dictionary.thefreedictionary.com/Severe+Acute+Respiratory+Syndrome+(S....)
- The Robert Wood Johnson Foundation. 2004. "Poor Diets, Little Exercise Leading Cause of Preventable Illness and Deaths." Retrieved November 20, 2011, from <http://www.rwjf.org/reports/grr/032016.htm>.
- The World Bank. 1995. *World Development Report 1995: Workers in an Integrating World*. New York, NY: Oxford University Press.
- _____. 2006. "World Development Indicators" (online). Retrieved November 29, 2010, from <http://devdata.worldbank.org/wdi2006/contents/index2.htm>.
- Timmreck, T.C. 1994. *An Introduction to Epidemiology*. Boston, MA: Jones and Bartlett Publishers.
- Ubokudom, S.E., and J. Khubchandani. 2010. "The Ecology of Health Policymaking and Reform in the United States of America." *World Medical & Health Policy* 2(1), Article 19. DOI: 10.2202/1948-4682.1010.
- United States Department of Health and Human Services (USDHHS). 1988. *The Surgeon General's Report on Nutrition and Health*. Washington, DC (DHHS Publication No. (PHS) 88-50210), 1–750.
- _____. 1996. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA (Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion Publication No. S/N 017-023-00196-5).
- U.S. General Accounting Office. 2003. *Bioterrorism: Public Health Response to Anthrax Incidents of 2001*. Washington, DC: (GAO Report No. 04-152), 1–44.
- United States Preventive Services Task Force (USPSTF) Procedure Manual, 2011. "Section 1: Overview of U.S. Preventive Services Task Force Structure and Processes." Retrieved January 2, 2011, from <http://www.uspreventiveservicestaskforce.org/uspstf08/methods/proceduremanual1.htm>.
- Ventura, S.J., W.D. Mosher, S.C. Curtin, J.C. Abma, and S. Henshaw. 2001. "Trends in Pregnancy Rates for the United States, 1976-97: An Update." *National Vital Statistics Report* 49(4): 1–10.

- Watts, S. 1997. *Epidemics in History: Disease, Power and Imperialism*. New Haven, CT: Yale University Press.
- Wikipedia. 2010. "Health." Retrieved December 8, 2010, from <http://en.wikipedia.org/wiki/Health>.
- Wilkinson, R.G. 1996. *Unhealthy Societies: The Affliction of Inequality*. London, England: Routledge.
- Williams, D.R., and P.B. Jackson. 2005. "Social Sources of Racial Disparities in Health." *Health Affairs* 24(2): 325–334.
- _____. 1990. "Socioeconomic Differences in Health: A Review and Redirection." *Social Psychology Quarterly* 53(12) (June): 81–99.
- Winkelstein, W., Jr. 1993. "Letter: Medical Care is not Health Care." *JAMA* 269(19): 2504.
- Womenshealth.gov. 2011. "Men's Health: Chronic Lower Respiratory Diseases." Retrieved November 20, 2011, from <http://www.womenshealth.gov/mens-health/top-health-concerns-for-men/chronic-lower-r...>
- Woodall, P. 2006. "The New Titans: A Survey of the World Economy." *The Economist* (September 14, 2006). Retrieved January 16, 2011, from <http://www.economist.com/node/7877959/print>.
- World Health Organization (WHO). 1948. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
- _____. 2004. *The World Health Report 2004: Changing History*. Geneva, Switzerland, 1–157.
- Ziskin, L.Z., and D.A. Harris. 2007. "State Health Policy for Terrorism Preparedness." *American Journal of Public Health* 97(9) (September): 1583–1586.

Chapter 7

Demographic Influences

The previous chapters of the book have demonstrated that two of the most serious problems of the health care system are cost inflation and limited access to care for some segments of the population. High costs and access problems are very closely intertwined in that people who cannot afford private health insurance, or those who do not qualify for public insurance programs, such as Medicare and Medicaid, lack the first, and perhaps the most important, prerequisite for access, an insurance card.

Health care inflation and the numerous approaches used to attempt to control costs were dealt with in great detail in Chap. 4. Because the discussion in Chap. 4 did not include the impact of technology on health care inflation, Chap. 5 was devoted to that topic, while Chap. 6 dealt with the physical, social and cultural, and global environments of the health care system. This chapter deals with access to health care, as well as disparities in access and in some vital measures of health among different races and ethnicities in the United States. We begin by defining access to care.

Access to Health Care Services

Access to care has been conceptualized in different ways by different researchers. Some of them have equated access with some population characteristics, such as family income, insurance coverage, and cultural attitudes toward medical care, while others link it to the characteristics of the health care delivery system, such as the locations, distribution, diversity, and organization of health manpower and facilities. Still, others argue that access can be analyzed or evaluated through outcome measures of patients' passage through the health care system, such as rates of utilization or satisfaction with the care received (Aday and Andersen 1974, p. 208; Donabedian 1973; Bodenheimer 1970, p. 26; Freeborn and Greenlick 1973, p. 68).

Those who equate access to health care with the availability of financial and medical resources use rural and urban areas to advance their argument. For example, it is argued that rural and urban dwellers do not have equal access to health care

services. Rural areas are characterized by shortages of personnel and physical facilities, and by the inability of the people to pay for the costs of care. Access to health care in these areas may be impeded by the lack of a sufficient and accessible number of primary care physicians and other specialty providers (Rogers 1973, p. 1377).

Mechanic (1972) argues that the characteristics of health care services and resources are not enough to measure entry or nonentry to the health care system. Rather than concentrating on those factors alone, one must also consider the patients' health care seeking behaviors and their willingness to seek care, which are influenced by the social and cultural beliefs discussed in the previous chapter. This line of reasoning is furthered by the argument that the measurement of access in terms of costs, availability of resources, duration of appointment waiting times, and delays and interruptions in receiving the necessary services, does not tell us whether those who want access to the system actually get it (Somers 1971; Aday and Andersen 1974, p. 210; Fox 1972, p. 272; Beck 1973, p. 341).

Access Frameworks

After careful review of the different conceptualizations of access, Aday and Andersen (1974, p. 211) proposed a framework for the study of access to health care services. This framework conceptualized access "as proceeding from health policy objectives through the characteristics of the health care system and of the populations at risk (inputs) to the outcomes or outputs" of care or the actual utilization of health care services to consumer satisfaction with the utilized services. Except for some revisions to include characteristics of health policy (such as Medicare, Medicaid, and CHIP), and characteristics of the health care delivery system (such as Medicaid managed care and community health centers) (Aday et al. 1980; Docteur et al. 1996, p. 5), the original framework has largely remained intact. We examine the components of the framework below.

Aday's and Andersen's Access Framework

As discussed earlier, the framework has five distinct components: the objectives of health policy, the characteristics of the health care system as well as those of the population needing care, the outputs or outcomes of care or the actual utilization of health services, and consumer satisfaction with the health care services available and utilized.

The Objectives of Health Policy

One of the important goals of health policy is to improve access to the health care system. This goal has very often been considered through the political process. For example, the passage of Medicare and Medicaid in 1965, the setting up of the CHIP

through the *Balanced Budget Amendment* (BBA) of 1997, the provision of grants for physician training and the building of health facilities, are some of the efforts made to increase access to medical care. Therefore, according to Aday and Andersen, it would not be out of place to characterize health policy as the starting point for consideration of the access concept.

The growth of managed care and other cost containment measures that have led to the integration of the financing, delivery, payment, and insurance functions of the health care delivery system induced Docteur et al. (1996, p. 5) to propose a revision of the access framework. Their model depicts access as a two-stage process under managed care. First, managed care enrollees select among the health plans available to them, but they are constrained by structural, financial, and their personal characteristics. Second, after selecting their plans, they seek care under plan- and non-plan-specific constraints. The plans made available and the constraints under each plan are the result of the objectives of the policies under which different managed care plans operate. This revised framework, therefore, takes into account the advent and objectives of managed care.

The Characteristics of the Health Care System

Some of the characteristics of the health care delivery system that affect access to care include the resources of manpower, personnel, and the infrastructure used to deliver care, as well as the means through which patients gain access to the health care system (travel time, waiting time, etc.) and the characteristics of the system that determine what the patients will experience once they gain entry into the system (who the patients see and how they are treated).

The Characteristics of Patients

The characteristics of patients include their need for health services, as well as the predisposing and enabling factors that may induce some patients to use more medical services than others (Andersen and Newman 1973, p. 95). The need for health services involves the illness or acuity level, which dictates the level and amount of health services utilized. This need for care may be either perceived by the patient or determined by a health care provider. Predisposing factors include such demographic characteristics as race, level of education, gender, etc., that exist prior to the patient getting diseased or ill. As we discussed in the previous chapter, predisposing factors are associated with a person's likelihood of using medical care.

Enabling factors focus on the means available to individuals to procure medical services. These include the money available to the patient and his family, the type of insurance coverage available, the health manpower and other resources available in the community where the patient lives, and the prices providers charge for medical care.

The distinction between patients' enabling and predisposing factors can be used to make judgments on the equity of a health care delivery system. For example, if enabling factors, such as socioeconomic status, the lack of health care resources in

a community, and the type of insurance coverage, lead to differences in service utilization, the delivery of health services can be considered inequitable. If, on the other hand, variations in utilization are explained by need, and by such predisposing conditions as age and severity of illness, the delivery of health care can be considered equitable (Gulliford et al. 2002, p. 186; Aday et al. 1994).

According to Aday and Andersen (1974, p. 214), the variables that can be easily manipulated, such as income or health insurance coverage, are characteristics that health policy seeks to change in order to affect access to care. Similarly, as we discussed in Chap. 6, cultural, behavioral, and enabling factors, such as dietary choices, sexual behavior, alcohol intake, income or health insurance coverage, are characteristics that health policy and health education programs seek to change in order to affect peoples' access to medical care and their health outcomes.

The Actual Utilization of Services

The actual utilization of health services involves the kinds of services provided to patients, the provider or providers who provide the services, the settings where care is provided, the purpose for which the service is provided, and the time interval between visits to health providers. Therefore, utilization is concerned with whether the services provided are relevant, whether they are provided by qualified medical personnel in the appropriate setting, whether they are provided in a timely manner when needed, and whether the purpose for which the services are provided is indicated by the patients' diagnostic conditions. For example, preventive checkups that are provided every 6 months by primary care physicians in their offices would probably not be considered irrelevant.

Patient Satisfaction with Utilized Services

This final component of the access framework involves the positive or negative perceptions of those who use the health care system. It involves consumers' subjective perceptions of their experiences with regard to costs, convenience, the courtesy shown by health workers, coordination of care, whether the patients were given relevant, adequate, and timely information on how to manage their illnesses, and their judgments about the quality of care provided. The utilization of services may influence a patient's satisfaction with the health care system, just as the satisfaction or dissatisfaction experienced may influence subsequent utilization of services (Aday and Andersen 1974, p. 216).

Penchansky and Thomas (1981, p. 127) took the empirical approach to identify five dimensions of access to care, namely: availability, accessibility, accommodation, affordability, and acceptability. These five dimensions of access that were proposed and tested were intended to disaggregate the broad and ambiguous notion of access into a set of measures that could be given specific definitions, and for which operational measures could be developed. The definitions of each of the five dimensions of access are presented below.

Penchansky's and Thomas' Access Framework

As was discussed earlier, access is viewed as a general concept that summarizes a set of more specific areas of fit between the patient and the health care system. Availability, one of the terms that has been equated with access, is defined as the relationship between the volume and type of existing services and resources and the patients' volume and types of needs. It is used to refer to the adequacy of the supply of physicians, dentists, clinics and hospitals, and specialized programs and services, such as mental health and emergency care (Penchansky and Thomas 1981, p. 128; Bice et al. 1972, p. 261; Donabedian 1973; Fein 1972, p. 157).

Accessibility, on the other hand, is defined as the relationship between the locations of health facilities and personnel and the locations of patients, taking into account the availability of transportation and travel times, distances, and costs. Similarly, in their discussion of accessibility, Freeborn and Greenlick (1973, p. 68) posit that "individuals should have access to the system at the time and place needed, through a well-defined and known point of entry. A comprehensive range of personnel, facilities, and services that are known and convenient should be available." Furthermore, Simon et al. (1979, p. 894) describe an index of accessibility for outpatient services delivery to include the timeliness of response to patients' request for care, the appropriateness of the response to the request for care, and the time that the patient must expend to be served.

Accommodation refers to the relationship between the manner health services are organized, including systems for making medical appointments, hours of operation, walk-in arrangements and telephone services, and the patient's ability to accommodate to these factors and their perceptions of their appropriateness (Penchansky and Thomas 1981, p. 128; Simon et al. 1979, p. 895).

Penchansky and Thomas define affordability as the relationship between prices of services and the acceptable means of payment, as well as patients' incomes, abilities to pay, and existing health insurance. Also of interest here are patients' perceptions of the worthiness of the medical services and their knowledge of provider prices, total costs, and possible credit arrangements. Similarly, Bice et al. (1972, p. 261) identify access to health care with affordability or patients' socioeconomic status, distance traveled to receive care, and relative lack of supply or availability.

The final dimension of access is acceptability or patients' reactions to such provider characteristics as age, culture, race, gender, ethnicity, type of facility, the neighborhood where the facility is located, and the religious affiliation of the facility or provider. Like patients, providers also have expectations about the types of clients they prefer to serve, and the types of insurance plans they carry. For example, as we discussed in the previous chapter, some providers either do not accept Medicaid beneficiaries or they limit their Medicaid caseloads. Similarly, while elaborating on the acceptability concept, Donabedian (1973) cites the reluctance of some men to see female physicians, and the refusal of some white dentists to treat black patients.

Penchansky's and Thomas' five dimensions of access to health care discussed above are closely related. Whereas accessibility may be closely intertwined with availability in some settings, various service areas with identical availability may

experience different accessibility. In many instances, acceptability, which may involve the race and gender of the provider or some other characteristic, may be a more important determinant of where people receive their health care services than accessibility (Bashshur et al. 1971, p. 61; Morrill and Earickson 1969, p. 128; Studnicki 1975, p. 679). Availability may, and does often, affect accommodation and acceptability. For example, when demand is high relative to supply, physicians may practice patient, price, and insurance coverage discrimination (Sloan et al. 1978, p. 211; Garner et al. 1979, p. 43; Mitchell 1983, p. 929; Mitchell and Schurman 1984, p. 1026; Orr and Forrest 1985, p. 63; Ubokudom 1997, p. 82, 149; Barrilleaux and Miller 1992, p. 97; Fanning and de Alteriis 1993, p. 27; Zuckerman and Welch 1990, p. 39; Gabel and Rice 1985, p. 595; Wedig et al. 1989, p. 601; Cromwell and Mitchell 1984, p. 197; Fuchs 1978, p. 35; Fossett and Peterson 1989, p. 386).

But, although the five access dimensions are closely related, they are distinct enough for Penchansky and Thomas (1981) to measure and study separately. The study concludes that access is a measure of the fit between characteristics of health care providers and health services and characteristics and expectations of clients. Regression analyses, using each of the five dimensions of access as the dependent variable, show that the factors are generally valid measures of the concepts they are hypothesized to represent. In other words, the analysis provides support to the existence and validity of the five dimensions of access to health care services. Other studies, including that of Gulliford and his colleagues, are generally supportive of these conclusions.

Gulliford's and Colleagues' Access Framework

In reviewing how well the British health care system has achieved the founding principles of the National Health Service (NHS) system, Gulliford et al. (2002, p. 186) stress the importance of evaluating four components of the concept of access in the British context. Although the first three components of access they identify (health service availability, health service utilization, and health service outcomes) are generally consistent with those identified in the United States by the studies reviewed above, the British researchers make a special effort to stress a fourth component, equity in the distribution of health services. Their primary concern is that health care resources be utilized to meet the needs of different groups in the population. This provision, they note, is central to the concept of access.

Two types of equity in the distribution of health care services can be identified. First, there is horizontal equity, which implies that people with identical needs should be given identical services. In other words, there should be fairness in access to health care for groups with equivalent needs (Gulliford et al. 2002, p. 188). Second, there is vertical equity, which involves treating people with different health care needs differently or in accordance with their differing needs. This vertical dimension to equity is acknowledged to be more difficult to measure than horizontal equity, partly because there is little consensus on how vertical equity can be judged to exist (van Doorslaer et al. 2000, p. 553; Mooney 1996, p. 99).

Albritton's and Eden's Access Framework

The review by Albritton and Eden (2008, p. 1094) of the evidence that teenagers or adolescents and young adults may be disadvantaged with regard to access to cancer treatment identifies the factors that define access to cancer care to include the least delay between a patient's first symptom or sign of disease and the start of treatment, the experience and expertise of the provider, the availability of evidence-based therapy and clinical trials, and the provision of resources and support services appropriate to the needs of the patient. The review supports the available evidence that teenagers or adolescents and young adults with cancer are disadvantaged with regards to access to care, compared with younger and older patients; recruitments into clinical trials are markedly lower for teenagers and young adults than for children; recruitments into clinical trials are sometimes even lower for teenagers and young adults than for older patients; there is evidence from the United States of delays in the diagnosis of cancer in 15–30 year olds who are under- or uninsured compared to those who have adequate private insurance; there is an average difference of 7 weeks in the lag time in receiving treatment between those with public insurance and those with private insurance; except for tumor type, multivariate analysis shows that type of insurance coverage is more significant in predicting how soon treatment would begin than median household income, age, race, and urban or rural residence; and entry into clinical trials, types of therapy provided, the location of treatment, and the expertise of the health provider all influence survival, quality of life, and satisfaction with care (Albritton and Eden 2008, p. 1094; Bleyer et al. 1997, p. 374, 2005, p. 60). Obviously, the Albritton's and Eden's review clearly points to inequities in cancer treatments and selections of patients for clinical trials in the United States. These inequities are not limited to cancer treatments alone.

The equity concept introduces the principles of fairness and social justice in the health care system (Gulliford et al. 2002, p. 188), concepts that, as the discussion in Chap. 3 shows, generate heated and serious arguments and controversies in the United States.

Justice Principles and Access to Health Care

Ethical standards are norms and standards of behavior that are applied to the work of government officials and citizens for the purposes of guiding and assessing their behavior. Especially when applied to the public sector, ethical standards inform public office holders of how they are expected to act in the course of carrying out their responsibilities. The word “ethics” is not synonymous with “morals.” To be ethical is to live up to some set of accepted norms and standards of behavior, but there is no guarantee that these standards of behavior will be moral in the social, theological, or philosophical sense (Dubnick and Romzek 1991, p. 73).

There are numerous ethical standards in the public policy arena in the United States. Some of these include the ethic of responsiveness (taking into account the

preferences of clients or constituents), majoritarianism (responsiveness to the wants of the majority of the people), utilitarianism (doing the greatest good to the greatest number of people), and equality (treating all clients or constituents the same). Of the four ethical standards listed above, equality is the most widely known in the United States (Dubnick and Romzek 1991, p. 75).

The notion of equality, however, does not imply that all citizens will own the same types and sizes of houses or earn the same salaries. The capitalist culture in the country allows people to accumulate more wealth than others if the disparities are due to differences in their efforts and levels of perseverance. When applied to health care, equality does not imply that all citizens should have identical insurance coverage.

Following the writings of philosopher Rawls (1971, p. 11), a standard of *justice-as-fairness* has also commanded the attention of public policy and administration scholars. As articulated by Rawls, this ethic is based on a strict adherence to the need for equality in the distribution of rights and duties and acceptance of social and economic inequalities only if they result in benefits for every citizen, especially the disadvantaged members of society. In keeping with Rawls' advice, an approach to ethics based on social equity has been advanced.

In a 1971 essay, Frederickson suggested that social equity be added to the classical norms of efficient, economical, and coordinated management as criteria for evaluating the performance of public officials, especially public administrators. The content of social equity is egalitarian in principle and redistributive in policy. The concerns about equitable access to health care services are highlighted by the contrasts between the social and market justice theories of the allocation of health care services. We examine them briefly below.

The Social Justice Model of the Allocation of Health Services

The principle of social justice has been used to criticize the excesses of capitalism, and to describe what the good society should entail (Kristol 1978, p. 57). The social justice principle views the allocation or distribution of health care services as one of the responsibilities of society. Under this model, health care is a social or collective good, not an economic good, and should be collectively financed and available to all citizens, regardless of their socioeconomic status or ability to pay for care. Under the model, the distribution of health care services can best be achieved by allowing government to assume the production and distribution functions.

The social justice model recognizes that resources are limited, or that government just does not have an infinite amount of the health care resources of manpower and equipment. Accordingly, the government must use rational planning tools to determine the amounts and levels of health services to produce, and how to distribute the produced services among the population. The denial of health services because of inability to pay is unjust and inconceivable under the model. Rather than deny services to any citizen, government can limit overconsumption and guarantee a standard package of benefits to every citizen. This approach falls under the planned

rationing, supply-side rationing, or nonprice rationing discussed under the ethical concerns raised by medical technology in Chap. 5. The social justice model contrasts sharply with market justice principles.

The Market Justice Model of the Allocation of Health Services

The starting point for the market justice model is the recognition that health care resources, indeed all resources available to society, are finite. Accordingly, the model views health care as an economic good.

As we discussed in Chap. 4, economic issues are important considerations in public policy discourse (Dye 2008, p. 24). The availability of economic and human resources affect how much health services are produced and consumed, who produces the services, where the services are produced, the types of services produced, and the distribution of the produced services. The model recognizes that the consumption of any good limits what is left for others. Therefore, if more of one good, such as health care, is produced, people will have to do without some other goods, such as food, recreation, clothing, etc.

The market justice model assigns the fair distribution of health services to the market forces in a free economy. Therefore, people are free to purchase the health care services they prefer and are able to pay for. They earn the services when they purchase them with their own money, money that is assumed to have been legally acquired. The model assumes that the conditions necessary for a free and well-functioning market discussed in the final pages of Chap. 2 are in force or operational.

Unlike the social justice model, the denial of health services because of inability to pay is a fact of life under the market justice model. Individuals have responsibility for their health under this model. Accordingly, they demand health care because of the benefits they expect to receive from improved health. These expected benefits induce them to procure health services. These individual decisions do not require guidance from government. The pursuit of individual self-interests yields benefits for society as a whole.

Under the market justice model, equality in health status among the population is not a much sought after goal (Starfield 1998). Individuals who lack the income to pay for services face a financial barrier to obtaining health care services (Santerre and Neun 1996, p. 7). Therefore, price rationing, demand-side rationing, or rationing by ability to pay, which we discussed in Chap. 5, are consistent with the market justice model.

While the public programs of Medicare, Medicaid, and CHIP that are the subject of Chap. 8 are reminiscent of the social justice model of health services allocation, the private insurance system in the United States has largely operated under market justice principles. The rationing of health care based on ability to pay has drastically limited access to care. First, millions of Americans have no health insurance coverage, resulting in delays or forgoing needed care, paying high prices to obtain needed

care, and shifting costs from those who do not have insurance to those who do. Second, an insurance card alone does not eliminate all barriers to access. Additional issues are as important as the possession of an insurance card, including the extent and adequacy of the coverage, whether providers will accept the insurance, the levels of co-payments and deductibles, and adequacy or acceptability of the payments made to medical providers.

In addition, patients with an insurance card can also face serious noneconomic barriers to care that can have dramatic effects on access, utilization, and health outcomes. Consequently, in the remainder of this chapter we examine the extent of uninsurance in the country; the demographic characteristics of the uninsured; the reasons for uninsurance; the consequences of uninsurance; the noneconomic barriers to access; and the health status of the population groups that are very likely to be uninsured and underinsured. We begin by looking at the extent of uninsurance in the United States.

The Extent, Causes, and Consequences of Uninsurance

The number of people with health insurance decreased to 253.6 million in 2009 from 255.1 million in 2008. That was the first year there had been a decline in the number of people with health insurance since 1987, the first year that comparable health insurance data were collected by the US Census Bureau. Similarly, the number of people enrolled in private health insurance plans decreased to 194.5 million in 2009 from 201.0 million in 2008. By contrast, as would be expected from our discussion in Chap. 4, the number of people enrolled in public or government-sponsored health insurance plans increased to 93.2 million in 2009 from 87.4 million in 2008. The trends reported above resulted in about 16.7% of the population, or 50.7 million people not having health insurance in 2009, up from 15.4% and 46.3 million people, respectively, in 2008 (DeNavas-Walt et al. 2010, p. 22). Table 7.1 presents data on some selected demographics of the uninsured between 2008 and 2009.

Analyses of the data presented in Table 7.1 show that in 2009, the uninsured rate and the number of uninsured for non-Hispanic Whites increased to 12.0% and 23.7 million, from 10.8% and 21.3 million in 2008; the uninsured rate and the number of uninsured for Blacks in 2009 were higher than in the previous year, at 21.0% and 8.1 million, from 19.1% and 7.3 million in 2008. For Asians, the uninsured rate and number of uninsured were 17.2% and 2.4 million, down from 17.6% and 2.3 million in 2008. This small decline in the uninsurance rate for the Asian population was statistically insignificant. The uninsured rate and the number of uninsured among Hispanics were 32.4% and 15.8 million in 2009, from 30.7% and 14.5 million people in 2008. Therefore, except for Asians, Whites, Blacks, and Hispanics experienced increased rates of uninsurance between 2008 and 2009.

The uninsurance rate for all persons under 65 years of age increased between 2008 and 2009, with the highest increase occurring among those 25–34 years of age, followed by those 35–44 years old, 18–24 years old, 45–64 years old, and the under 18 years old category, respectively. The percentages of children under 18

Table 7.1 Some selected demographics of the uninsured, 2008–2009^a

Demographics	2008 uninsured			2009 uninsured			Change in uninsured	
	Total	Number	Percent	Total	Number	Percent	Number	Percent
Total	301,483	46,340	15.4	304,280	50,674	16.7	4,335	1.3
White, not Hispanic	197,159	21,322	10.8	197,436	23,658	12.0	2,336	1.2
Black	38,076	7,284	19.1	38,624	8,102	21.0	818	1.8
Asian	13,315	2,344	17.6	14,011	2,409	17.2	65	(0.4)
Hispanic (any race)	47,485	14,558	30.7	48,901	15,820	32.4	1,263	1.7
Under 18 years	74,510	7,348	9.9	75,040	7,513	10.0	165	0.1
18–24 years	28,688	8,200	28.6	29,313	8,923	30.4	723	1.9
25–34 years	40,520	10,754	26.5	41,085	11,963	29.1	1,209	2.6
35–44 years	41,322	8,035	19.4	40,447	8,759	21.7	723	2.2
45–64 years	78,655	11,355	14.4	79,782	12,840	16.1	1,485	1.7
65 years and older	37,788	646	1.7	38,613	676	1.8	30	0.1
Native born	264,733	34,036	12.9	266,674	37,694	14.1	3,658	1.3
Naturalized citizen	15,475	2,792	18.0	16,024	3,044	19.0	252	1.0
Noncitizen	21,274	9,511	44.7	21,581	9,936	46.0	425	1.3
Income ^b less than \$25,000	55,814	13,673	24.5	58,159	15,483	26.6	1,811	2.1
\$25,000–49,999	69,621	14,908	21.4	71,340	15,278	21.4	369	–
\$50,000–74,999	57,525	8,034	14.0	58,381	9,352	16.0	1,318	2.1
\$75,000 or more	118,523	9,725	8.2	116,400	10,561	9.1	836	0.9
Full-time worker ^c	100,626	14,723	14.6	95,808	14,589	15.2	(134)	0.6
Part-time worker ^c	47,837	13,049	27.3	49,376	14,674	29.7	1,625	2.4
Did not work	40,723	10,573	26.0	45,443	13,222	29.1	2,649	3.1

^aNumbers given in thousands; employs single-race concept; details may not add up to totals because of rounding

^bIndicates household income

^cFull-time, all year work or half-time, all year work

Source: DeNavas-Walt, Proctor, and Smith. 2010

years of age, and the elderly 65 years of age and older, who had no health insurance in 2009 were not statistically different from the percentages reported in 2008. This is an indication that even though the rest of the population saw significant declines in insurance coverage partly due to the steep economic recession, CHIP and Medicare buffered children and the elderly from high uninsurance rates.

But even though there was no statistically significant difference in uninsurance among all children between 2008 and 2009, uninsurance rates for children varied by poverty status, age, race, and Hispanic origin. For example, data not shown in Table 7.1 show that children aged 12–17 had a higher rate of uninsurance (11.3%) than those under 6 years of age (9.2%). In 2009, children in poverty were more likely to be uninsured (15.1%) than all children (10%). Also, the uninsurance rates were 7% for

non-Hispanic White children, 11.5% for Black children, 10% for Asian children, and 16.8% for Hispanic children. These 2009 uninsurance rates for children were not statistically different from the corresponding rates for 2008 (DeNavas-Walt et al. 2010).

Although nearly all the elderly 65 years of age and above are covered by Medicare, yet about 676,000 of the elderly were uninsured in 2009, up from 646,000 in 2008, or an increase of 30,000 between 2008 and 2009. These uninsured elderly are very likely to be noncitizens or naturalized citizens who do not qualify for either Medicare or Medicaid. As Table 7.1 shows, about 19% of naturalized US citizens and 46% of noncitizens were without health insurance coverage in 2009. This trend is very likely to continue as pressures to cut social and health benefits to noncitizens and illegal immigrants continue to grow.

As we discussed in Chap. 2 and subsequent chapters of the book, the health insurance system in the United States is largely employer-based. This means that most nonelderly Americans under age 65 receive health insurance coverage through their employer or the employer of a family member (Clemans-Cope and Garrett 2006). But while the possession of a job was closely associated with the possession of health insurance coverage, there has been a steady decline in employer-sponsored health insurance (ESI) coverage since 2000 (The Henry Kaiser Family Foundation 2010, p. 1).

At its peak in 2000, ESI covered about 67% of the nonelderly American population (Blumenthal 2006, p. 83). By 2004, only about 61% of nonelderly Americans under age 65 were covered by ESI, a decline of about 6% from 2000 to 2004 (Clemans-Cope and Garrett 2006). In 2009, about 57% of people in the United States under age 65 received health insurance coverage as an employer benefit (The Henry Kaiser Family Foundation 2010). This is convincing evidence of the continuing decline in ESI and the erosion of the association between employment and health insurance coverage. It is no coincidence, then, that as shown in Table 7.1, 15.2% of the uninsured in 2009 worked full-time, full-year, compared to 14.6% in 2008. Similarly, 29.7% of full-year, part-time workers were uninsured in 2009 compared to 27.3% in 2008. Furthermore, 29.1% of those who did not hold any jobs in 2009 were uninsured compared to 26% in 2008.

Closely associated with the role of employment in influencing the possession of health insurance is family household income. This should be expected since, as we discussed at the beginning of this chapter, income is an enabling factor that allows people to procure medical services (Andersen and Newman 1973, p. 95). Table 7.1 shows a strong linear relationship between household income and the possession of health insurance. As demonstrated by the data, 26.6% of those who had household incomes of less than \$25,000 in 2009 were uninsured, compared to a 24.5% uninsurance rate among that population group in 2008; 21.4% of those whose household incomes were between \$25,000 and \$49,999 were uninsured in each of the 2 years, 2008 and 2009; and only 9.1% of those whose household incomes were \$75,000 or more were uninsured in 2009, compared to 8.2% in 2008. Obviously, as household income increases, the likelihood of being uninsured decreases.

The US Census Bureau data summarized in Table 7.1 do not include a separate category for women, an important and significant subset of the US population. Luckily, the Kaiser Family Foundation and the Urban Institute analyses of the

Census Bureau 2010 Current Population Survey data provide important insights about insurance coverage for women in 2009. According to the evidence, most of the 96 million women ages 18–64 had some form of health insurance coverage in 2009. However, about 20% of women were uninsured that year (Kaiser Family Foundation Women’s Fact Sheets 2010).

Specifically, ESI covered about 59% or 57 million women between the ages of 18 and 64 in 2009, with about 23% of those being covered as dependents. The remaining 36% got job-based insurance in their names through their employers. Further, individually purchased insurance accounted for 6%, Medicaid covered 12% (only very low-income women who were pregnant, had children living with them at home, or those who were disabled, could qualify for Medicaid), and “other” government insurance programs, such as Medicare and TRICARE, accounted for 3% of the coverage of nonelderly women in 2009.

Uninsurance also varies among states and regions of the country. The lowest regional uninsurance rates, which occurred in the Northeastern part of the country, were 11.4, 11.6, and 12.4%, in 2007, 2008, and 2009, respectively. The Midwestern region had the next lowest uninsurance rates with 11.4% for 2007, 11.6% for 2008, and 13.3% for 2009. The rates for the Western part of the country were 16.9% for 2007, 17.4% for 2008, and 18.3% for 2009. Finally, the Southern part of the country had the highest uninsurance rates for those years, with rates of 18.4, 18.2, and 19.7%, respectively, for 2007, 2008, and 2009 (DeNavas-Walt et al. 2010, p. 23, 28).

Between 2008 and 2009, the topmost five states with the lowest nonelderly uninsurance rates expressed in percentages were Massachusetts (5.7), Hawaii (9.4), Minnesota (9.9), Vermont (10.9), and Wisconsin (11.0). During the same period, the bottom-most five states with the highest uninsurance rates expressed in percentages were Texas (28.1), New Mexico (25.7), Florida (25.3), Nevada (22.1), Arizona (21.6), and California (21.4). Consistent with the data on regional variations in uninsurance rates reported above, states in the Northeast had the lowest uninsurance rates while Southern states had the highest rates (The Henry Kaiser Family Foundation Supplemental Data Tables 2010).

The data presented in Table 7.1 show the extent of uninsurance between 2008 and 2009, and important characteristics of the uninsured. But while important causal relationships can be estimated from the evidence, the data do not fully explain the factors that facilitate or mitigate the possession of health insurance. Accordingly, we shall try to shed some more light on the dynamics of the insurance and uninsurance phenomena below.

The Causes of Uninsurance

There are numerous, and oftentimes interrelated, reasons for the prevalence of uninsurance in the country. First, in an employment-based system such as we have in the United States, having a job is instrumental to getting health insurance coverage. But getting insurance through an employer depends on several factors, such as the availability of the

health insurance benefit from the employer, and the employee's ability and willingness to pay their own share of the premiums.

Some of the important factors that determine whether firms will provide insurance benefits to their employees and their dependents are the size of the firms (Claxton et al. 2004); the financial fortunes of the firms, which are influenced by global economic and competitive trends; government policies; and the behaviors of public, private, and nonprofit regulatory agencies, such as the Financial Accounting Standards Board (FASB).

For example, large companies are much more likely to provide the insurance benefit to their employees than small companies. This is due to the fact that the larger firms with large numbers of employees are in a better position to negotiate discounts from insurance companies than smaller companies. As was discussed in Chaps. 2 and 4, large firms' premiums are community-rated (while those of small firms are experience-rated). Similarly, businesses in certain economic sectors, such as the service sector, agriculture, retail sales, and restaurants, are less likely to provide the insurance benefit to their workers than those in other sectors. Like the first example above, this particular point may be due to the size of the businesses and the numbers of their employees (Blumenthal 2006, p. 86; The Henry Kaiser Family Foundation 2010; Claxton et al. 2004).

The manner the Internal Revenue Service (IRS) treats the costs of health insurance benefits is another reason why employers willingly provide health insurance to their employees, and why employees willingly pay their share of the health insurance premiums. The IRS allows employers to count the costs of employee health benefits as part of their business expenditures; self-employed individuals are allowed to deduct their insurance premium costs from their taxes. Similarly, employer health insurance costs are not included in the calculation of employees' incomes. These tax subsidies lower the costs of employer-subsidized health care benefits to both the employer and the employee. Further, employees are currently allowed to set up pretax flexible spending accounts that can be used to offset out-of-pocket health care costs.

Global factors influence the US economy and the provision of health insurance in the country. As we discussed in Chap. 6, globalization is driven by the current worldwide exchange of culture and information, the growth of migration and population mobility, international trade, outsourcing of manufacturing jobs from the developed countries to the developing countries where labor costs are cheaper, and by the increased interdependence of the world's economic system (Ubokudom and Khubchandani 2010, p. 19). Some of the important adverse consequences of globalization that affect the health insurance market and the affordability of health insurance in the United States include the perpetuation and exacerbation of the gap between the rich and the poor, which make the poor or near-poor less likely to afford health insurance; job insecurity and reduced wages and the resulting loss of buying power; the collapse of the large manufacturing businesses that were more likely to offer health insurance benefits than the smaller businesses; and increased availability and demand for illicit drugs and the emergence of new infectious diseases that may make it easier for insurance companies to raise the costs of individually purchased insurance plans.

Federal law, such as the Employee Retirement Income Security Act (ERISA) of 1974, has had some effects on ESI benefits. While the law was specifically intended to protect employee pension funds from abuses, the loopholes built into it have had the effect of preempting the application of state insurance mandates and regulations to the employee benefit plans of self-insured firms. This allows self-insured employers to avoid state minimum benefit requirements. In addition, the law has had the effect of destabilizing employer-sponsored insurance plans through self-selection. In other words, when large, self-insured firms remove their relatively healthy and better-paid employees from private insurance risk pools, premiums for small employers and other firms in the risk pools become more expensive and less affordable, making it more difficult for them to participate in the ESI system (Blumenthal 2006, p. 84).

The FASB, a group of professionals that sets standards for the accounting industry, decreed in 1990 that as of 1992, firms and businesses had to carry the expected future health care expenditures of their retired employees on their balance sheets and financial statements. This directive effectively reduced both the assets of these companies and the values of their stocks. In response, a large number of mid-sized and large firms dropped health insurance coverage for their retired employees. Similarly, public employers who faced the same accounting standards beginning in 1999 have had to rethink their retiree and current employee health insurance benefits and premiums (Ubokudom 2008, p. 22; Blumenthal 2006, p. 84, 85).

Another important factor that has affected the provision and procurement of health insurance is health care cost inflation. As Table 4.1 shows, health care costs have grown at several times the rate of general economic inflation since 1960. The 2008 expenditures of about \$2.3 trillion were slightly over 16% of the nation's GDP. High costs have reduced business profits and employee wages and limited their ability to pay for health insurance costs. Governments and public agencies are not immune to this devastating effect of health care cost inflation. The recent economic downturn that began in December 2007 has devastated the revenues of businesses, governments, and individual citizens. All levels of government are particularly hard hit because the recession has substantially increased their Medicaid and CHIP rolls. The most recent efforts to change public employee collective bargaining laws in Wisconsin, Ohio, and Michigan were partly blamed on high employer health insurance costs. The fights that ensued were reminiscent of the importance that the opposing sides attached to the issues they contested. The manner these disputes are finally resolved will have profound impacts on public employee health insurance benefits, costs, and coverage.

Still, another important factor that has contributed to the growth of uninsurance is the growth in the numbers of part-time and seasonal or temporary workers. More than three-quarters of the uninsured in 2009 were in working families—61% were from families with one or more full-time workers while 16% were from families with part-time workers (The Henry Kaiser Family Foundation 2010).

A part-time job is a form of employment that carries fewer hours per week than a full-time job. According to the US Bureau of Labor Statistics, working part-time is defined as working between 1 and 35 h/week (Wikipedia 2011).

Typically, part-time employees in the United States are not entitled to employee benefits, such as health insurance. They are also unlikely to have health insurance even if they work in companies that provide the benefit to their full-time employees (Patel and Rushefsky 2006, p. 197).

Finally, uninsurance is explained by the fact that the safety-net programs, Medicaid and CHIP, provide coverage to some, but not all, low-income individuals and people with disabilities (The Henry Kaiser Family Foundation 2010, p. 3). As will be discussed in the next chapter devoted to examining health programs for specific population groups, Medicaid and CHIP cover about 20% of the nonelderly population, primarily children, their parents, pregnant women, and disabled individuals. Poor adults without dependent children are now generally ineligible for Medicaid coverage. Even though some children and their parents are still uninsured, adults without dependent children comprise the majority of the uninsured primarily because they are less likely to qualify for Medicaid (The Henry Kaiser Family Foundation 2010, p. 3).

Underinsurance

Apart from the uninsured, there are those who are underinsured. The underinsured have insurance cards, but their coverage is inadequate for their current and future health care needs. These include people whose employer-provided levels of benefits are insufficient or not commensurate with their needs; those with individually purchased private insurance who only procure the levels of benefits they can afford; or those on Medicaid from states that do not cover the optional benefits recommended under federal Medicaid guidelines. In addition, people with severe or complicated diseases that are expensive to treat, such as AIDS, multiple sclerosis (MS), or chronic obstructive pulmonary disease (COPD), may be underinsured.

Uninsurance is not without consequences. In fact, it impacts patients and their utilization of health services, patients' health status and outcomes of care, as well as the health care delivery system itself. We examine the consequences of uninsurance below.

The Consequences of Uninsurance

The lack of health insurance causes serious health problems for the uninsured, as well as serious financial problems for the health care system, the safety net providers that treat a disproportionate proportion of the uninsured, governments that must scramble to stabilize the safety net providers and keep them from closing their doors to the indigent, and results in some uncompensated care costs being shifted to those with insurance.

Specifically, the uninsured are less likely to have a regular source of care and to receive the recommended screenings and treatments for chronic conditions. They are more likely to be hospitalized for avoidable hospital conditions (AHCs); and

they are more likely to receive substandard medical care, to experience delays in their care, or to forgo necessary medical care because of its cost (The Henry Kaiser Family Foundation 2010, p. 10; Aday and Andersen 1984, p. 1331; Wilper et al. 2009, p. 2289; Weissman et al. 1992, p. 2388; Shi and Stevens 2005, p. 148).

Uninsured Americans are more likely to suffer undiagnosed chronic conditions. They are equally more likely to experience deteriorations in health, to report poorer health status, to skip medications, to use emergency departments for routine care, and to be hospitalized than those with insurance. Among elderly and poor or low-income insured persons, increased cost sharing for prescription drugs has been followed by reductions in the use of essential drugs, a higher rate of serious adverse events, and emergency department visits associated with these reductions or curtailment of essential drug use (Ayanian et al. 2000, p. 2061, 2003, p. 2051; Tamblyn et al. 2001, p. 421; Baker et al. 2001, p. 1106; Powell-Griner et al. 1999, p. 882).

The uninsurance problems cited above involve women and children as well. Uninsured children with common childhood illnesses and injuries do not receive the same level of care as others. As a result, they are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions. Disparities are said to exist even among children with special needs, including access to specialists (Institute of Medicine 2002, 2009, p. 60). Similarly, women without private health insurance are less likely than privately insured women to be screened for breast cancer, and their treatment may differ after cancer is diagnosed (Mitchell and Hadley 1997, p. 448; Hand et al. 1991, p. 3429).

Furthermore, uninsured patients and those covered by Medicaid have more advanced breast cancer than privately insured patients when the disease is initially diagnosed. This is very likely due to the fact that uninsured women and those on Medicaid are less likely than privately insured women to receive cancer-screening services (Retchin et al. 1997, p. 1878; Francis et al. 1984, p. 418; Ayanian et al. 1993, p. 329). Cancer survival is worse for uninsured patients and those on Medicaid than for privately insured patients with both localized (tumor that is confined to the breast) and regionalized diseases (tumor that has spread to internal mammary lymph nodes, the chest wall, subcutaneous tissue, or overlying skin) (Ayanian et al. 1993, p. 328).

The uninsured are very likely to incur expensive and unaffordable medical bills when they seek care. When they receive care, they pay a large portion of the bill out-of-pocket and are often charged higher amounts than the insured pay (Hadley et al. 2008, p. W399; Anderson 2007, p. 780; The Henry Kaiser Family Foundation 2010, p. 6). Hospitals often charge uninsured patients two to four times what health insurers and public insurance programs actually pay for hospital services (Anderson 2007, p. 780). This is because there is no intermediary to negotiate discounts for the uninsured. These medical bills put severe strains on the uninsured, thereby straining their physical, social, emotional, and financial well-being (The Henry Kaiser Family Foundation 2010, p. 6).

Adverse health effects occur after people lose health insurance coverage (Lurie et al. 1984, p. 480, 1986, p. 1266). But regaining the lost coverage helps diminish the adverse health effects that occurred during the period of uninsurance (The Henry Kaiser Family Foundation 2010, p. 11). Among previously uninsured adults who gain Medicare coverage upon reaching age 65, preventive care utilization increases, access

to physician and hospital care improves, resulting in improved health and functional status (McWilliams et al. 2007a, p. 2886, b, p. 143). Similarly, upon gaining health coverage, uninsured children receive more timely diagnoses, fewer preventable hospitalizations, and miss fewer days of school (Institute of Medicine 2009, p. 60).

Finally, some studies have examined the association between lack of health insurance and the risk of subsequent mortality. These studies conclude that lacking health insurance is associated with an increased risk of subsequent mortality, an effect that is evident in all sociodemographic health insurance and mortality groups examined (Franks et al. 1993, p. 737; Wilper et al. 2009, p. 2289; Ayanian et al. 2000, p. 2061, 2003, p. 2051; Sorlie et al. 1994, p. 2409; Baker et al. 2006, p. 277).

After adjustment for age and income, persons with Medicare and Medicaid had the highest mortality in comparison with those with employer-sponsored insurance, and uninsured persons had higher mortality than those with employer-sponsored insurance (Sorlie et al. 1994, p. 2409). As was discussed in Chap. 1, the total numbers of annual deaths due to uninsurance are thought to be much higher than the Institute of Medicine's estimates of 18,314 persons reported in 2002. Mortality does not appear to be a short-term consequence of being uninsured. Rather, higher long-term mortality among those who have no insurance appears to be a result of the erosion of the health status of the uninsured over time (Baker et al. 2006, p. 277).

We stated earlier in this chapter, shortly before we launched the discussion of the extent, causes, and consequences of uninsurance and underinsurance, that an insurance card alone does not eliminate all barriers to access to health care services. As our discussion has shown, the other factors that can impact access are the extent and adequacy of the coverage, acceptability of the insurance, the levels of co-payments and deductibles, etc. Furthermore, people with an insurance card may face additional noneconomic barriers to access. In the next two paragraphs we shall briefly examine the noneconomic barriers to care.

Noneconomic Barriers to Access

The noneconomic barriers to care are as important as the economic barriers or the possession of an insurance card. For example, some of the studies we discussed in the previous section reveal that after controlling for such demographic variables as income, insurance status, age, etc., there are still important differences in access and health status among blacks, whites, Hispanics, and women. While it is likely that methodological difficulties may have contributed to some of the disparities reported by researchers, the differences by race or ethnicity and gender are substantial and persist across numerous studies employing a variety of methodological techniques (Billings 1999, p. 414).

Although it is difficult to draw definitive conclusions, the effects of intended and unintended racial, cultural, and gender bias within the health care delivery system cannot be dismissed casually. Stated differently, it is possible that race, gender, social isolation of ethnic minorities and their distrust of Western medicine, unfamiliarity with the health care delivery system, different perceptions of disease and

illness, differences in care seeking behaviors and methods of treatment, distrust of providers that are culturally different from the patient, language difficulties, or, for illegal immigrants, the fear of being apprehended and deported, can have independent effects on the utilization of health care services, and on the outcomes of care (Billings 1999, p. 414). Therefore, the rest of this chapter is devoted to examining the available data on the disparities in selected health measures among different segments of the population.

Demographic Differences in Select Health Indicators Among the Population

We have selected a few health indicators from the 33rd annual report on the health status of the United States prepared in 2009 by the Department of Health and Human Services (DHHS) to show the health disparities prevalent among the population. The specific variables examined are the gender and racial differences in life expectancy; gender and racial differences in age-adjusted homicide and HIV deaths, behavioral risk factors, and mammography use; racial and ethnic variations in obesity, physical activity, and infant and maternal mortality rates; and the racial and ethnic differences in the use of prenatal care. The data are summarized below in Table 7.2.

Differences in Life Expectancy

In 1990, life expectancies at birth for white males and females were 72.7 and 79.4 years, respectively. In the same year, life expectancies at birth for black males and females were 64.5 and 73.6 years, respectively. In 2006, the white male and white female life expectancies had increased to 75.7 and 80.6 years, while those of black males and black females were 69.7 and 76.5 years, respectively. Therefore, while the gaps in life expectancy between the black and white populations have narrowed, there are still some substantial differences between the two groups.

Variations in Homicide and HIV Deaths

Deaths due to homicide in 1990 were 5.5 per 100,000 population for Whites, 36.3 for Blacks, 10.4 for American Indians or Alaska Natives, 5.0 for Asians or Pacific Islanders, and 16.2 for Hispanics or Latinos. By 2006, homicide death rates per 100,000 population were 3.7 for Whites, 21.6 for Blacks, 7.5 for American Indians or Alaska Natives, 2.8 for Asians or Pacific Islanders, and 7.3 for Hispanics or Latinos. Therefore, even though all five population groups experienced substantial declines in homicide rates between 1990 and 2006, the 2006 Black rate was about three times the rates for American Indians and Hispanics, and approximately six times the rates for Asians and Whites.

Table 7.2 Differentials in health status indicators, 2009^a

Demographic variables					
A					
	Life expectancy in years				
	1990	2000	2004	2006	% Change, 1990–2006
Males	71.8	74.1	74.9	75.1	4.6
Females	78.8	79.3	79.9	80.2	1.8
White males	72.7	74.7	75.4	75.7	4.1
White females	79.4	79.9	80.4	80.6	1.5
Black males	64.5	68.2	69.3	69.7	8.1
Black females	73.6	75.1	76.0	76.5	3.9
B					
	Age-adjusted homicide deaths/100,000 population				
Whites	5.5	3.6	3.6	3.7	(32.7)
Blacks	36.3	20.5	20.1	21.6	(40.5)
American Indian or Alaska Native	10.4	6.8	7.0	7.5	(27.9)
Asian or Pacific Islander	5.0	3.0	2.5	2.8	(44.0)
Hispanic or Latino	16.2	7.5	7.2	7.3	(54.9)
C					
	HIV deaths/100,000 population				
Male	18.5	7.9	6.6	5.9	(68.1)
Female	2.2	2.5	2.4	2.2	0
White male	14.1	3.8	3.4	2.8	(80.1)
White female	0.7	0.7	0.6	0.6	(14.3)
Black male	46.3	35.1	29.6	26.3	(43.2)
Black female	10.1	13.2	13.0	12.2	20.8
Hispanic male	28.8	10.6	8.2	7.0	(75.7)
Hispanic female	3.8	2.9	2.4	1.9	(50.0)
D					
	Percent of mothers who smoked during pregnancy				
	1990	2000	2005	2006	% Change, 1990–2006
All races	18.4	12.2	12.4	12.2	(33.7)
White	19.4	13.2	13.2	13.0	(32.9)
Black	15.9	9.1	10.0	9.8	(38.4)
American Indian or Alaska Native	22.4	20.0	21.7	21.2	(5.3)
Asian or Pacific Islander	5.5	2.8	2.4	2.4	(56.4)
Hispanic or Latina	6.7	3.5	2.7	2.6	(61.2)
E					
	Percent of women having mammograms				
	1990	2000	2005	2008	% Change, 1990–2008
Total 40 years and over	51.4	70.4	66.8	67.6	31.5
White	52.7	72.2	68.3	68.7	30.4
Black	46.0	67.9	65.2	68.3	48.5
Hispanic or Latina	45.2	61.2	58.8	61.2	35.4
Asian	46.0	53.5	54.6	66.1	43.7

(continued)

Table 7.2 (continued)

Demographic variables					
F	Percentage of population overweight or obese				% Change, 1988–2006
	1988–1994	1999–2002	2003–2006	2007–2010	
Both males and females	22.9	30.4	33.4	–	45.8
Males	20.2	27.5	32.4	–	50.1
Females	25.5	33.2	34.3	–	34.5
White males	20.3	28.0	32.4	–	59.6
White females	22.9	30.7	31.6	–	37.9
Black males	20.9	27.8	35.7	–	70.8
Black females	38.3	48.6	53.4	–	39.4
Mexican males	23.8	27.8	29.5	–	23.9
Mexican females	35.2	38.0	41.8	–	18.7
G	Percent adults not involved in physical activities				% Change, 1998–2007
	1998	2006	2007	2008	
Whites	38.8	38.2	37.4	–	(3.6)
Blacks	52.2	48.9	51.0	–	(2.3)
American Indians or Alaska Natives	49.2	32.8	39.6	–	(19.5)
Asians	39.4	39.8	38.9	–	(1.3)
Hispanics	55.5	53.4	51.3	–	(7.6)
H	Percent live births/third-trimester prenatal care or no prenatal care				% Change, 1980–2006
	1980	1990	2005	2006	
All races	5.1	6.1	7.7	8.2	60.8
Whites	4.3	4.9	7.0	7.5	74.4
Blacks	8.9	11.3	11.5	11.9	33.7
American Indians or Alaska Natives	15.2	12.9	12.7	12.4	(18.4)
Asian or Pacific Islander	6.5	5.8	6.6	7.2	10.8
Hispanic or Latina	12.0	12.0	11.9	12.2	1.7
I	Maternal mortality/100,000 live births				% Change, 1980–2006
	1980	1990	2005	2006	
All ages, age adjusted	9.4	7.6	12.4	11.2	19.1
Whites	6.7	5.1	9.1	8.1	20.8
Blacks	24.9	21.7	31.7	28.7	15.3
Hispanic or Latina	–	7.4	8.2	8.8	18.9 ^b

– Not reported

^aThe original data source has clarifications of the measures reported and computation methods^bPercent difference from 1990 to 2006

Source: US Department of Health and Human Services. Health, United States, 2009 (Data, pp. 73, 99, 123, 132, 143, 159, 162, 184, 191, 231, 299, and 302)

The HIV death rates per 100,000 population in 1990 were 14.1 for White males, 46.3 for Black males, and 28.8 for Hispanic males. The HIV death rate for Black males peaked in 1995, at 89.0 deaths per 100,000 population, while White and Hispanic rates for the same year were 17.9 and 40.8 deaths per 100,000 population, respectively. In 2000, the HIV death rates per 100,000 population were 3.8 for White males, 35.1 for Black males, and 10.6 for Hispanic males. The 2006 rates per 100,000 population were 2.8 for White males, 26.3 for Black males, and 7.0 for Hispanic males. Even though all three male groups have seen declines in HIV death rates from 1990 to 2006, the Black male death rate in 2006 was almost nine times that of White males, and about four times that of Hispanic males.

The HIV death rates for females of the three population groups are much lower than those of their male counterparts. Additionally, similar to the male statistics, the female HIV death rates show steady declines from 1990 to 2006. In 1990, the HIV death rates per 100,000 population were 0.7 for White females, 10.1 for Black females, and 3.8 for Hispanic females. By 2006, the HIV death rates per 100,000 population were 0.6 for White females, 12.2 for Black females, and 1.9 for Hispanic females. The 2006 Black female HIV death rate was approximately 20 times that of White females, and approximately six times that of Hispanic females. Black females actually experienced an increase of 20.8% in the HIV death rates per 100,000 population between 1990 and 2006. Also, of the 35,962 new HIV cases diagnosed in 2007, most of the incidences were among Blacks, followed by Whites, Hispanics, Asians, American Indians or Alaska Natives, and Native Hawaiians or other Pacific Islanders, respectively. Therefore, similar to the other cases we have already examined, there are significant disparities in HIV infections and deaths among different racial and ethnic groups in the country.

Variations in Behavioral Risk Factors

The 2009 health data revealed high prevalence of behavioral and risk factors, such as tobacco use, high cholesterol, obesity, and sedentary lifestyles, which may induce chronic diseases and ailments such as heart disease, cancer, diabetes, and hypertension (DHHS 2009). The rate of decline in tobacco use has slowed markedly since 1995. In 2007, 22% of men and 17.5% of women smoked. In 2006, 12.2% of all mothers smoked during pregnancy. The 2006 smoking rates for pregnant women of different races and ethnicities were 13% for White women, 9.8% for Black women, 21.2% for American Indian women, and 2.4% for Asian women.

Differences in Mammography Usage

The use of mammography by all women 40 years of age and over was only slightly above 50% in 1990. In that year, the usage rate for White women was about 53% while Hispanic, Asian, and Black women were all below 50%. Between 1990 and 2000, mammography use by all women 40 years of age and over increased by an

average of 37%. The specific increases were 35% for Hispanic women, 16% for Asian women, 37% for White women, and 48% for Black women.

Except for Asian women, who experienced an insignificant 1% increase in mammography usage between 2000 and 2005, Hispanic, White, and Black women experienced declines during the same time period. The 2008 rates for all five groups (all women, Hispanics, Asians, White, and Blacks) were higher than the 2005 rates, and were evenly distributed among the five groups, with an average usage rate of 66%. These data show that mammography usage rates for all five women groups are substantially lower than optimum, with the optimum point defined here as a 100% usage rate. The total usage rate in 2008 was about 34 points less than 100%. It remains to be seen what the effects of the USPSTF downgrading of its recommendation for routine mammography in women from grade B to C will be.

Variations in Obesity and Physical Activity

The prevalence of obesity is equally troubling. Slightly over 33% of adults 20 years of age and over were classified as obese between 2003 and 2006. Obesity rates among women continue to vary by race and ethnicity, with about 53% of non-Hispanic Black women 20 years of age and over being classified as obese between 2003 and 2006, compared with about 32% of White women and 42% of Mexican women. The rates for males were about 32% for Whites, 36% for Blacks, and 29% for Mexicans. Incidentally, the 2007 male and female rates of noninvolvement in leisure-time physical activity were 37% for Whites, 51% for Blacks, 40% for American Indians, 39% for Asians, and 51% for Hispanics. Involvement in physical activity declined for all the population groups examined between 1998 and 2007. Despite increased publicity of the importance of exercise to health, the percentage of adults 18 years of age and over who engage in leisure-time physical activity has not increased between 1998 and 2007 (DHHS 2009).

Variations in Prenatal Care and Infant and Maternal Mortality Rates

The United States' infant mortality rate continues to lag behind levels in many other developed countries. Of the 37 countries ranked in 2009, the United States was close to the bottom, at number 28. At a time when Medicaid and CHIP have been expanded to cover more and more children, the poor performance on this measure points to other factors, other than medical care, that might be influencing infant mortality rates. These are likely to include social and cultural factors and parental educational levels.

Similarly, at a time of generous medical benefits for pregnant women, 8.2% of the live births recorded in 2006 were for women who had no prenatal care, or for those who began prenatal care during the third trimester of pregnancy. American Indians or Alaska Natives were most likely to have no prenatal care, or to begin prenatal care during the third trimester of pregnancy, followed by Blacks, Asians or Pacific Islanders, and Whites, respectively. Except for American Indians or Alaska

Natives, the percentages of women who had no prenatal care, or began care during the third trimester of pregnancy, increased between 1980 and 2006. Furthermore, maternal deaths increased for all women groups between 1990 and 2006. Most of the 2006 maternal deaths occurred among Blacks, at 28.7 per 100,000 live births, followed by Hispanics at 8.8 deaths, and Whites at 8.1 deaths per 100,000 live births (DHHS 2009).

The uninsurance rates and health disparities among segments of the population of the United States documented in this chapter would very likely have been worse had it not been for specific health programs that have been put in place by states, local units of government, and the national government to provide a safety net for the poor, elderly, disabled, and pregnant women and their children. Some of these programs, such as Medicare and Medicaid, date back to 1965 and cover a large segment of the vulnerable population; the other, the CHIP, was enacted through the federal BBA of 1997. The 1997 BBA also made significant changes in the Medicare program.

Conclusion

This chapter is devoted to discussing disparities in access to health care services and in some select health measures among various segments of the population of the United States. Access to health care services is a measure of the fit between characteristics of health care providers and health services and characteristics and expectations of clients. In assessing the accessibility of health services, one must consider vertical and horizontal equity. The market justice model that largely informs health care delivery and policymaking in the United States leads to uninsurance and underinsurance and inequity in health services distribution. Behavioral, geographic, economic, and demographic factors, as well as inequity in the distribution and consumption of health care services, lead to serious and significant disparities in the health status of the population. Had it not been for the safety net programs that are in place to protect the indigent and vulnerable members of society, these health disparities probably would have been worse. Therefore, the next chapter looks at the existing safety net health programs of Medicare, Medicaid, and CHIP.

Review Questions

1. Identify the different models or frameworks used to measure or analyze access to health care services.
2. What are the dimensions of equitable health care services?
3. What are the differences between the social and market justice models of the allocation of health care services?
4. What factors cause the uninsurance problems in the United States?

5. Explain why the noneconomic barriers to care are as important as the economic barriers.
6. What factors explain the disparities in health status among the population?
7. Based on what you learned in this chapter and in Chap. 6, would providing every citizen with an insurance card eliminate the health disparities prevalent in the population? Elaborate.

References

- Aday, L., and R. Andersen. 1974. "A Framework for the Study of Access to Medical Care." *Health Services Research* 9(3) (Fall): 208–220.
- . 1984. "The National Profile of Access to Medical Care: Where Do We Stand?" *American Journal of Public Health* 74(12) (December): 1331–1339.
- Aday, L.A., R. Andersen, and G.V. Fleming. 1980. *Health Care in the U.S.: Equitable for Whom?* Newbury Park, CA: Sage.
- . C.E. Begley, D.R. Lairson, and C.H. Slater. 1994. *Evaluating the Medical Care System: Effectiveness, Efficiency, and Equity*. Ann Arbor, MI: Health Administration Press.
- Albritton, K.H., and T. Eden. 2008. "Review: Access to Care." *Pediatric Blood Cancer* 50: 1094–1098. DOI 10.1002/pbc.21461.
- Andersen, R., and J. Newman. 1973. "Societal and Individual Determinants of Medical Care Utilization." *Milbank Memorial Fund Quarterly: Health and Society* 51(1) (Winter): 95–124.
- Anderson, G. 2007. "From 'Soak the Rich' To 'Soak the Poor': Recent Trends in Hospital Pricing." *Health Affairs* 26(4): 780–789.
- Ayanian, J.Z., J.S. Weissman, E.C. Schneider, J.A. Ginsburg, and A.M. Zaslavsky. 2000. "Unmet Health Needs of Uninsured Adults in the United States." *JAMA* 284(16) (October 25): 2061–2069.
- . A.M. Zaslavsky, J.S. Weissman, E.C. Schneider, and J.A. Ginsburg. 2003. "Undiagnosed Hypertension and Hypercholesterolemia Among Uninsured and Insured Adults in the Third National Health Nutrition Examination Survey." *American Journal of Public Health* 93(12) (December): 2051–2054.
- Ayanian, J., B. Kohler, T. Abe, and A. Epstein. 1993. "The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer." *The New England Journal of Medicine* 329 (July): 326–331.
- Baker, D.W., J.J. Sudano, J.M. Albert, E.A. Borawski, and A. Dor. 2001. "Lack of Health Insurance and Decline in Overall Health in Late Middle Age." *The New England Journal of Medicine* 345(15) (October): 1106–1112.
- . R. Durazo-Arvizu, J. Feinglass, W.P. Witt, and J. Thompson. 2006. "Health Insurance Coverage and the Risk of Decline in Overall Health and Death Among the Near Elderly, 1992–2002." *Medical Care* 44(3) (March): 277–282.
- Barrilleaux, C.J., and M.E. Miller. 1992. "Decisions Without Consequences: Cost Control and Access in State Medicaid Programs." *Journal of Health Politics, Policy and Law* 17(1): 97–118.
- Bashshur, R.L., G.W. Shannon, and C.A. Metzner. 1971. "Some Ecological Differentials in the Use of Medical Services." *Health Services Research* 6(1) (Spring): 61–75.
- Beck, R.G. 1973. "Economic Class and Access to Physician Services Under Public Medical Care Insurance." *International Journal of Health Services* 3(3) (Summer): 341–355.
- Bice, T.W., R.L. Eichhorn, and P.D. Fox. 1972. "Socioeconomic Status and Use of Physician Services: A Reconsideration." *Medical Care* 10(3) (May–June): 261–271.
- Billings, J. 1999. "Access to Health Care Services. In *Health Care Delivery in the United States*, 6th ed., eds. A.R. Kovner and S. Jonas. New York, NY: Springer Publishing Company, 401–438.

- Bleyer, A., C. Ulrich, S. Martin, M.F. Munsell, G.O. Lange, and S.H. Taylor. 2005. "Status of Health Insurance Predicts Time from Symptom Onset to Cancer Diagnosis (TDx) in Young Adults." *Journal of Clinical Oncology*, 2005 ASCO Annual Meeting Proceedings 23(165) (Part 1 of 11) (June 1 Supplement): 60–79.
- Bleyer, W.A., H. Tejeda, S.B. Murphy, L.L. Robison, J.A. Ross, B.H. Pollock, R.K. Severson, O.W. Brawley, M.A. Smith, and R.S. Ungerleider. 1997. "National Cancer Clinical Trials: Children Have Equal Access; Adolescents Do Not." *Journal of Adolescent Health* 21(6) (December): 366–373.
- Blumenthal, D. 2006. "Employer-Sponsored Health Insurance in the United States – Origins and Implications." *The New England Journal of Medicine* 355(1): 82–88.
- Bodenheimer, T.S. 1970. "Patterns of American Ambulatory Care." *Inquiry* 7 (September): 26–37.
- Claxton, G., I. Gil, B. Finder, and E. Holve. 2004. "Employer Health Benefits 2004 Annual Survey." Menlo Park, CA and Chicago, IL: The Henry Kaiser Family Foundation and Health Research and Educational Trust.
- Clemans-Cope, L., and B. Garrett. 2006. "Changes in Employee-Sponsored Health Insurance Sponsorship, Eligibility and Participation: 2001 to 2005." Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.
- Cromwell, J., and J.B. Mitchell. 1984. "An Economic Model of Large Medicaid Practices." *Health Services Research* 19(2) (June): 197–216.
- DeNavas-Walt, C., B.D. Proctor, and J.C. Smith. 2010. *Income, Poverty, and Health Insurance Coverage in the United States: 2009*. (U.S. Census Bureau, Current Population Reports, P60–238), Washington, DC: U.S. Government Printing Office, 1–79.
- Docteur, E.R., D.C. Colby, and M. Gold. 1996. "Shifting the Paradigm: Monitoring Access in Medicare Managed Care." *Health Care Financing Review* 17(4) (Summer): 5–21.
- Donabedian, A. 1973. *Aspects of Medical Care Administration*. Cambridge, MA: Harvard University Press.
- Dubnick, M.J., and B.S. Romzek. 1991. *American Public Administration: Politics and the Management of Expectations*. New York, NY: Macmillan.
- Dye, T.R. 2008. *Understanding Public Policy*, 12th ed. Upper Saddle River, NJ: Pearson/Prentice Hall.
- Fanning, T., and M. de Alteriis. 1993. "The Limits of Marginal Economic Incentives in the Medicaid Program: Concerns and Cautions." *Journal of Health Politics, Policy and Law* 18(1) (Spring): 27–42.
- Fein, R. 1972. "On Achieving Access and Equity in Health Care." *Milbank Memorial Fund Quarterly* 50(4) (Part 2): 157–190.
- Fossett, J., and J. Peterson. 1989. "Physician Supply and Medicaid Participation: The Causes of Market Failure." *Medical Care* 27(4) (April): 386–396.
- Fox, P.D. 1972. "Access to Medical Care for the Poor: A Federal Perspective." *Medical Care* 10(3) (May-June): 272–277.
- Francis, A.M., L. Polissar, and A.B. Lorenz. 1984. "Care of Patients With Colorectal Cancer: A Comparison of a Health Maintenance Organization and Fee-For-Service Practices." *Medical Care* 22(5) (May): 418–429.
- Franks, P., C.M. Clancy, and M. Gold. 1993. "Health Insurance and Mortality: Evidence From A National Cohort." *JAMA* 270(6) (August): 737–741.
- Frederickson, H.G. 1971. "Organization Theory and New Public Administration." In *Toward a New Public Administration*, ed. F. Marini. New York, NY: Chandler Press, 309–331.
- Freeborn, D.K., and M.R. Greenlick. 1973. "Evaluation of the Performance of Ambulatory Care Systems: Research Requirements and Opportunities." *Medical Care* 11(2) (Supplement): 68–75.
- Fuchs, V.R. 1978. "The Supply of Surgeons and the Demand for Operations." *Journal of Human Resources* 13 (Supplement): 35–56.
- Gabel, J.R., and T.H. Rice. 1985. "Reducing Public Expenditures for Physician Services: The Price of Paying Less." *Journal of Health Politics, Policy and Law* 9(4) (Winter): 595–609.

- Garner, D.D., W.C. Liao, and T.R. Sharpe. 1979. "Factors Affecting Physician Participation in a State Medicaid Program" *Medical Care* 17(1): 43–53.
- Gulliford, M., J. Figueroa-Munoz, M. Morgan, D. Hughes, B. Gibson, R. Beech, and M. Hudson. 2002. "What Does 'access' to health care Mean?" *Journal of Health Services Research and Policy* 7(3) (July): 186–188.
- Hadley, J., J. Holahan, T. Coughlin, and D. Miller. 2008. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs* 27(5): W399–W415. DOI: 10.1377/hlthaff.2.7.5.w399.
- Hand, R., S. Sener, J. Imperato, J.S. Chmiel, J.A. Sylvester, and A. Fremgen. 1991. "Hospital Variables Associated With Quality of Care for Breast Cancer Patients." *JAMA* 266(24): 3429–3432. DOI: 10.1001/jama.1991.03470240051031.
- Institute of Medicine. 2002. *Health Insurance is a Family Matter*. Washington, DC: National Academies Press, 1–278.
- _____. 2009. *America's Uninsured Crisis, Consequences for Health and Health Care*. Washington, DC: National Academies Press, 1–215.
- Kristol, I. 1978. "A Capitalist Conception of Justice." In *Ethics, Free Enterprise, and Public Policy: Original Essays on Moral Issues in Business*, eds. R.T. De George and J.A. Pichler, New York, NY: Oxford University Press, 57–69.
- Lurie, N., N.B. Ward, M.F. Shapiro, R.H. Brook. 1984. "Special Report: Termination From Medi-Cal—Does It Affect Health?" *The New England Journal of Medicine* 311(7) (August): 480–484.
- _____. C. Gallego, R. Vaghaiwalla, and R.H. Brook. 1986. "Special Report: Termination of Medi-Cal Benefits: A Follow-Up Study One Year Later." *The New England Journal of Medicine* 314(19) (May): 1266–1268.
- McWilliams, J.M., E. Meara, A.M. Zaslavsky, and J.Z. Ayanian. 2007a. "Health of Previously Uninsured Adults After Acquiring Medicare Coverage." *JAMA* 298(24) (December): 2886–2894.
- _____. "Use of Health Services by Previously Uninsured Medicare Beneficiaries." *The New England Journal of Medicine* 357(2) (July): 143–153.
- Mechanic, D. 1972. *Public Expectations and Health Care: Essays on the Changing Organization of Health Services*. New York, NY: John Wiley and Sons.
- Mitchell, J.B. 1983. "Medicaid Participation by Medical and Surgical Specialists." *Medical Care* 21(9): 929–938.
- _____. and R. Schurman. 1984. "Access to Private Obstetrics/Gynecology Services Under Medicaid." *Medical Care* 22(11): 1026–1037.
- Mitchell, J., and J. Hadley. 1997. "The Effect of Insurance Coverage on Breast Cancer Patient's Treatment and Hospital Choices." *The American Economic Review* 87(2) (May): 448–453.
- Mooney, G. 1996. "And Now for Vertical Equity? Some Concerns Arising from Aboriginal Health in Australia." *Health Economics* 5(2) (March–April): 99–103.
- Morrill, R., and R. Earickson. 1969. "Locational Efficiency of Chicago Area Hospitals: An Experimental Model." *Health Services Research* 4(2) (Summer): 128–141.
- Orr, M.T., and J. Forrest. 1985. "The Availability of Reproductive Health Services from U.S. Private Physicians." *Family Planning Perspectives* 17(2): 63–69.
- Patel, K., and M. Rushefsky. 2006. *Health Care Politics and Policy in America*, 3rd ed. Armonk, NY: Sharpe.
- Penchansky, D.B.A., and W. Thomas. 1981. "The Concept of Access: Definition and Relationship to Consumer Satisfaction." *Medical Care* 19(2): 127–140.
- Powell-Griner, E., J. Bolen, and S. Bland. 1999. "Health Care Coverage and Use of Preventive Services Among the Near Elderly in the United States." *American Journal of Public Health* 89(6) (June): 882–886.
- Rawls, J. 1971. *A Theory of Justice*. Cambridge, MA: Belknap Press.
- Retchin, S.M., L. Penberthy, C. Desch, R. Brown, D.E.B. Jerome, and D. Clement. 1997. "Perioperative Management of Colon Cancer Under Medicare Risk Programs." *Archives of Internal Medicine* 157(16) (September): 1878–1884.
- Rogers, D.E. 1973. "Shattuck Lecture: The American Health-Care Scene." *New England Journal of Medicine* 228 (June): 1377–1383.

- Santerre, R.E., and S.P. Neun. 1996. *Health Economics: Theories, Insights, and Industry Studies*. Chicago, IL: Irwin.
- Shi, L., and G.D. Stevens. 2005. "Vulnerability and Unmet Health Care Needs: The Influence of Multiple Risk Factors." *Journal of General Internal Medicine* 20(2) (February): 148–154. DOI: 10.1111/j.1525–1497.2005.40136.x
- Simon, H., A. Reisman, S. Javad, and D. Sachs. 1979. "An Index of Accessibility for Ambulatory Health Services." *Medical Care* 17(9) (September): 894–901.
- Sloan, F.A., J. Mitchell, and J. Cromwell. 1978. "Physician Participation in State Medicaid Programs." *Journal of Human Resources* 13 (Supplement): 211–245.
- Somers, A.R. 1971. *Health Care in Transition: Directions for the Future*. Chicago, IL: Hospital Research and Educational Trust, 23.
- Sorlie, P.D., N.J. Johnson, E. Backlund, D.D. Bradham. 1994. "Mortality in the Uninsured Compared With That in Persons With Public and Private Health Insurance." *Archives of Internal Medicine* 154(21) (November): 2409–2416.
- Starfield, B. 1998. *Primary Care and Health Services*. Oxford, England: Oxford University Press.
- Studnicki, J. 1975. "The Minimization of Travel Effort as a Delineating Influence for Urban Hospital Service Areas." *International Journal of Health Service* 5(4): 679–693.
- Tamblyn, R., R. Laprise, J.A. Hanley, M. Abrahamowicz, S. Scott, N. Mayo, J. Hurley, R. Grad, E. Latimer, R. Perreault, P. McLeod, A. Huang, P. Larochelle, and L. Mallet. 2001. "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Persons." *JAMA* 285(4) (January): 421–429.
- The Henry Kaiser Family Foundation. 2010. *The Uninsured: A Primer (Key Facts About Americans Without Health Insurance)*. Menlo Park, CA, 1–38.
- The Henry Kaiser Family Foundation Women's Fact Sheet, Women's Health Policy Facts. 2010. "Women's Health Insurance Coverage." Publication No. 6000–08, Retrieved January 2, 2011, from <http://www.kff.org>.
- The Henry Kaiser Family Foundation Supplemental Data Tables. 2010. Retrieved January 2, 2011, from <http://www.kff.org>.
- Ubokudom, S.E. 1997. *Physician Participation in Medicaid Managed Care*. New York, NY: Garland Publishing, Inc.
- _____. 2008. "Employer-Sponsored Insurance (ESI), Medicare and Medicaid Policy Changes, and the Future." *Pulse* (Ohio Chapter, American College of Surgeons, Membership Edition, 2008 Desktop Reference Guide): 19–25.
- _____. and J. Khubchandani. 2010. "The Ecology of Health Policy Making and Reform in the United States of America." *World Medical and Health Policy* 2(1): Article 19. DOI: 10.2202/1948–4682.1010.
- United States Department of Health and Human Services (DHHS). 2009. *Health, United States, 2009: With Special Feature on Medical Technology*. National Center for Health Statistics, Hyattsville, MD: U.S. Government Printing Office, 1–563.
- van Doorslaer, E., A. Wagstaff, H. van der Burg, T. Christiansen, D. De Graeve, I. Duchesne, U-G. Gerdtham, M. Gerfin, J. Geurts, L. Gross, U. Hakkinen, J. John, J. Klavus, R.E. Leu, B. Nolan, O. O'Donnell, C. Propper, F. Puffer, M. Schellhorn, G. Sundberg, and O. Winkelhake. 2000. "Equity in the Delivery of Health Care in Europe and the U.S." *Journal of Health Economics* 19(5) (September): 553–583.
- Wedig, G., J.B. Mitchell, and J. Cromwell. 1989. "Can Price Controls Induce Optimal Physician Behavior?" *Journal of Health Politics, Policy and Law* 14(3) (Fall): 601–620.
- Weissman, J.S., C. Gatsonis, and A.M. Epstein. 1992. "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland." *JAMA* 268(17) (November): 2388–2394.
- Wikipedia. 2011. "Part-time." Retrieved March 2, 2011, from (<http://en.wikipedia.org/wiki/Part-time>).
- Wilper, A.P., S. Woolhandler, K.E. Lasser, D. McCormick, D.H. Bor, and D.U. Himmelstein. 2009. "Health Insurance and Mortality in U.S. Adults." *American Journal of Public Health* 99(12) (December): 2289–2295.
- Zuckerman, S., and W.P. Welch. 1990. "A Geographic Index of Physician Practice Costs." *Journal of Health Economics* 9(1) (June): 36–69.

Chapter 8

Safety Net Programs: Medicare, Medicaid, and SCHIP (CHIP)

In the previous chapter, we discussed access to health care services in the United States, and critically examined the disparities in the accessibility of health services and in some health measures among the country's different ethnic and racial groups. We concluded Chap. 7 by noting that the identified differences in uninsurance rates and in health disparities among segments of the population would probably have been worse were it not for the safety net programs that have been funded to provide insurance coverage and health care services for the poor, elderly, disabled, and pregnant women and their children.

The review of the history of the evolution of the health care system undertaken in Chap. 2 shows that the health expansions put in place during the postindustrial period, such as passage of the Hill-Burton program and massive investments in biomedical research, did not curtail the perceived inequities in the distribution of health services. At the same time, the prices charged for medical services increased significantly, thereby putting severe strains on the elderly and the needy. It was in response to these concerns about inequity in the distribution of health services and the inability of some people to pay for care that led to the passage of the Kerr-Mills Act of 1960, the predecessor to Medicare and Medicaid. In 1965, 6 years after the launching of the Kerr-Mills program, Medicare and Medicaid were passed. Consequently, this chapter is devoted to examining Medicare, Medicaid, and the changes that were made to Medicaid in 1997 that resulted in the State Children's Health Insurance Program (SCHIP), simply called Children's Health Insurance Program (CHIP) since March 2009. We begin by examining Medicare.

Medicare

Medicare, Title XVIII of the *Social Security Act* (SSA) or Health Insurance for the Aged and Disabled, is a federal program for financing hospital, physician, and other acute care and prescription drug services for the elderly and disabled. The disabled

became eligible for Medicare in July 1973 (Davis et al. 1990, p. 16), and the prescription drug program started on January 1, 2006.

The passage of Medicare, which came about after many unsuccessful attempts to enact a national health insurance program for the country, ushered in a new era for the federal government's role in health care. Medicare was expected to be the first step toward the enactment of a national health insurance plan.

The History of Medicare

As we discussed in Chap. 2, political discontent led to the introduction of social insurance in almost all of the major European countries on the eve of World War I. But unlike in Europe, there was no significant threat to the United States' political system and governing arrangements during the period. In addition, labor unions, employers, and the then powerful AMA were opposed to national health insurance. As a result, the Progressive Movement's proposal for national health insurance did not make any headway in the early 1920s.

Furthermore, the linking of social insurance to Nazi Germany effectively ensured that the idea would not enjoy strong public support in the United States. In addition, the Great Depression changed the order of social reform in the country by placing unemployment insurance on top of the social policy agenda. It was out of this environment that the Roosevelt administration decided, on coming into office in 1932, not to push the national health insurance idea. In other words, President Roosevelt and his advisers decided to invest their political capital in promoting and seeking passage of the SSA in 1935 (Marmor 2000, p. 6). For example, the original language in the draft Social Security legislation, which authorized the federal government to study the concept of health insurance, was removed from the final legislation on the orders of President Roosevelt and his top advisers (Oberlander 2008, p. 311).

President Harry Truman and his advisers, who succeeded Roosevelt, were very open to the idea of a national health insurance program. The President openly and formally endorsed a national health insurance plan for the country. However, the new Administration was not successful in pushing the idea to the policy formulation and legitimation phases. The AMA coined the phrase "socialized medicine" to attack the Truman administration's proposal. This opposition led Truman and his advisers to adopt an entirely new approach, incrementalism.

The incremental approach, drafted by Truman advisers Wilbur J. Cohen and I. S. Falk, limited health insurance to the beneficiaries of the Old Age and Survivors Insurance (OASI) program, the national, contributory, earnings-related pension program for the retired aged and their survivors, established by the SSA of 1935 (Marmor 2000, p. 9). In 1951, a new plan to insure the seven million aged social security beneficiaries for 60 days of hospital care per year was announced. By focusing on social security beneficiaries whose medical and financial deprivations were due to the natural process of aging, and who had paid their dues during their productive working years, the new proposal sought to avoid the pitfalls of the earlier proposals that could not be enacted.

A new and modest Medicare proposal covering only hospital costs for the elderly on Social Security was introduced in 1958 by Aime Forand, a congressman from Rhode Island. As in the past, the AMA opposed the plan, but the linking of the proposal to the aged poor resulted in what Starr (1982, p. 368) calls “a groundswell of grassroots support” for the proposal. Congress responded to these pressures by passing the *Kerr-Mills Act* in 1960. The Kerr-Mills program extended federal support for indigent medical care programs in the country; between 50 and 80% of the funding for the program was borne by the federal government.

Liberal members of Congress were unhappy with the means-tested nature of the Kerr-Mills program, which was thought to be a source of humiliation for the aged. In addition, the program was said to be an insufficient response to the medical and financial needs of the elderly. Furthermore, it was argued that state governments would not move vigorously to take advantage of the program. This latest fear was validated by a report in 1963 which found that only 32 of the 50 states had programs in effect to take advantage of the provisions of the Kerr-Mills legislation (Marmor 2000, p. 29; Harris 1966, p. 110, 144). Many states had not acted at all, and five industrial states, with one third of the nation’s population, were receiving 90% of the Kerr-Mills funds.

The 1964 general elections, in which Lyndon Johnson won the presidency in a landslide and Democrats gained wide majorities in both Houses of Congress, broke the power of the conservative coalition that was successful in blocking previous health care legislative proposals. Ironically, the AMA introduced its own “Eldercare” plan that promised the elderly more generous benefits, including payment for physician services. Similarly, the senior Republican member of the House Ways and Means Committee also introduced a voluntary insurance plan, subsidized out of government revenues, which would cover major medical and doctors’ services and drugs. The elderly share of the costs of the proposal was to be scaled to their Social Security benefits (Starr 1982, p. 369).

The AMA and Republican Medicare proposals exposed the limitations of the Democratic proposal. Therefore, convinced that the public wanted a more generous plan, Representative Wilbur Mills decided to expand the Democratic proposal. He proposed combining the Democratic and Republican proposals and adding a third program to provide medical services for the poor, for a total of three distinct components.

The first component of Rep. Mills’ proposal was the Democratic compulsory hospital insurance program under Social Security. The second component was a revised Republican proposal of a government-subsidized voluntary insurance program to pay for physicians’ services; and the third component provided expanded assistance to the states for medical care for the poor. The three components became Medicare Parts A, B, and Medicaid. These programs were enacted without serious difficulty and signed into law by President Johnson in July 1965. The combination of three distinct proposals sponsored by different interest groups to form the Medicare and Medicaid programs supports the assertion we made when discussing advocacy coalitions in Chap. 1 that the initial Medicare and Medicaid legislations were the result of the equilibrium that was reached among the competing groups that took part in designing the programs.

The threat by some physicians to organize a boycott of Medicare did not materialize when the medical profession discovered, after the program went into effect, that the indirect benefits to them were substantial. However, as we shall soon discuss, Medicaid was not widely accepted by the medical profession (Starr 1982, p. 370). These differences in acceptability of Medicare and Medicaid were partly due to the differences in their organization, financing, and goals.

Medicare Financing, Organization, and Goals

Medicare is a federal program financed through a combination of payroll taxes. The program was intended to provide health insurance coverage to elderly retirees who were no longer eligible for employer-sponsored insurance (ESI). Its design was based on the argument that to correct the insurance problems the elderly experienced, government should provide some assistance through a universal entitlement—the provision of aid without regard to personal income or means, but based on some more or less objective indicator of need, in this case, age and previous work record (Aaron and Reischauer 1995, p. 9).

Since Medicare is a form of universal entitlement, it is solely financed by the federal government and involves the same eligibility standards and benefit levels throughout the country. Accordingly, the program covers everyone aged 65 and older who has worked in a job subject to payroll deduction, or a spouse of an entitled worker, including the relatively recent addition of the disabled and persons with end-stage renal disease (ESRD). The program is structured to achieve specific goals related to hospitalizations, physician and laboratory services, and prescription drugs.

Program Structure and Benefits

Medicare comprises four parts, A, B, C, and D, which are discussed in detail below.

Part A: Hospital Insurance

Medicare Part A is a hospital insurance (HI) program that covers inpatient hospital stays (including semiprivate room, food, and medical tests), skilled nursing facility (SNF) (noncustodial), hospice, and home health care. The inpatient hospital stay is covered when a doctor says it is needed to treat a beneficiary's illness or injury. Recipients are covered for up to 90 days per benefit period plus a lifetime reserve of 60 hospital days. Covered hospital services include a semiprivate room, meals, general nursing, and other hospital services and supplies. The services covered do not include private-duty nursing, a television or telephone in a beneficiary's room, and personal care items, such as razors or slipper socks. Private rooms are also not covered, unless medically necessary.

In 2011, a Medicare Part A recipient pays the following for each benefit period: \$1,132 for the first 60 days of inpatient hospital stay; \$283 coinsurance for each day from days 61 to 90; \$566 coinsurance for each “lifetime reserve day” after 90 days during each benefit period; all costs incurred after exhausting all the lifetime reserve days. Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime (Medicare.gov. [2011a](#), p. 30).

The coverage for convalescence in a SNF is subject to certain conditions. First, a preceding hospital stay must be at least 3 days, 3 midnights, not counting the discharge date. Second, the skilled nursing home care must be for illness diagnosed during the hospital stay or for the main diagnosis that led to the hospital stay. Third, if the patient is not undergoing rehabilitation, there must be some other acceptable condition that requires skilled nursing care. And fourth, the care given in the SNF must indeed be skilled, and not involve custodial, nonskilled, or long-term care (LTC) activities, including moving around the house, toileting, cooking, cleaning, eating, etc.

The maximum length of stay that Medicare Part A will cover in a SNF per ailment or episode of illness is 100 days. The first 20 days would be paid for in full by Medicare, while the remaining 80 days would require a copayment. As of 2011, the copayment is about \$141.50 per day. If a recipient uses some portion of their Part A SNF benefit and then goes at least 60 days without receiving facility-based skilled nursing services, the 100-day clock is reset and the person qualifies for a new 100-day benefit period (Wikipedia [2011a](#), p. 1; Medicare.gov. [2011a](#), p. 43).

Part B: Medical Insurance

Part B is medical insurance that helps pay for some services and products that Part A does not cover, mostly services that are provided on an outpatient basis. This benefit is optional and may be deferred to a later date or time if the beneficiary or their spouse is still working and receiving ESI.

Part B coverage starts once the beneficiary meets his or her deductible. After that, Medicare covers 80% of approved services, while the beneficiary pays the remaining 20%. There is a lifetime penalty of about 10% per year if an eligible individual who is not actively working fails to enroll in Part B.

Medical insurance coverage includes physician and nursing services, X-rays, medical laboratory and diagnostic tests, influenza and pneumonia vaccinations, blood transfusions, renal dialysis, outpatient hospital procedures, limited ambulance transportations, immunosuppressive drugs for patients receiving organ transplants, chemotherapy for cancer patients, hormonal treatments, and other doctor office outpatient medical treatments, including medication administration.

Medicare Part B also covers durable medical equipment, such as canes, walkers, wheelchairs, and mobility scooters for those the device has been prescribed by a licensed physician. Artificial limbs, breast prosthesis following mastectomy, one pair of eyeglasses following cataract surgery, and oxygen for home use are covered. Periodic coverage advisories known as National Coverage Determinations (NCDs) are issued by the CMS. Local Coverage Determinations (LCDs) apply within the multistate area managed by a specific regional Medicare Part B contractor (Wikipedia [2011a](#), p. 6).

Part C: Medicare Advantage

The *Balanced Budget Act* (BBA) of 1997 (PL 105-33) made significant and broad policy changes to Medicare and children's health insurance. The legislation, signed into law by President Clinton on August 5, 1997, gave Medicare beneficiaries the option of receiving their Medicare benefits through private health insurance plans, rather than getting benefits through the original Medicare Parts A and B. The new private health insurance plans that Medicare beneficiaries could receive services from were known as "Medicare+Choice" or "Part C" plans. The *Medicare Prescription Drug, Improvement, and Modernization Act* of 2003 (MMA 2003) attempted to make Part C plans more attractive to Medicare beneficiaries by adding prescription drug coverage and renaming the plans "Medicare Advantage" (MA) plans.

In addition to the changes made to Medicare, the BBA of 1997 also made available nearly \$13 billion in federal money to provide health insurance coverage to children who lost coverage as a result of the 1996 federal welfare reform legislation (National Association of Social Workers (NASW) 1997, p. 1). This provision essentially established SCHIP, which is discussed more fully under Medicaid.

Medicare Part C or Medicare Advantage is essentially an attempt to introduce managed care into Medicare. Unlike the traditional Medicare program which has a standard package of benefits that members can receive from any hospital or physician in the United States, under Medicare Advantage plans a fixed or capitated amount is paid per enrollee per month. Enrollees typically also pay a monthly premium in addition to the Medicare Part B premium to cover services not covered by traditional Medicare (Parts A and B). These additional services may include prescription drugs, dental and vision services, catastrophic coverage, and exercise or health club memberships. These additional services give enrollees "advantage" over traditional Medicare enrollees. However, Advantage Plans' enrollees may be subject to gatekeeping practices, such as a limited network of providers or extra fees for using nonpanel or nonnetwork providers.

Similar to the different types of managed care plans discussed in Chap. 4, there are equally different types of Medicare Advantage Plans. These include HMO Plans, PPO Plans, Private Fee-for-Service (PFFS) Plans, and Special Needs Plans (SNP) which, as the name suggests, are designed for people with special medical needs. In addition, other less common types of plans may be available, such as Health Maintenance Organization Point of Service (HMOPOS) Plans, Medical Savings Account (MSA) Plans, and Prescription Drug Plans (PDP) or MA-PDs (Medicare.gov. 2011b).

Since the payment formulas established by the MMA of 2003 overpay MA plans compared to traditional Medicare, in 2006 enrollees in Medicare Advantage PFFS plans were offered more benefits than enrollees in traditional Medicare (Merlis 2008). However, some concerns have been raised about the quality of care received by minorities and older, poorer, and sicker persons in MA plans (Trivedi et al. 2006, p. 1998; Hellinger 1998, p. 833). These concerns may cause minorities and the older and sicker MA enrollees to drop their enrollments in MA plans and to reenroll in traditional Medicare, resulting in adverse selection within the traditional program.

Additionally, the Government Accountability Office (GAO) reported in 2008 that the administrative costs of private Medicare Advantage plans for 2006 were much higher than those of traditional fee-for-service Medicare. In that year, the plans earned profits of 6.6%, had overhead of 10.1%, and provided 83.3% of the revenue dollar in medical benefits (GAO-09-132R).

In fairness, it must also be noted that an analysis of the AHRQ data published by America's Health Insurance Plans (AHIP) found that Medicare Advantage enrollees spent fewer days in the hospital than FFS enrollees, were less likely to have "potentially avoidable" admissions, and had fewer readmissions. The comparisons among MA and FFS enrollees adjusted for age, sex, and health status using the risk score used in the MA risk adjustment process (Chovan et al. 2009; Chovan and Chen 2009).

Part D: Prescription Drugs

Medicare insurance drug coverage made possible by the passage of the MMA of 2003 became effective on January 1, 2006. Prescription drug coverage is insurance run by an insurance company or other private company approved by Medicare. In order to get the prescription drug benefit, a Medicare beneficiary must either enroll in a Medicare PDP, or enroll in a Medicare Advantage (MA) Plan. PDPs add prescription drug coverage to original Medicare, Medicare Cost Plans, Medicare PFFS Plans, or to Medicare MSA Plans; MA Plans, which were described under the previous sub-heading, offer all Medicare Parts A and B services, along with prescription drug benefits. Those who do not join a Medicare drug plan when they first become eligible and who have no other credible prescription drug coverage at the time they fail to enroll are likely to pay a late enrollment penalty when they finally decide to enroll.

Unlike the original Medicare program (Parts A and B), Part D coverage is not standardized. Each plan can vary in drugs covered and cost. In other words, the plans choose the drugs they cover, the level (tier) of coverage, and are free to choose not to cover some drugs at all. The exceptions to these are the drugs that Medicare specifically excludes from coverage, such as benzodiazepines, cough suppressants, and barbiturates. If a drug plan chooses to cover the Medicare-excluded drugs, their costs cannot be passed on to Medicare. However, Medicaid may pay for drugs not covered by Medicare Part D on behalf of dual eligibles (those eligible for both Medicare and Medicaid).

Just as Part D plans may vary in costs and drugs covered, the monthly premiums paid by enrollees may also vary based on income. The monthly premium cost is determined by comparing beneficiaries' average modified adjusted gross incomes from the previous 2 years' tax records to a certain predetermined amount. Those with higher average modified adjusted gross incomes from the previous 2 years pay higher premiums than those with lower average modified adjusted gross incomes for the same period. In that sense, the premium costs among beneficiaries are progressive in nature, with higher income earners paying higher premiums than lower income earners.

As was stated during our discussion of Medicare Part A, Medicare recipients are covered for 90 days of hospital stay per benefit period plus a lifetime reserve of 60 hospital days. Similarly, Part B also has deductibles that the elderly must pay. Therefore, neither Part A nor Part B pays for all the medical costs of the elderly. These limitations or gaps in Parts A and B coverage are out-of-pocket costs that must be borne by program beneficiaries. Some people elect to purchase a type of supplemental coverage, called a Medigap policy, to help cover the gaps in original Medicare Parts A and B.

Medigap Policies

Medicare supplemental insurance or Medigap policies are sold and administered by private insurance companies, but are standardized by the CMS in order to minimize variations in the policies sold to the elderly. Policy holders pay the full costs of this additional insurance coverage. Some Medigap policies sold before 2006 could include coverage for prescription drugs, but after the MMA came into force on January 1, 2006, Medigap policies are prohibited from covering drugs. Similarly, Medicare regulations prohibit a Medicare beneficiary from having both a Medicare Advantage Plan and a Medigap Policy.

Medigap policies follow Federal and State laws. The standardized Medigap policies that insurance companies sell are required to provide the same benefits, with the only difference between them being the costs. In most states, except Massachusetts, Minnesota, and Wisconsin, insurance companies can only sell standardized policies identified by letters A through N. Plans M and N were new as of June 1, 2010. Plans E, H, I, and J are no longer sold, but people who had those plans prior to the change in policy on June 1, 2010, can keep them (CMS 2011a). Additionally, one may be able to buy Medicare Select policies, variants of managed care plans, which may limit enrollees to a select group of physicians and hospitals. In return for subjecting enrollees to gatekeeping practices, select plans may be cheaper than other plans.

Table 8.1 summarizes the standardized Medigap Plans currently available. Insurance companies that sell Medigap policies are required to make Plan A, the most basic coverage, available. If they offer any plan, they must also offer either of the two most popular plans, Medigap Plan C or Plan F.

As we noted earlier, Medigap policies are standardized in different ways in Massachusetts, Minnesota, and Wisconsin, than shown in Table 8.1. In Massachusetts, the basic benefits include: coverage of the Medicare Part A coinsurance plus coverage for 365 additional days after Medicare coverage ends; coverage of the Medicare Part B coinsurance, generally 20% of the Medicare-approved amount; coverage of the first three pints of blood each year; coverage of Part A Hospice coinsurance or copayment; coverage of 60 days of care per Calendar Year in inpatient mental health hospitals; and coverage of some state-mandated benefits, such as annual pap tests and mammograms. Additional benefits are available under a supplemental plan.

Minnesota's Medigap basic benefits include: coverage of the Medicare Parts A and B coinsurance; coverage of the first three pints of blood each year; coverage of

Table 8.1 Standardized Medigap plans

	Medigap plans									
Medigap benefits	A	B	C	D	F ^a	G	K	L	M	N
Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	X	X	X	X	X	X	X	X	X	X
Medicare Part B coinsurance or copayment	X	X	X	X	X	X	50%	75%	X	X ^b
Blood (first three pints)	X	X	X	X	X	X	50%	75%	X	X
Part A hospice care coinsurance or copayment	X	X	X	X	X	X	50%	75%	X	X
Skilled nursing facility (SNF) care coinsurance			X	X	X	X	50%	75%	X	X
Medicare Part A deductible		X	X	X	X	X	50%	75%	50%	X
Medicare Part B deductible			X		X					
Medicare Part B excess charges					X	X				
Foreign travel emergency (up to plan limits)			X	X	X	X				X
Out-of-pocket limits ^c							\$4,640	\$2,320		

^aPlan F also offers a high deductible plan. Those enrolled in this plan must pay for Medicare-covered costs up to the deductible amount of \$2,000 in 2011 before the Medigap plan pays anything

^bPlan N pays 100% of the Medicare Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to \$50 copayment for emergency room visits that result in an inpatient admission

^cAfter enrollees meet their out-of-pocket yearly limit and their yearly Part B deductible (\$162 in 2011), the Medigap policy pays for 100% of covered services for the rest of the calendar year

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (2011a), p. 11

Medicare Part A Hospice and respite, as well as the home health services and supplies' cost sharing; coverage of 100 days of Medicare Part A SNF Coinsurance, Medicare-covered preventive care, specified payments for foreign travel emergencies, outpatient mental health, and physical therapy; and coverage of State-mandated benefits, such as diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations. Additional benefits are available under the Extended Basic Plan.

In Wisconsin, the Medigap basic benefits include: coverage of the Medicare Part A coinsurance for inpatient hospital care, as well as the Medicare Part B coinsurance, usually 20% of the Medicare-approved amount; coverage of the first three pints of blood each year, as well as the Part A Hospice coinsurance or copayment; 175 days inpatient mental health coverage per lifetime in addition to Medicare's mental health benefit; and 40 home health care visits in addition to those paid by Medicare. Furthermore, insurance companies are allowed to offer additional specified riders to a Medigap policy, plans known as "50 percent and 25 percent Cost-Sharing Plans," and a high deductible plan (\$2,000 in 2011) (CMS 2011b).

Buying Medigap Policies

Medigap insurance companies use medical underwriting to decide who to insure and how much to charge for a policy. However, applicants who elect to buy policies during their open enrollment period may not be subjected to medical underwriting. In other words, applicants who elect to buy coverage during their open enrollment period may buy any Medigap policy the insurance company sells, even if they have health problems or preexisting conditions, for the same price as people in good health or without preexisting conditions. Only those who meet limited specified conditions may buy Medigap policies outside of their open enrollment periods. In addition, insurance companies are required to offer a 30-day “free look” period for Medigap plans, during which people who buy policies can cancel for a full refund.

In addition to the Medicare direct benefits identified in the course of our discussion of the program’s financing, organization, and goals, Medicare confers additional important indirect benefits on society and the families of Medicare beneficiaries. According to Gusmano and Schlesinger (2001, p. 37), since its inception, the Medicare program has addressed needs beyond those of its titular beneficiaries. It has also provided some services that are only loosely related to insuring beneficiaries against the costs of medical care. Both the direct and indirect benefits have significantly increased the costs of the program, leading to cost controls. In the following pages, we examine Medicare’s indirect benefits, program costs, and the strategies that have been employed to contain program costs. We begin with the program’s indirect benefits.

Medicare’s Indirect Benefits

The number and scope of Medicare’s indirect benefits have increased significantly since the program’s inception in 1965 (Gusmano and Schlesinger 2001, p. 38). The costs of the indirect benefits, in association with the perception that Medicare faces serious financial problems in the years to come, have made the indirect benefits more controversial (Altman et al. 1997; Institute of Medicine 1997). The Medicare program’s indirect benefits include support for graduate medical education or residency training, subsidies to insurance company intermediaries and health care providers, various forms of information collection and dissemination, support for health services research, beneficiary education programs, and financial and psychological relief for the families of the elderly who would have had to pay their loved one’s medical bills if the program was not in place.

Support for Graduate Medical Education

Medicare has supported the residency training functions or graduate medical education of teaching hospitals since its enactment in 1965 (Altman et al. 1997; Institute of Medicine 1997). These support activities include payments for the so-called

direct medical education (DME) costs, including stipends paid to residents and their trainers. The program also pays teaching hospitals for the indirect costs of graduate medical education (IME payments). Both the DME and IME payments run into billions of dollars annually (Gusmano and Schlesinger 2001, p. 41).

Subsidies to Intermediaries and Providers

The political struggle for the passage of Medicare that we discussed under the history of the program caused supporters to adopt strategies that would lessen interest groups' opposition to the legislation. To ensure the support of the AMA, the Medicare legislation avoided prescribing a fee schedule for physicians and stipulated instead that physicians treating Medicare patients would be paid their "usual and customary fee," provided the fee was also "reasonable" (Marmor 2000, p. 61). Furthermore, physician fees were decoupled from hospital fees, and it was not required that the physician directly charge the insurance company intermediaries that were enlisted to handle the government payments. Rather than directly charging the insurance company, the physician could bill the Medicare patient, who would pay the bill and present the receipt to the insurance intermediary for reimbursement. Based on this provision, the physician could bill the Medicare patient for more than the government would be willing to pay.

Furthermore, the Medicare legislation used a generous cost-based or retrospective payment method for hospital services provided to Medicare beneficiaries. This initial hospital payment method also included a 2% bonus payment to cover capital costs (Oberlander 2008, p. 314). In addition, the utilization of insurance intermediaries that typically enjoyed close relationships with hospitals and doctors to fulfill the program's payment functions ensured that Medicare would not be used to regulate the practice of medicine. It also caused significant increases in the program's overhead costs. Therefore, those who were initially bent on blocking the Medicare legislation became prominent indirect beneficiaries of the program—they made large sums of money from the programs.

As was discussed in Chap. 7 under access to health care services, the characteristics of patients affect their access to health care services. Specifically, predisposing factors, such as race, level of education, and gender, may influence the care physicians provide their patients and the patients' ability to access necessary health care services. For example, because some providers either do not accept Medicaid or limit their Medicaid caseloads, Medicaid beneficiaries and other poor patients are very likely to use public facilities and emergency rooms for their health care needs. These public and institutional settings, especially those located in large urban areas and in inner cities, tend to see a disproportionate proportion of the poor and uninsured than their counterparts in affluent middle-class areas. Disproportionate share adjustments are available to disproportionate share hospitals (DSHs) under both Medicare and Medicaid.

The Medicare-DSH adjustment provision was enacted by Section 9105 of the *Consolidated Omnibus Budget Reconciliation Act* (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986. Hospitals can qualify

based on a complex statutory formula that yields a DSH patient percentage, or by demonstrating that more than 30% of their net inpatient revenues come from State and local governments for indigent care, excluding Medicare and Medicaid. The payments are meant to compensate DSHs both for higher average Medicare patient costs and higher costs associated with providing care to indigent patients (Gusmano and Schlesinger 2001, p. 41; CMS 2011b).

The so-called Sole Community Hospitals (SCH) Program, established under amendments to the SSA in 1972, resulted in the Health Care Financing Administration (HCFA), and now the CMS, subsidizing the SCHs. Similarly, as a result of the introduction of the Medicare prospective payment system (PPS) in 1983, rural hospitals received lower base payments because they had lower average patient care costs, and many of them had to close their doors. The Medicare PPS was blamed for these rural hospital closings, and Congress reacted by instructing the HCFA to eliminate the distinction between rural and “other urban” hospitals (Gusmano and Schlesinger 2001, p. 42). This policy change had the effect of subsidizing rural hospitals in order to improve their financial fortunes.

As we discussed in Chap. 4, the total amount of money raised in any given year to pay for health care is the product of the quantities of health care services provided during the period and their average prices, which in turn are the product of the average incomes of health workers and the hours they expend to provide care. It then follows that when Medicare payments are cut or frozen, providers lay off employees, especially nonphysician employees, or cut their work hours, or both.

This author was a medical technologist in Wichita, Kansas, at the time of the implementation of the Medicare PPS in 1983. The decline in hospital revenues caused by the PPS resulted in layoffs of nurses and other hospital personnel and in a decline in the volume of laboratory tests physicians ordered for Medicare patients. The point, therefore, is that providers, their employees, equipment manufacturers, and the localities where the health providers that participate in Medicare are located are some of the indirect beneficiaries of the Medicare program. These indirect benefits are substantial and have important economic consequences.

Support for Health Services Research

The CMS provide grants and access to data to health policy researchers to conduct meaningful research and disseminate the research findings. Separately, the CMS conduct in-house research and demonstration projects that seek to improve health care financing. In addition, Medicare makes other indirect contributions to biomedical and health services research through its support of teaching hospitals and other federal agencies and their researchers.

Information Collection and Dissemination

The CMS collect large quantities of data regarding the costs of medical services provided to Medicare and Medicaid beneficiaries, utilization patterns, providers’

profiles, and total public and private health care expenditures. For example, a large part of the information presented in this chapter, and throughout the book, is acquired from the CMS website. The CMS database is beneficial to health care researchers, Medicare and Medicaid beneficiaries, state and local governments, and the general population. Those who use the data are continuously asked to participate in surveys that are designed to gather the information necessary to make the database more user-friendly.

Beneficiary Education Programs

From my personal observation and experience while working in government, not many redistributive programs make the effort to contact potential beneficiaries and advise them of their eligibility for benefits. But Medicare administrators and, perhaps, the Department of Veterans Affairs, do a good job of being client-centered. The CMS try to provide Medicare beneficiaries with better information about benefits, insurance plan options, copayments and deductibles, and treatment options (McMullan 1996, p. 9). For example, the Medigap policies, benefits, and guidelines referenced earlier in this chapter were developed for Medicare beneficiaries jointly by the CMS and the National Association of Insurance Commissioners (NAIC).

Financial and Psychological Relief for Families

This last category of indirect benefits is not frequently talked or written about, but is nonetheless very important. While Medicare has alleviated the elderly's fear and anxiety of growing old without care and opened the door to greater economic security for the nation's elderly and disabled populations (Frist 1995, p. 82; Moon and Davis 1995, p. 31), it has at the same time alleviated the families of elderly and disabled persons the burden and anxiety of worrying about how to provide and pay for their loved ones' health care services. This benefit, which can be substantial if quantified in monetary terms, allows the family members to focus their energies and resources on other important needs, such as the education of their children.

As was discussed earlier, the direct and indirect benefits of the Medicare program have resulted in significant expenditures. As shown in Table 8.2, in Calendar Year 2006, there were a total of 43.2 million disabled and aged Medicare Parts A, B, and D enrollees, a total expenditure of \$408.3 billion, and an average benefit of \$10,221 per enrollee. By contrast, in Calendar Year 2010, there were a total of 47.5 million aged and disabled Medicare Parts A, B, and D enrollees, a total expenditure of \$522.8 billion, and an average benefit of \$11,762 per enrollee. Therefore, between 2006 and 2010, the total number of Parts A, B, and D enrollees increased by about 10%, total expenditures increased by about 28%, and average benefits per enrollee increased by about 15%.

Another important lesson that can be learned from Table 8.2 is that in both 2009 and 2010, total Medicare Parts A, B, and D expenditures exceeded incomes.

Table 8.2 Growth in Medicare enrollees and expenditures, 2006–2010

Year	Variables	Part A	Part B	Part D	Total
2010	Aged enrollment (millions)	39.2	36.7	N/A	39.6
	Disabled enrollment (millions)	7.9	7.1	N/A	7.9
	Total enrollment (millions)	47.1	43.8	34.5	47.5
	Total income (billions)	215.6	208.8	61.7	486.0
	Total expenditures (billions)	247.7	212.9	62.0	522.8
	Average benefit per enrollee	\$5,187	\$4,786	\$1,789	\$11,762
2009	Aged enrollment (millions)	38.3	36.0	N/A	38.7
	Disabled enrollment (millions)	7.6	6.8	N/A	7.6
	Total enrollment (millions)	46.0	42.8	33.4	46.3
	Total income (billions)	225.4	221.9	60.9	508.2
	Total expenditures (billions)	242.5	205.7	60.8	509.0
	Average benefit per enrollee	\$5,205	\$4,728	\$1,810	\$11,743
2008	Aged enrollment (millions)	37.5	35.2	N/A	36.9
	Disabled enrollment (millions)	7.4	6.6	N/A	7.2
	Total enrollment (millions)	44.9	41.7	32.3	44.1
	Total income (billions)	230.8	200.6	49.4	480.8
	Total expenditures (billions)	235.6	183.3	49.3	468.1
	Average benefit per enrollee	\$5,179	\$4,322	\$1,517	\$11,018
2007	Aged enrollment (millions)	36.6	34.6	N/A	36.9
	Disabled enrollment (millions)	7.2	6.4	N/A	7.2
	Total enrollment (millions)	43.8	40.9	30.9	44.1
	Total income (billions)	223.7	188.7	49.5	461.9
	Total expenditures (billions)	203.1	178.9	49.5	431.5
	Average benefit per enrollee	\$4,573	\$4,312	\$1,575	\$10,460
2006	Aged enrollment (millions)	35.9	34.1	N/A	36.3
	Disabled enrollment (millions)	7.0	6.1	N/A	7.0
	Total enrollment (millions)	42.9	40.3	27.9	43.2
	Total income (billions)	211.5	177.3	48.2	437.0
	Total expenditures (billions)	191.9	169.0	47.4	408.3
	Average benefit per enrollee	\$4,410	\$4,121	\$1,690	\$10,221

Totals do not necessarily equal the sums of rounded components

N/A indicates that data are not available

Source: 2006–2010 Annual Reports of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

The 2010 expenditures were \$36.8 billion, or about 7.6% above income. Similarly, except in 2006 when Part D total income was \$0.8 billion above expenditures, Part D incomes and expenditures were about the same between 2007 and 2009, and Part D income was below expenditures in 2010. These trends are justifications for the concerns expressed by the Medicare Board of Trustees about the long-term financial health of the program.

In their 2010 Calendar Year report, the Medicare Board of Trustees notes that while the lower expenditures and additional tax revenues instituted by the PPACA of 2010 have substantially improved the financial status of the Health Insurance (HI) trust fund, the fund is still not adequately financed over the next 10 years. Furthermore, the

Board notes that Part B costs have been increasing rapidly and are likely to continue to increase. The improvements that the Medicare Board of Trustees expects in the HI trust fund are likely to evaporate if the PPACA is repealed and steps are not taken to retain the financial benefits it confers on the HI trust fund.

Similar to other health insurance programs, Medicare administrators and policy-makers have taken various steps to contain program expenditures. Since most of the measures employed to contain Medicare expenditures (prospective payment based on DRGs, health planning, PSROs, PROs, RBRVS used to pay for physician services, Medicare Part C or managed care in Medicare) have already been discussed in this and previous chapters, the discussion that follows is brief and merely summarizes materials that have already been presented in the book.

Medicare Cost Containment

Since the United States relies on a pluralistic system of public and private financing of health services, the approaches employed to contain costs have equally been fragmented. In other words, responsibility for cost containment has been shared by both the public and private sector. Following the design of Medicare and Medicaid, efforts to contain Medicare costs have been applied uniformly throughout the country, while Medicaid cost containment approaches vary from state to state.

Once the Medicare program was enacted, the most serious and persistent of its problems involved the methods and costs of paying doctors and hospitals. According to Theodore Marmor (2000, p. 89), in the year between the enactment of the Medicare legislation and its initial operation, the rate of increase in physician fees more than doubled. Similarly, hospital price increases presented the most intractable political problem for the Johnson administration. For example, in the first year of Medicare's operation, the average daily service charge in American hospitals was reported to increase by as much as 21.9% (Marmor 2000, p. 89).

As shown in Table 8.2, reimbursement for services and the population of Medicare beneficiaries continue to increase. Therefore, Medicare cost containment began just as soon as the program went into effect. Additionally, throughout the late 1960s, the debate on reforming Medicare and the rising cost of care continued (Davis et al. 1990, p. 16).

As we discussed in Chap. 4, the first major attempt to minimize health care costs came with the Nixon administration's 1971 Economic Stabilization Program (ESP). The ESP put a freeze on wages and prices in the entire economy, including the hospital industry. But following the lifting of the ESP controls, Medicare hospital and other health expenditures increased much faster than was the case prior to the imposition of controls.

Following the lifting of the ESP controls, Section 223 of legislation passed by the Congress in 1972 to amend the original 1965 Medicare legislation gave program administrators the authority to disallow costs that were deemed unnecessary to the efficient provision of care. The Section 223 regulations, first implemented in July 1974,

applied to routine costs, or specifically, it applied only to hospital costs associated with room and board and nursing services; it did not include ancillary services, special care units, or outpatient care. The Section 223 regulations were continually refined to account for new knowledge about the factors that affected hospital costs. For example, the original proxy for hospital input costs, county per capita income, was soon replaced by a wage index for hospital workers in an area (Davis et al. 1990, p. 19).

In order to respond to increases in Medicare utilization rates that were not anticipated at the time of the initial debate over the Medicare legislation, PSROs were created by the 1972 Medicare amendments to ensure efficiency and economy in federally funded health care services. Similarly, the 1972 amendments encouraged state government to develop other approaches to cost containment, such as incentive reimbursement demonstrations, voluntary and mandatory rate-setting programs, alternative care delivery methods, and other innovations that were deemed effective in controlling expenditures. By 1976, Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington had established mandatory rate-setting programs (Biles et al. 1980, p. 664).

In addition to attempts to directly control costs, other attempts were made in the 1970s to increase the supply of health providers, especially physicians. The *Emergency Health Personnel Act* of 1970 established the National Health Service Corps to furnish physicians and other providers to the underserved areas of the country. Similarly, the *Health Manpower Training Act* of 1970 further encouraged the training of physicians, more especially primary care physicians (PCPs). Furthermore, HMOs were promoted by the HMO Act of 1973, while the *National Health Planning and Resources Development Act* of 1974 (PL 3-641) attempted to make group practice and alternative health care delivery systems important objectives of federal health policy (U.S. Department of Health, Education, and Welfare (U.S. DHEW) 1971; Ubokudom 1998, p. 59; Davis et al. 1990, p. 25).

President Carter and his advisers made attempts to control hospital costs that were still on the rise when they assumed office in 1977. The Carter Administration argued that costs should be controlled before attempting to expand insurance coverage to all Americans. In response to the Carter administration's legislative proposals to control hospital costs, the industry responded by forming a coalition of providers and payers called the Voluntary Effort (VE) in December 1977. The VE was temporarily effective in controlling some hospital costs, but costs went up as soon as the Carter legislative proposal failed and the threat of regulation was gone. Next, it was up to the Reagan Administration to do something about high health care costs.

The Reagan administration and Republican members of Congress preferred market-based approaches to health care cost containment (Oberlander 2008, p. 316). Congressional efforts were driven by the desire to frustrate Reagan's efforts to cut the benefit and eligibility standards in the Medicare and Medicaid programs. In order to reduce the size of government, the Reagan administration was forced to support more federal regulations to contain spending. Legislators worked to institute cuts to providers' reimbursements rather than cuts in benefits and eligibility standards.

The OBRA of 1981 tightened the limits on Medicare reimbursement under Section 223 of the Medicare Amendments of 1972 in order to generate additional

savings. It also required the Secretary of the DHHS to develop a new method of hospital reimbursement under Medicare and Medicaid and to report to Congress on the new system by July 1982. States were also allowed the flexibility to design and implement their hospital payment arrangements for Medicaid.

The *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982 made significant changes in the existing hospital payment methods in order to control Medicare hospital expenditures (Iglehart 1982, p. 1288). For example, the rates of growth in Medicare hospital payments per admission were curtailed. Additionally, Section 223 of the 1972 Medicare amendments was modified to incorporate a case-mix index based on DRGs and to provide incentive payments to hospitals that were deemed efficient. TEFRA applied only to hospital care provided Medicare beneficiaries. It mandated that limits be set on Medicare hospital payments per discharge using case-mix indexes based on DRGs developed at Yale University.

TEFRA did little to change the variability in payment rates across hospitals, because it granted the same rate of increase in payments to all hospitals, whether they initially had high or low costs. Therefore, it relied on a methodology that did not fully acknowledge and reward efficient hospitals. In October 1982, the DHHS announced plans to switch to prospective payment based on DRGs as mandated by the TEFRA.

As was discussed briefly in Chap. 1, the prospective payment legislation was attached to another more popular legislation that was designed to ensure the solvency of the Social Security program in order to guarantee its passage. It was passed in March 1983 and quickly signed into law.

The PPS was limited to hospitals. Following its successful adoption, Congress enacted the Medicare Fee Schedule for Physicians based on the resource-based relative value scale (RBRVS) in 1989. The RBRVS, also discussed in Chap. 4, is a method of paying physicians based on the time, skill, and effort involved with different health care services. This new methodology replaced the customary, prevailing, and reasonable slogan on which the initial physician reimbursement method was based. The RBRVS was followed about 8 years after by the enactment of Medicare Part C or managed care in Medicare.

Favorable risk selection has made the Medicare managed care strategy less successful than anticipated. Medicare actually lost money on beneficiaries enrolled in private managed care plans, spending more for their HMOs than it would have spent if they had remained in traditional Medicare (Oberlander 2008, p. 320). Therefore, the quest to contain Medicare costs continues. At the time of this writing, Medicare cost containment and overall federal expenditure levels are generating heated debates among the two major political parties.

Medicare and Long-Term Care

As was noted in the preceding discussion, Medicare focuses on acute or short-term care for the elderly 65 years of age and above and the disabled. It provides limited

coverage for skilled nursing home care after a Medicare patient has experienced an episode of illness that requires hospitalization. But since age is one of the determinants of the need for LTC services, one would have expected that Medicare, a program designed to provide medical services to the elderly population, would also cover the LTC needs of the elderly. That is, however, not the case. The designers of the Medicare program did not intend for it to cover beneficiaries' custodial LTC needs. Consequently, the institutional LTC needs of the elderly have to be met elsewhere.

The bulk of LTC services for the elderly are provided by family members or the so-called informal long-term caregivers, and by institutional providers, such as nursing homes. Medicaid, passed at the same time as Medicare, pays for most of the institutional LTC services used by the elderly. In order to further address the Medicare LTC gap, Congress, in the doomed *Medicare Catastrophic Care Act* (MCCA) of 1988, raised the amount of money seniors could retain for themselves when their spouses received Medicaid nursing home benefits. According to Grogan and Patashnik (2003, p. 51), the adoption of the spousal impoverishment provision reflects the emergence of Medicaid as the nation's de facto LTC program.

Given the nation's budget problems and high deficits, it is not likely that Medicare will be expanded to cover custodial LTC services. Rather, Medicaid, which is facing its own budget pressures from state governments, will continue to be both the de facto LTC program and the vehicle for providing health services to the poor. Therefore, our discussion now shifts to Medicaid, its organization and goals, benefits and beneficiaries, expenditures, and its cost containment strategies.

Medicaid

Medicaid (Title XIX of the SSA) is a joint federal and state program that provides medical assistance for certain individuals and families who meet eligibility criteria and assets requirements. Each state establishes its own Medicaid eligibility standards within broad federal guidelines; determines the type, amount, duration, and scope of services; establishes the rates that will be paid for the services provided to program beneficiaries; and administers its program (Klees et al. 2010, p. 3).

As was noted while discussing Medicare, Medicaid grew out of the struggle to improve access to health care for the elderly. In 1964, there were three specific proposals to improve access to health care for American senior citizens, namely: a universal hospital insurance program based on Social Security (the King-Anderson bills of 1963 and 1964, named after Senator Clinton Anderson of New Mexico and Representative Cecil King of California, high-ranking members of the Senate Finance Committee and the House Ways and Means Committee, respectively); a voluntary program to finance physician services that was to be supported by beneficiary premiums; and an expansion of the Kerr-Mills program, which, as we have already discussed, offered a range of health care benefits to the low-income elderly (Grogan and Patashnik 2003, p. 824; Grogan 2008, p. 331; Marmor 2000, p. 51).

The Social Security Amendment of 1965 combined the above three approaches into a single package consisting of three parts. As we have already discussed, the first and second parts were Medicare Parts A and B, while the third part became the Medicaid program, originally called Medicare Part C. Medicaid liberalized the Kerr-Mills means test so as to cover additional elderly citizens. Similarly, eligibility among the poor was broadened to include the blind, the permanently disabled, and recipients of Aid to Families with Dependent Children (AFDC).

Like the Kerr-Mills program, Medicaid financing was to be shared by federal general revenues and state funds. Exceptions were made to the age restriction of the Medicare program. The original legislation authorized comprehensive health benefits for all persons who, regardless of age, qualified for public assistance.

As was the case with the Kerr-Mills program, the federal share of Medicaid was increased to an open-ended commitment to pay for an established set of services. But even with the federal commitment to pay for an established set of services, estimates of Medicaid's future budgetary outlays assumed that the program would not lead to a dramatic expansion of health care coverage (Stevens and Stevens 1974). For example, it was assumed that even if all the 50 states implemented the Medicaid program, Medicaid expenditures would be no more than \$238 million per year above what was being spent on medical welfare programs (Grogan and Patashnik 2003, p. 826).

The health programs of the 1960s were intended to reduce the exclusion from medical care of the poor and the aged, people who were marginal to the core sectors of the economy where health insurance was available as a fringe benefit (Starr 1982, p. 373). The available evidence showed that these goals were greatly impacted. For example, the decade after 1965 witnessed a measurable increase in the use of medical services by the poor. Davis and Schoen (1978, p. 164) write that in 1964 the nonpoor saw physicians about 20% more frequently than the poor; by 1975, the poor visited physicians 18% more often than the nonpoor. Similarly, in 1964, whites saw physicians 42% more often than blacks; by 1973, the difference between white and black physician visits had narrowed to 13%.

Additionally, in 1963 those who earned less than \$2,000 per year had only half as many surgical procedures per 100 people as those who earned \$7,500 or more; by 1970, the surgical rate for the low-income group was 40% higher than the rate for the high-income group. Furthermore, 1969 data showed that for every level of health status, public assistance beneficiaries eligible for Medicaid used medical care much more often than other poor people who were not eligible for Medicaid. It follows, therefore, that some or most of the reported increases in the utilization of medical services were likely due to Medicare and Medicaid.

Another reason that was suggested for the increased use of medical care reported above was the change in the composition of poor people. As the poverty population dropped following the enactment of the Great Society redistributive programs, there was a higher proportion of chronically ill and disabled people among the poor relative to the rest of the population (Starr 1982, p. 374). These chronically ill and disabled people are likely to be in poorer health than the rest of the members of the population. Obviously, those in poor health are likely to use more health care services than those in good health.

Medicaid Beneficiaries

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, particularly dependent children and their mothers, the disabled, and the elderly (Klees et al. 2010, p. 28). Since the initial enactment, Medicaid eligibility has been slowly expanded beyond its original association with persons eligible for cash assistance programs. Although states generally have broad discretion in determining who their Medicaid programs will cover, to be eligible for the Federal Medical Assistance Percentage (FMAP) or matching funds, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, some States have additional “State-only” medical assistance programs that target specified poor persons who do not qualify for Medicaid. However, federal monies are not provided for State-only programs.

Medicaid beneficiaries for which the federal government provides matching funds to state governments are divided into mandatory and nonmandatory or optional categories.

Mandatory Beneficiaries

The mandatory category includes the following: limited-income families with children, as described in Section 1931 of the SSA, who meet the requirements for the AFDC program that was in effect in their State on July 16, 1996; children under age 6 whose family income is at or below 133% of the federal poverty level (FPL); pregnant women whose family income is below 133% of the FPL, who receive pregnancy-related services, and complications of pregnancy, delivery, and postpartum care; infants born to Medicaid-eligible mothers, for the first year of life with certain restrictions; Supplemental Security Income (SSI) recipients in most States, or aged, blind, and disabled persons in States that use more restrictive Medicaid eligibility requirements that predate SSI; recipients of adoption or foster care assistance under Title IV-E of the SSA; special protected groups, typically people who lose their cash assistance under Title IV-A or SSI due to earnings from work or from increased Social Security payments, but who are allowed to keep their Medicaid for a period of time; all children under age 19, in families with incomes at or below the FPL; and dual Medicare-Medicaid-eligible persons, who are usually referred to as Qualified Medicare Beneficiaries (QMBs), as well as the so-called Specified Low-Income Medicare Beneficiaries (SLMBs).

To elaborate further, QMBs are Medicare beneficiaries who have financial resources at or below twice the standard allowed under the SSI program, and incomes at or below 100% of the FPL. For QMBs, Medicaid pays the Medicare Parts A and B premiums and coinsurance and deductibles, subject to any limits imposed by their States.

SLMBs are Medicare beneficiaries who have resources similar to QMBs, but with incomes that are higher, though still less than 120% of the FPL. Medicaid pays only the Medicare Part B premiums for SLMBs. Similar to QMBs and SLMBs, employed disabled individuals who previously qualified for Medicare due to their disability, but who lost entitlement because of their return to work despite the disability, are allowed to purchase Medicare Parts A and B coverage. If they have incomes below 200% of the FPL and do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums under a category called Qualified Disabled and Working Individuals (QDWIs).

In addition to QMBs and SLMBs, the federal government provides States with a capped amount of funds to pay Medicare Part B premiums for Medicare beneficiaries with incomes above 120% and less than 135% of the FPL. These beneficiaries, who are called Qualifying Individuals (QIs), cannot be otherwise eligible for medical assistance under a State Medicaid plan. The QI benefit is 100% federally funded, up to the State's allowed amount. Established by the BBA of 1997 to take effect during Fiscal Years 1998 through 2002, the QI benefit has been extended several times. The most recent extension continued the program through December 2011 (Klees et al. 2010, p. 30).

Nonmandatory or Optional Beneficiaries

States have the option of providing Medicaid coverage for other categorically defined or optional groups. Whereas the optional groups share characteristics of the mandatory groups discussed earlier, the eligibility criteria for the optional groups are more liberally defined (Klees et al. 2010, p. 23). States can receive FMAP or matching funds under the Medicaid program for coverage of the following optional groups: infants up to age 1 and pregnant women not covered under the mandatory rules, whose family income is no more than 185% of the FPL, with the exact percentage determined by each State; children up to age 21 who meet criteria more liberal than the AFDC income and assets requirements that were in effect in their States on July 16, 1996; persons in institutions and those in home and community-based waiver programs, who are eligible under a special income level set by each State, and which may be up to 300% of the SSI Federal benefit rate; persons who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers; certain aged, blind, or disabled persons who have incomes above those requiring mandatory coverage, but below the FPL; aged, blind, or disabled recipients of State supplementary income payments; certain working-and-disabled individuals with family income less than 250% of the FPL, who would be eligible for SSI if they did not work; TB-infected individuals who would be financially eligible for Medicaid at the SSI income level if they were in a Medicaid-covered category, with coverage limited to TB-related ambulatory services and TB drugs; some uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the CDC, as required by the *Breast and Cervical Cancer Prevention and Treatment Act* of 2000 (PL 106-345); optional

targeted low-income children included in the CHIP; and “medically needy” persons whose incomes and resources are above the Medicaid eligibility level set by their State, or who spend down by incurring medical bills that reduce their incomes to or below their State’s medically needy income level.

Medicaid eligibility and benefit levels for the medically needy may be more restrictive than what is available for mandatory beneficiaries. The federal government provides matching funds for medically needy programs. If a State elects to have a medically needy program, federal rules require the coverage of certain groups of people and the provision of certain services. For example, children under age 19 and pregnant women who are medically needy must be covered. Similarly, prenatal and delivery services for pregnant women, as well as ambulatory care for children, must be made available. Furthermore, a State may decide to provide medically needy coverage to certain additional groups and may elect to provide certain additional services under its medically needy program.

While the expectation that Medicaid would reduce the exclusion from medical care of the poor, the aged, and the disabled was met, the expectation that the program would not lead to a dramatic expansion in health care coverage and costs was not borne out. It turned out that the anticipated \$238 million annual expenditure above what was spent on medical welfare programs around 1965 was reached only after six States had implemented their Medicaid programs (Grogan 2008, p. 332). The Congressional Research Service (1993, p. 30) reported that by 1967, 37 states were implementing Medicaid programs, and that spending was going up by 57% annually. Before looking at the measures that have been employed to contain these expenditures, we briefly look at the expenditure trends between 1975 and 2008.

Medicaid Expenditures

The early expenditure growth in the Medicaid program was attributed to the establishment of generous eligibility standards under states’ medically needy programs. For example, New York is reported to have enrolled families with incomes of up to \$6,000 per year (four person family income) in 1966. Congress responded by passing legislation in 1967 that lowered the medically needy eligibility level to 133.33% of a State’s AFDC means-tested level (Grogan 2008, p. 332). But in spite of this effort by the Congress to curtail program costs, Medicaid expenditures continued to increase.

Table 8.3 is a tally of Medicaid recipients and expenditures for selected years between 1975 and 2008. The data show that the most dramatic increases in program beneficiaries and expenditures occurred between 1985 and 2004. For example, total Medicaid recipients and expenditures increased by about 152 and 587% points, respectively, between 1985 and 2004 (there were 21.8 million total beneficiaries in 1985, and about 55 million total beneficiaries in 2004; there were total expenditures of about \$37.5 billion in 1985, and about \$257.7 billion in total expenditures in 2004). These sharp increases in recipients and expenditures between 1985 and 2004 were attributed to Congressional action which expanded Medicaid between 1984

Table 8.3 The distribution of Medicaid expenditures and recipients, 1975–2008

Recipients (thousands)	1975	1980	1985	1990	1995	2000	2004	2008
Total	22,007	21,605	21,814	25,255	36,282	42,763	55,002	58,771
Children ^a	9,598	9,333	9,757	11,220	17,164	19,723	26,459	28,071
Adults	4,529	4,877	5,518	6,010	7,604	8,750	12,244	12,947
Aged	3,615	3,440	3,061	3,202	4,119	3,371	4,318	4,147
Disabled	2,464	2,911	3,012	3,718	5,858	6,889	7,933	8,864
Other/unknown	1,801	1,044	466	1,105	1,537	3,671	4,048	4,912
Recipients (%)								
Total	100	100	100	100	100	100	100	100
Children ^a	43.6	43.2	44.7	44.4	47.3	46.1	48.1	47.8
Adults	20.6	22.6	25.3	23.8	21.0	20.5	22.3	22.0
Aged	16.4	15.9	14.0	12.7	11.4	8.7	7.9	7.1
Disabled	11.2	13.5	13.8	14.7	16.1	16.1	14.4	14.8
Other/unknown	8.2	4.8	2.1	4.4	4.2	8.6	7.4	8.4
Expenditures (millions) ^b								
Total	12,242	23,311	37,508	64,859	120,141	168,307	257,748	296,830
Children	2,186	3,123	4,414	9,100	17,976	26,775	44,205	57,137
Adults	2,062	3,231	4,746	8,590	13,511	17,763	30,721	37,698
Aged	4,358	8,739	14,096	21,508	36,527	44,503	59,541	61,131
Disabled	3,145	7,621	13,452	24,404	49,418	72,742	111,614	129,040
Other/unknown	491	597	800	1,257	2,709	6,524	11,667	11,824
Expenditures (%) ^c								
Total	100	100	100	100	100	100	100	100
Children	17.9	13.4	11.8	14.0	15.0	15.9	17.1	19.2
Adults	16.8	13.9	12.6	13.2	11.2	10.5	11.9	12.7
Aged	35.6	37.5	37.6	33.2	30.4	26.4	23.1	20.6
Disabled	25.7	32.7	35.9	37.6	41.1	43.2	43.3	43.5
Other/unknown	4.0	2.5	2.1	1.9	2.2	3.9	4.5	4.0

^aIncludes nondisabled children and foster care children

^bExpenditures for the “other/unknown” category were not reported separately by the CMS; rather, they were lumped together in the “total” category. Amounts shown are nominal dollars

^cThe sum of the percentages for the separate categories may not add up to 100 because of rounding

Source: Centers for Medicare and Medicaid Services Health Care Financing Review, (2010), Tables 13.4 and 13.10

and 1990, and to economic slowdown. Both of these factors resulted in additional individuals qualifying for Medicaid coverage (Letsch et al. 1992, p. 1). On the other hand, Medicaid expenditures increased at a much slower rate in the early 1980s due to reductions in the FMAP or matching rates and other cuts instituted by the *Omnibus Budget Reconciliation Act of 1981 (OBRA-81)* (Holahan and Cohen 1986).

In addition to the total number of beneficiaries and the total expenditures for each of the years shown in Table 8.2, analyses of the categories of recipients incurring the least and most expenditures reveal additional interesting trends. When children, adults, disabled, and the aged are compared, the data show that since 1975, children outnumber each of the other groups, but account for the least expenditures.

Additionally, while children were about three times more than disabled beneficiaries in each of the years reported in Table 8.2, the total expenditures for disabled beneficiaries during the period were about 2.5 times more than those of children.

In 2008, the disabled accounted for 14.8% of the Medicaid population and incurred about 43.5% of the total Medicaid expenditures for that year. Similarly, the aged accounted for 7.1% of the Medicaid population in 2008 and incurred about 20.6% of the total expenditures for the year. The aged and disabled, who together made up about 22% of the Medicaid population in 2008, accounted for about 64% of the expenditures for the year.

To further elaborate on the Medicaid costs for specific population groups, the national data for 2008 demonstrate that Medicaid payments for health services for children averaged \$2,035 per child. The 2008 payments for adults averaged \$2,912 per adult; payments for the elderly averaged \$14,742 per person; and payments for the disabled averaged \$14,558 per person (CMS 2010). These trends are certainly due to the creation in 1972 of the SSI program that conferred Medicaid eligibility to the elderly, blind, and disabled, and the fact that the aged and disabled are far more expensive to insure than adults and children.

Similar to Medicare, increased Medicaid expenditures has raised serious concerns among State and Federal policy makers. Therefore, shortly before 1980 till now, one of the primary goals of Federal and State lawmakers and Medicaid administrators has been efforts to control the growth in program expenditures. Therefore, in the next few pages, we examine the approaches and measures that have been utilized to contain Medicaid expenditures.

Medicaid Cost Containment

The quest for Medicaid cost control began in the 1970s during the Nixon administration. The 1972 amendments to the SSA provided the first major changes in the direction of Medicaid coverage. The amendments eliminated Medicaid's goal of comprehensive health care coverage for the poor in response to state governments' concerns about Medicaid expenditure growth. This quest for Medicaid cost control became more intense after President Reagan assumed office in January 1981, with a public mandate to cut federal spending and curtail federal regulations.

The budget President Reagan submitted to the Congress in 1981 proposed to put a limit or cap on how much the federal government would spend on Medicaid in any given year. If the cap had been implemented, the proposal would have cut about \$9 billion in federal Medicaid spending from 1981 to 1985 (Iglehart 1985, p. 59). The proposal was not adopted by the Congress, but other spending proposals were on the way.

The *Omnibus Budget Reconciliation Act* of 1981 (OBRA-81) imposed a temporary reduction in the federal matching rate for Medicaid in each State of 3% in 1982, 4% in 1983, and 4.5% in 1984 (Davis et al. 1990, p. 73). In addition, the legislation allowed state governments to experiment with new approaches to control Medicaid costs, such as innovative new provider payment methods and other approaches to

Table 8.4 Medicaid managed care trends^a

Year	Total Medicaid population	Managed care population	Other population	Percent managed care enrollment
2009	50,471,859	36,202,281	14,269,578	71.73
2008	47,142,791	33,427,582	13,715,209	70.91
2007	45,962,271	29,463,098	16,499,173	64.10
2006	45,652,642	29,830,406	15,822,236	65.34
2005	45,392,325	28,575,585	16,816,740	62.95
2004	44,355,955	26,913,570	17,442,385	60.68
2003	42,740,719	25,262,873	17,447,846	59.11
2002	40,147,539	23,117,668	17,029,871	57.58
2001	36,562,567	20,773,813	15,788,754	56.82
2000	33,690,364	18,786,137	14,904,227	55.76

^aThe figures represent point-in-time enrollment as of June 30 for each reporting year. The unduplicated managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits, as well as individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards. The national figures for the Total Medicaid population and Other population are unduplicated

Source: CMS (2011c)

curtail health care utilization by beneficiaries. Under the law, states were given the authority to determine Medicaid hospital payment levels and methods and to find alternatives to the fee-for-service physician payment model. These innovations centered on case management, capitated reimbursement practices, and gatekeeping.

State governments responded to the new authority granted them under OBRA-81 and to increased local pressures to contain expenditures, by limiting Medicaid income eligibility standards, limiting coverage of the optional groups discussed earlier, finding new ways to pay for hospital care, such as rate setting and selective contracting, devising alternative delivery systems, or by doing all of those things. The waiver application process for alternative delivery plans was streamlined and simplified in order to make it faster and easier to implement.

The authority granted to states by the OBRA-81 generated interest in the managed care option within the Medicaid program. Managed care, discussed in greater detail in Chap. 4, was expected to contain program costs, curtail Medicaid beneficiaries' use of hospital emergency rooms for routine care, and to minimize the relatively high inpatient hospital admission rates and lengths of stay among the Medicaid population. Therefore, since the early 1980s, significant growth occurred in the enrollment of Medicaid beneficiaries in managed care plans.

As shown in Table 8.4, as of June 30, 2009, about 36.2 million Medicaid beneficiaries, or 72% of the 2009 Medicaid population of about 50.5 million people, were enrolled in managed care plans throughout the 50 states, the Virgin Islands, and the District of Columbia. Additionally, except between 2006 and 2007, managed care enrollment has grown steadily between 2000 and 2009. While the Medicaid population grew by 50% between 2000 and 2009, the Medicaid managed care population grew by about 93% during the same period (CMS 2011c).

The growth in Medicaid managed care enrollment documented above has been facilitated by the authority granted to state governments under OBRA-81, as well as the grant of waiver authority to make it easier to implement managed care programs. Waiver authority under Sections 1915(b), 1915(c), and 1115 of the SSA is an important part of the Medicaid program.

Medicaid Waivers

As was discussed earlier, States design and operate their Medicaid programs under broad federal guidelines. These federal guidelines specify what they can or cannot do. For example, while the BBA of 1997 allows States to implement primary care case management services without the need for a waiver, there are generally three major federal limitations. First, under the freedom of choice provision of the Medicaid law, States are required to allow Medicaid beneficiaries to choose their medical providers. Second, the comparability requirement mandates that States offer the same benefit packet to all mandatory groups. And, third, the statewideness provision mandates that every managed care program must be statewide and not confined to a small area of the State.

Under the Medicaid waiver program, States can apply for and use the 1915(b) waiver authority to limit Medicaid beneficiaries' freedom to choose their providers. This allows the State to assign Medicaid recipients specific PCPs in order to curtail the inappropriate utilization of specialists and other higher levels of care. Similarly, Section 1115 waivers allow states to implement experimental, pilot, or demonstration projects that may not be statewide in nature.

Flexibility under Section 1115 waivers is broad enough to allow states to test substantially new ideas of policy merit that have not been demonstrated on a widespread basis. Projects are usually approved for an initial 5-year period, with the option to submit renewal requests to continue the project for additional periods of time. Section 1115 waiver proposals must be approved by the CMS, the Office of Management and Budget (OMB), and the DHHS and may be subject to site visits and evaluations before implementation.

Section 1915(c) waivers allow states to provide HCBS to their disabled and elderly populations. Additionally, States may opt to simultaneously use Section 1915(b) and 1915(c) program authorities to offer a range of services to disabled and elderly Medicaid populations. By this method, states can offer traditional LTC services, such as home health, personal care, and institutional services, as well as the nontraditional services, such as homemaker and adult day care services, and respite care.

States implementing 1915(b) and 1915(c) concurrent waivers must meet the federal requirements for both programs. Accordingly, when applying for the concurrent waiver authority, states are required to submit a separate application for each waiver type and to satisfy all the applicable requirements, such as the neutrality requirement of the 1915(c) waiver, the cost-effectiveness requirement of the 1915(b)

waiver, as well as the separate reporting requirements for each waiver. According to the CMS (2011d), while meeting the separate requirements for a 1915(b) and 1915(c) concurrent waiver authority can be a potential impediment to States considering such a program, the ability to develop an innovative managed care program that integrates HCBS with traditional state plan services is appealing enough to some states to outweigh the potential impediments.

Public perceptions of different groups affect their likelihood of getting Medicaid benefits and the generosity of the benefits they receive. As our discussion so far has shown, children and the elderly fare better than able-bodied unemployed and poor employed citizens, who fare better than noncitizens and illegal immigrants. For example, the *Deficit Reduction Act* (DRA) of 2005 (PL 109-171) refined eligibility requirements for Medicaid beneficiaries by tightening standards for citizenship and immigration documentation, thereby making it harder for noncitizens and both legal and illegal immigrants to qualify for Medicaid. On the other hand, as the following discussion about the plight of children under welfare reform demonstrates, efforts have always been made to maintain or expand Medicaid eligibility for poor children who are perceived to have no control over their socioeconomic conditions.

The Repeal of the AFDC Program and the Creation of SCHIP

As a result of the fear that the repeal of the AFDC program would result in more uninsured children, the SCHIP, now simply called the CHIP, was implemented in 1997.

The *Personal Responsibility and Work Opportunity Reconciliation Act* of 1996 (PL 104-193), also known as the “welfare reform” bill, created the block grant program, Temporary Assistance for Needy Families (TANF), to replace the AFDC program on which Medicaid eligibility for dependent children was based. TANF generally limits a family’s lifetime cash welfare benefits to a maximum of 5 years and permits States to impose other wide-ranging requirements related to employment.

Under welfare reform, people who would have been eligible for AFDC under the program requirements in effect on July 16, 1996, are generally still eligible for Medicaid. In other words, welfare reform cut Medicaid’s longstanding tie to AFDC, but kept Medicaid intact. Therefore, a large number of families and children continued to be eligible for Medicaid, but not TANF. But the problem was how to keep track of the Medicaid-eligible children who were, until welfare reform, tracked through the AFDC program. This concern generated the fear that many of the untracked children would go without Medicaid coverage. Congress created the SCHIP in 1997 to address these concerns.

SCHIP was authorized under Title XXI of the SSA. At its creation in 1997, it was the largest expansion of taxpayer-funded health insurance coverage for children in the United States since the passage of Medicaid in 1965 (Wikipedia 2011b). Similar to Medicaid, the program is jointly funded by the federal and state governments.

States administer the program according to guidelines set by the CMS. The federal government allows States the option of designing their SCHIP independent of Medicaid (separate child health programs), or using SCHIP funds to expand their Medicaid programs (SCHIP Medicaid expansion programs), or combining the two approaches (SCHIP combination programs). Separate child health programs have a lot more flexibility than Medicaid programs. Overall, federal matching rates for SCHIP are more generous than the regular Medicaid match. To qualify for these enhanced SCHIP funds, states must submit their coverage expansion plans to the CMS.

The SCHIP was initially authorized for 10 years. In order to continue to receive funding after federal fiscal year 2007, a reauthorization bill had to be passed. Two reauthorization bills, which also expanded the scope of the program, were vetoed by President George W. Bush. However, a 2-year reauthorization bill that did not involve any program expansion was signed by President Bush in December 2007. When Democrats gained majorities in both Houses of Congress following the 2008 Presidential and Congressional election cycles, SCHIP was reauthorized (PL 111-3) in January 2009. President Obama signed the reauthorization legislation on February 4, 2009, and SCHIP was simply called CHIP with effect from March 2009. Therefore, we have been using SCHIP and CHIP interchangeably throughout the book.

As of 2010, about 7.7 million American children were enrolled in CHIP. The results of studies conducted to evaluate the impacts of the program are mixed. For example, Rimsza et al. (2007, p. 1026) have found that children who drop out of SCHIP cost states more money because they shift away from using routine care to more frequent emergency care use. The CBO, in a 2007 study, concludes that “for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children,” possibly because of the desire to remain in the public programs that offer better benefits at lower costs than private programs. Similarly, Kenney and Chang (2004, p. 51) argue that while SCHIP has improved children’s access to health care and sparked innovation in program design and improvements in Medicaid, the program has added to the complexity of the insurance system and introduced new inequities in access to insurance. For example, they argue that SCHIP is imperfectly targeting eligible children who are uninsured, and its financing is problematic because of the block grant funding structure and the use of program funds to cover adults.

As we noted at the beginning of this chapter, the health disparities among different population groups in the United States would have been worse had it not been for the creation of the safety net programs of Medicare, Medicaid, and CHIP. These programs have improved access to health care for the elderly, the poor, the disabled, and children. However, at a time of changing beliefs about the role of government, serious economic problems, and large public debts, serious concerns are raised about the survivability of the safety net programs. The supporters of the PPACA argue that the legislation is necessary to address these concerns and to expand insurance coverage to the large population of the uninsured. As would be expected, the opponents of the PPACA disagree. Therefore, it is important to devote the next chapter to the health care reform legislation and its likely impacts, perceived or real, on Medicare, Medicaid, CHIP, and the uninsured.

Conclusion

The health expansions put in place during the postindustrial period of the evolution of the health care system did not curtail inequities in the distribution of health services. At the same time, the prices of medical care increased significantly, causing serious problems for the poor and elderly. Consequently, Medicare, Medicaid, and more recently, CHIP, were created to provide health insurance coverage to the nation's vulnerable population groups. Medicare finances hospital, physician, other acute care, and prescription drug services for the elderly and disabled. Medicaid is a joint federal-state program that provides medical assistance to certain individuals and families who meet income criteria and asset requirements, including the poor, elderly, disabled, and children. CHIP was established by the BBA of 1997 to provide health insurance coverage to children who were likely to lose Medicaid coverage because of welfare reform. All these safety net programs are being questioned and seriously scrutinized in the present environment characterized by calls for smaller governments and low debts and taxes; and by slow economic growth. Proponents of the PPACA of 2010 argue that the legislation has addressed some of the uncertainties associated with these safety net programs, while opponents vehemently disagree. Therefore, the next chapter is devoted to examining health care reform.

Review Questions

1. What impressions did the phrase, socialized medicine, coined by the AMA to attack President Harry Truman's proposal for a national health insurance program create in the minds of the public about the proposal?
2. Why did limiting the Medicare proposal to aged Social Security beneficiaries lead to what Paul Starr describes as "a groundswell of grassroots support" for the proposal?
3. What significant changes did the BBA of 1997 make to the Medicare program? What are the significance and implications of the changes?
4. What are the implications of Medigap insurance companies using medical underwriting to decide who to insure and how much premium to charge?
5. What are the indirect benefits of the Medicare program? How significant are these indirect benefits?
6. How did Medicare try to restrain its costs in the 1970s and 1980s?
7. What population groups receive health insurance coverage under Medicaid?
8. How well has Medicaid reduced the exclusion from medical care of the poor and the aged?
9. Why is it that even though children on Medicaid outnumber the program's aged and disabled beneficiaries, they, the children, account for the least expenditures under the program?
10. What measures has Medicaid employed to restrain its costs since the early 1980s?

11. Distinguish between Section 1115, 1915(b), and 1915(c) waivers. What effects have these waivers had on the Medicaid program and program beneficiaries?
12. How do the perceptions of different needy groups impact their likelihood of getting government assistance and the generosity of the assistance they receive? Cite some specific examples where possible.

References

- Aaron, H.J., and R.D. Reischauer. 1995. "Medicare Analysis—The Medicare Reform Debate: What Is the Next Step." *Health Affairs* 14(4) (Winter): 8–30.
- Altman, S.H., U. Reinhardt, and D. Schactmand, eds. 1997. *Policy Options for Reforming the Medicare Program*. Princeton, NJ: The Robert Wood Johnson Foundation.
- Biles, B., C.J. Schramm, and J.G. Atkinson. 1980. "Hospital Cost Inflation Under State Rate-setting Programs." *The New England Journal of Medicine* 303(12): 664–668.
- Centers for Medicare and Medicaid Services (CMS). 2011a. "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." Retrieved May 26, 2011, at <http://www.cms.gov/Medigap/>.
- _____. 2011b. "Disproportionate Share Hospital (DSH)." Retrieved May 26, 2011, at http://www.cms.gov/AcuteInpatientPPS/05/_dsh.asp.
- _____. 2011c. "National Summary of Medicaid Managed Care Programs and Enrollment as of June 30, 2009." Retrieved June 1, 2011, at <http://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/09Trends.pdf>.
- _____. 2011d. "Medicaid State Waiver Program Demonstration Projects—General Information." Retrieved June 1, 2011, at http://www.cms.gov/MedicaidStWaivProgDemoPGI/06_Combined1915bc.asp.
- _____. 2010. *Medicare and Medicaid Statistical Supplement*, 2010 Edition. Retrieved June 1, 2011, at http://www.cms.gov/MedicareMedicaidStatSupp/09_2010.asp.
- Chovan, T., C. Chen, K. Buck, and J. John. 2009. "Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions Among Medicare Advantage Enrollees in California and Nevada, 2006." *America's Health Insurance Plans (AHIP)*. Retrieved May 1, 2011, from <http://www.ahipresearch.org/pdfs/CAvsNV.pdf>.
- _____. 2009. "Working Paper: Comparisons of Utilization in Two Large Multi-State Medicare Advantage HMOs and Medicare Fee-for-Service in the Same Areas." *America's Health Insurance Plans (AHIP)*. Retrieved May 1, 2011, from http://www.ahipresearch.org/pdfs/MAvsFFS_CO9and10.pdf.
- Congressional Budget Office (CBO). 2007. "The State Children's Health Insurance Program." Retrieved June 1, 2011, at <http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf>.
- Congressional Research Service. 1993. *Medicaid Source Book: Background Data and Analysis: A Report*. Prepared by the Congressional Research Service for the Use of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives—A 1993 Update. Washington, DC: U.S. Government Printing Office, 1–1127.
- Davis, K., G.F. Anderson, D. Rowland, and E.P. Steinberg. 1990. *Health Care Cost Containment*. Baltimore, MD: Johns Hopkins.
- _____. and C. Schoen. 1978. *Health and the War on Poverty: A Ten-Year Appraisal*. Washington, DC: Brookings.
- Frist, B. 1995. "Perspectives on Medicare—The Future of Medicare: One Senator's Vision." *Health Affairs* 14(4) (Winter): 82–88.
- Grogan, C.M., and E.M. Patashnik. 2003. "Universalism Without Targeting: Nursing Home Care, the Middle Class, and the Politics of the Medicaid Program." *Social Service Review* 77(1): 51–71.

- Grogan, C.M. 2008. "Medicaid: Health Care for You and Me?" In *Health Politics and Policy*, 4th ed., eds. J.A. Morone, T.J. Litman, and L.S. Robins. Clifton Park, NY: Delmar, 329–354.
- Gusmano, M., and M. Schlesinger. 2001. "The Social Roles of Medicare: Assessing Medicare's Collateral Benefits." *Journal of Health Politics, Policy and Law* 26(1) (February): 37–79.
- Harris, R. 1966. *A Sacred Trust*. New York, NY: New American Library.
- Hellinger, F.J. 1998. "The Effect of Managed Care on Quality: A Review of Recent Evidence." *Archives of Internal Medicine* 158(8) (April 27): 833–841.
- Holahan, J.F., and J.W. Cohen. 1986. *Medicaid: The Trade-Off Between Cost Containment and Access to Care*. Washington, DC: Urban Institute Press.
- Iglehart, J.K. 1982. "The New Era of Prospective Payment for Hospitals." *The New England Journal of Medicine* 307(20): 1288–1292.
- . 1985. "Medical Care of the Poor—A Growing Problem." *The New England Journal of Medicine* 313(1): 59–63.
- Institute of Medicine (IOM). 1997. *On Implementing a National Graduate Medical Education Trust Fund*. Committee on Implementing a National Graduate Medical Education Trust Fund, Division of Health Care Services. Washington, DC: National Academy Press.
- Klees, B.S., C.J. Wolfe, and C.A. Curtis. 2010. "Brief Summaries of Medicare and Medicaid: Title XVIII and Title XIX of the Social Security Act as of November 1, 2010." Retrieved May 26, 2011, at <http://www.cms.gov/MedicareProgramRatesStats/downloads/MedicareMedicaidSum>.
- Kenney, G., and D.I. Chang. 2004. "The State Children's Health Insurance Program: Successes, Shortcomings, and Challenges." *Health Affairs* 23(5): 51–62. DOI: 10.1377/hlthaff.23.5.51.
- Letsch, S.W., H.C. Lazenby, K.R. Levit, and C.A. Cowan. 1992. "National Health Expenditures, 1991." *Health Care Financing Review* 14(2) (Winter): 1–30.
- Marmor, T.R. 2000. *The Politics of Medicare*, 2nd ed. New York, NY: Aldine De Gruyter.
- McMullan, M. 1996. "HCFA's Consumer Information Commitment." *Health Care Financing Review* 18(1): 9–14.
- Medicare.gov. 2011a. "Your Medicare Benefits." Retrieved May 26, 2011, from <http://www.medicare.gov/publications/pubs/pdf/I01116.pdf>.
- . 2011b. "Medicare Advantage (Part C): What is a Medicare Advantage Plan (Part C)?" Retrieved May 26, 2011, from <http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx>.
- Merlis, M. 2008. "The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006." Retrieved May 10, 2011, from <http://www.kff.org/medicare/upload/7744.pdf>.
- Moon, M., and K. Davis. 1995. "Medicare Analysis—Preserving and Strengthening Medicare." *Health Affairs* 14(4) (Winter): 31–46.
- National Association of Social Workers (NASW) 1997. "Balanced Budget Act of 1997 (Public Law 105–33): Significant Changes Made in Children's Health, Welfare, Medicaid and Medicare." Retrieved May 26, 2011, from <http://www.socialworkers.org/archives/advocacy/updates/1997/grbudget.htm>.
- Oberlander, J. 2008. "Medicare: The Great Transformation." In *Health Politics and Policy*, 4th ed., eds. J.A. Morone, T.J. Litman, and L.S. Robins. Clifton Park, NY: Delmar, 310–327.
- Rimsza, M.E., R.J. Butler, and W.G. Johnson. 2007. "Impact of Medicaid Disenrollment on Health Care Use and Cost." *Pediatrics* 119 (5) (May): e1026–e1032. DOI:10.1542/peds.2006–2747.
- Starr, P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York, NY: Basic Books.
- Stevens, R.B., and R. Stevens. 1974. *Welfare Medicine in America: A Case Study of Medicaid*. New York, NY: Free Press.
- Trivedi, A.N., A.M. Zaslavsky, E.C. Schneider, and J.Z. Ayanian. 2006. "Relationship Between Quality of Care and Racial Disparities in Medicare Health Plans." *JAMA* 296 (16) (October 25): 1998–2004.
- 2006–2010 Annual Reports of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Retrieved May 14, 2011, at <https://www.cms.gov/ReportsTrustFunds/downloads/tr2002–2011.pdf>.

- Ubokudom, S.E. 1998. "The Association Between the Organization of Medical Practice and Primary Care Physician Attitudes and Practice Orientations." *Social Science and Medicine* 46(1): 59–71.
- United States Government Accountability Office (GAO). 2008. "Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006." GAO-09-132R, Washington, DC (December 8).
- U.S. Department of Health, Education and Welfare (DHEW). 1971. *Towards a Comprehensive Health Policy for the 1970s: A White Paper*. Washington, DC: U.S. Government Printing Office.
- Wikipedia. 2011a. "Medicare (United States)." Retrieved May 26, 2011, from [http://en.Wikipedia.org/wiki/Medicare\(UnitedStates\)](http://en.Wikipedia.org/wiki/Medicare(UnitedStates)).
- _____. 2011b. "State Children's Health Insurance Program." Retrieved June 1, 2011, at http://en.wikipedia.org/wiki/State_Children%27s_Health_Insurance_Program.

Chapter 9

Health Care Reform in the United States

The previous chapters of the book have identified the major factors that influence the health care delivery and policymaking systems. The impacts of environmental factors on the health care system have been both positive and negative. On the one hand, the United States is foremost in the world in the development and deployment of advanced medical technologies and equipment. Furthermore, the standards adopted by the nation's medical schools and health facilities far surpass, or are comparable to, those of other advanced countries.

But, on the other hand, as we discussed in Chap. 1 and subsequent chapters of the book, the health care system experiences serious problems related to costs, quality, accessibility, and disparities in the health status of the population. These systemic problems have continuously led to calls to reform the health care system dating back several decades. Therefore, it is worthwhile and appropriate to devote this chapter to examine the attempts that have been made to reform the health care system since the early 1900s to the present time. We begin with the early history of health care reform in the country.

Early History of Health Care Reform

As we discussed in Chap. 2, the clamor for health insurance in Europe was due to at least four factors, namely, the loss of income people experienced due to illness, the burden of high health care costs on the individual, the decline of economic and industrial productivity caused by illness, and the social costs of medical care or the effects of high health care costs on family incomes and routines. Therefore, insurance was promoted as a means of spreading the risks of lost income to working families and curtailing the decline of industrial productivity. However, health insurance was not a major political issue in the United States before World War I (WWI) (Starr 1982, p. 236).

When health insurance finally became a political issue in America on the eve of WWI, the preexisting political conditions and institutions were ill-equipped to promote it.

According to Paul Starr (1982, p. 240), as of 1900, American government was highly decentralized, engaged in little direct regulation of the economy or social welfare, and had a small unprofessional civil service. The social, cultural, political, and attitudinal nature of the country in the early 1900s could not support the types of insurance reforms that took place in Europe. It appears that some of those early attitudinal, social, cultural, and political factors still prevail today. Therefore, as we stated in the introductory chapter of the book, efforts to achieve major reforms of the health care system failed from 1920 to 1994 (Hacker 2009, p. 11) primarily due to these environmental influences.

The list of policy makers, groups, organizations, and past presidents who failed in their bids to institute major reforms of the health care system and enact universal coverage is long. We cannot list all of them here, but some of the major ones include Theodore Roosevelt and the “Bull Moose Party,” the American Association for Labor Legislation (AALL), the Harry Truman administration, the John F. Kennedy and Lyndon B. Johnson administrations, and the William Clinton White House (Starr 1982, p. 235; Skidmore 2010, p. 185).

The efforts that some of the above policy makers and groups made to reform the health care system were discussed in Chap. 2 and subsequent chapters of the book. Accordingly, the presentation that follows is brief and only designed to reemphasize some of the important issues that have already been discussed, and to introduce new issues and political actors that were not part of the discussion in Chap. 2. We begin with the efforts of late President Theodore Roosevelt and his Bull Moose Party.

Theodore Roosevelt

Teddy Roosevelt, as he was nicknamed, was the 26th President of the United States, and 33rd Governor of the State of New York, who attempted to move the Republican Party toward “Progressivism.” He coined the phrase “Square Deal” to describe his domestic agenda. He declined to run for reelection in 1908, but jumped back into politics a few years after the decision not to seek reelection. In anticipation of another try at the presidency, he began, in 1910, to propose health care, social security, unemployment insurance, and the right of women to vote. His support for health care was based on the belief that a country whose citizens were sick and poor would not be strong.

In 1912, Theodore Roosevelt attempted to wrest the Republican Party nomination from William Howard Taft. Failing that, he formed his Progressive Party, nicknamed the Bull Moose Party based on his remark to supporters that he felt as fit as a bull moose. We have no way of knowing if he would have been successful in enacting his health care proposals had he won the presidential election of 1912. However, health policy scholars believe that his defeat by Woodrow Wilson postponed for another 2 decades active national government involvement in extensive management of social insurance and social welfare (Starr 1982, p. 244).

The AALL

The AALL, a group of social progressives founded in 1906, sought the prohibition of child labor and supported unemployment relief through public works, state employment agencies, and unemployment insurance (Yellowitz 1965, p. 55; Lubove 1970). The AALL organized the first national conference on social insurance in June 1913. The committee focused on health insurance and published a draft health insurance bill in 1915.

The draft AALL health insurance bill limited participation in the proposed scheme to workers and their dependents. The benefits that were to be payable under the program were of four kinds—medical aid, including all provider (physicians, nurses, and hospitals) services; sick pay, to cover a portion of lost wages for a specified period of time; maternity benefits for the wives of insured men, as well as for insured women; and a death benefit of \$50 to pay for the funeral expenses of deceased workers. The costs of these benefits were estimated at 4% of wages and were to be shared by employers, employees, and the government (Starr 1982, p. 244).

The AALL sought to involve the leaders of the medical profession in formulating the draft health insurance bill, and found prominent physicians who were both sympathetic and motivated to help secure the necessary legislation. Some of these supportive physicians were prominent leaders of the AMA, including the editor of the association's journal and the secretary of the newly created AMA Council on Health and Public Instruction (Numbers 1978; Tishler 1971, p. 167). The AMA set up a three-man committee to work with the AALL on the issue of health insurance.

Despite the obvious cooperation between the AALL and the AMA, there were areas of serious disagreement. These disagreements centered around physicians' incomes and autonomy, the possible subordination of medical practice to public health, the promotion of group practice, and a possible change in the method of payment from fee-for-service to salary or capitation. These disagreements grew into serious opposition from several state medical societies. Additionally, the American Federation of Labor (AFL) and business groups opposed the AALL's health insurance proposal.

Spokesmen for American businesses typically rejected the argument that health insurance would add to productive efficiency. The growing opposition from physicians and business groups did not help the health insurance movement. More importantly, America's entry into WWI in April 1917 diverted the nation's attention on social reform and made it easy for health insurance opponents to link the concept with Nazi Germany. These events led to the demise of the health insurance movement for at least the next decade, or until the advent of Franklin D. Roosevelt's presidency.

The Franklin D. Roosevelt Administration

As was discussed in Chap. 2, the problems caused by the Great Depression could have been the catalyst that was necessary to pass a national health insurance program. The Depression revived the social insurance movement in the country, led to the

spread of labor unions and the abandonment by the AFL of its long-standing opposition to social insurance programs, and brought to power a Democratic administration that was sympathetic to the federal government's involvement in economic and social programs.

But, with millions of Americans unemployed during the Depression, President Roosevelt and his advisers were more interested in old-age and unemployment insurance than in health insurance. The president shared the belief held by some of his cabinet members and top advisers that physician opposition precluded any action on health insurance. Therefore, as we noted previously, health insurance was omitted from the Social Security Act of 1935. Researchers attribute this action to the unwillingness of President Roosevelt to challenge the AMA (Blum 1967, p. 72; Altmeyer 1968, p. 57; Witte 1962, p. 174). His successor, Harry Truman, gave full support to the health insurance initiative.

The Harry Truman Administration

Supporters of health insurance came to agreement in the early 1940s that health insurance be operated as part of Social Security. They advocated the principles of comprehensiveness and universality and incorporated these principles into the Wagner-Murray-Dingell bill introduced in 1943. The bill also incorporated elements of the Beveridge model that was under consideration in Great Britain at the time. The Beveridge health service model involves universal coverage, general tax-based financing, and national ownership and control of the factors of production of health services (Poen 1979, p. 31).

Shortly after becoming president, Truman affirmed Roosevelt's 1944 call for an "economic bill of rights," including a right to adequate medical care. Stressing that he was not advocating socialized medicine, Truman called for, in the following order: the expansion of hospitals; increased support of public health and maternal and child health services; federal aid for medical research and education; and the establishment of a single health insurance system that was to include all classes of the society, such as professionals, agricultural workers, and domestic servants who were not part of Social Security. Under the plan, the public sector was to pay the insurance premiums of those who were too poor to pay for themselves.

As we stated in Chap. 2, the Truman administration's proposal did not receive the support of physicians, and there was no overwhelming Congressional support for the plan either. However, the effort did result in the establishment of the National Institute of Health and the passage of the Hill-Burton program, both in 1946.

The presidency of Dwight D. Eisenhower, from 1953 to 1961, was marked by recurring recessions, rising unemployment, and stagnant economic growth. The period was not characterized by any bold initiatives to solve the problems facing the nation and its people. Accordingly, John F. Kennedy's campaign for the presidency was based on the slogan of getting the country moving again. The economic expansion experienced during the Kennedy administration led to the planning of new social initiatives.

The John F. Kennedy Administration

The Kennedy administration criticized what it called complacency and resistance to change in Congress. In the early 1960s, there developed a movement for contributory hospital insurance for the aged, a call for the training of more medical personnel, especially physicians and nurses, and a call to expand ambulatory care services in the country. The Hill–Burton program of the Truman administration was said to have neglected ambulatory care and overemphasized inpatient hospital construction. Similarly, there was movement away from inpatient mental hospitals and toward community settings and nursing homes. Accordingly, the Kennedy administration championed community-based mental health services as a new federal program. In addition, the president asked his policy advisers to begin developing an antipoverty program. This antipoverty initiative and a limited health care program for the elderly were to be taken up and vigorously promoted by Kennedy’s successor, Lyndon B. Johnson.

The Lyndon B. Johnson White House

At the outset, medical care was not a central part of President Johnson’s antipoverty program. But as the president’s programs were initiated, medical care became an important component of the initiatives.

As was discussed in Chap. 2, Congress responded to the pressure to provide insurance coverage for the elderly by passing the Kerr–Mills Act in 1960, followed by passage of Medicare and Medicaid in 1965. In addition, there was a massive infusion of federal money to establish neighborhood health centers to provide comprehensive ambulatory care.

The years following the passage of Medicare and Medicaid witnessed the expansion of health services to large segments of the population, on the one hand, and increased costs, on the other hand. The assumptions that Americans needed more medical care than the existing system could provide, and that a large number of citizens lacked access to health services, were replaced by the assumptions that the health care system was too large and the costs too high. Therefore, the Nixon administration proposed only minor changes in health care programs during its first 2 years in office. As we discussed in Chap. 4, the focus of the administration was on containing expenditures, beginning around 1971.

Presidential candidate Jimmy Carter campaigned in 1976 on balancing the federal budget and enacting a national health plan to expand health insurance coverage to the entire population. However, rising costs and the need to contain those costs came to dominate the Carter administration’s health policy agenda. The president reasoned that he had to contain costs before attempting to expand coverage to those who were without it. The administration’s cost containment proposals set the groundwork for successful passage of the Medicare hospital payment reform in 1982 and 1983 (Davis et al. 1990, p. 31).

Like his predecessor, President Reagan focused on cutting federal health expenditures. On his urging, Congress enacted significant and important changes in federal health programs. These efforts sought to restrain federal spending for some health programs while also giving states greater discretion over health funding.

An exception to the cost containment posture of the Reagan presidency was the president's realization, at about the same time his cost containment laws were passed, that the Medicare program did not cover all the health expenditures of the elderly. This phenomenon, called "medigap," was described more fully in the previous chapter. Reagan's catastrophic insurance coverage proposal for the elderly resulted in the passage of the *Medicare Catastrophic Coverage Act* of 1988. This legislation, as we have already discussed, was repealed in November 1989, about 9 months after George H.W. Bush assumed the presidency.

High health care costs featured prominently in the 1992 presidential election debate. The incumbent president, George H.W. Bush, proposed specific tax credits for working families to offset the costs of health insurance. Poor families were to be given vouchers to buy health insurance. Similarly, some specified tax incentives were proposed for small businesses and the self-employed. As would be expected, President George H.W. Bush's challenger, William Clinton, also promised comprehensive health care reform if elected. Therefore, the *Health Security Act* of 1993 was an attempt by President Clinton to fulfill his health care-related campaign pledge to the American People.

The William Clinton White House

Weissert and Weissert (2002, p.106) write that although many past presidents had proposed major health reforms, none did so with the fervor and dedication of President Clinton. As we discussed in Chap. 3, Clinton and his advisers were credited with raising the problems of uninsurance and inflationary health care costs to national prominence during the 1992 presidential election campaign.

After decades of failures and "near misses," as the discussion in this chapter has so far shown, President Clinton wanted to ultimately be the one who would reform the health care system. The President was unwilling to compromise his vision of the type of reform the health care system needed. Toward this end, he assembled more than 500 health experts, divided into task forces, under the direction of his wife, Hillary Rodham-Clinton, to write a health care reform plan for the country within 100 days.

The work of writing the Clinton reform plan was done in secret. The goal was not to leak any parts of the plan to the groups that were to be directly affected by the planned changes, so as not to give them the opportunity to develop counterarguments and strategies to defeat the plan. Although keeping the deliberations of the task forces secret may have been a clever political strategy so as not to allow antireformers to strategize to defeat any proposals that came out of the deliberations, the strategy infuriated members of the press who questioned why the public's business

was conducted behind closed doors. The public, the media argued, had the right to know what was being discussed. These criticisms may have had the effect of casting serious doubts in the public's mind before the final plan was released.

The size of the group—more than 500 persons—that was assembled to write the reform proposal was itself problematic. The success of the task forces and the product of their deliberations were influenced by the actions of the participants, participants who differed in their goals, strategies, and motivations. Although they were highly educated and specialized in their different fields, the experts found it difficult to agree on the major elements of the reform (White 1995, p. 373). As a consequence, the plan that was proposed to the White House and eventually presented to the American people was very complex, liberal in approach, expensive (Quirk and Cunio 2000, p. 200), and was not supported either by the business community (Morone 1995, p. 391) or elites (Jacobs and Shapiro 1995, p. 411) or the general public (Brodie and Blendon 1995, p. 403). Table 9.1 shows the essential features of the Clinton administration's reform plan and their expected effects.

Table 9.1 clearly demonstrates that the Clinton reform plan was very comprehensive and ambitious. It was designed to fundamentally restructure the US health care system. It was not, in any way, similar to the other reform proposals we have examined up to this point. In other words, it did not follow the incremental approach that has dominated US health policymaking or, indeed, all public policymaking in the country. As we discussed in previous chapters, even though the Clinton administration enjoyed Democratic majorities in both the House and the Senate, the administration's reform plan was not voted on in either chamber.

Whole books and journals have been devoted to explaining why the Clinton plan failed. The explanations offered for the failure of the *Health Security Act* vary. Analysts attribute the failure of the reform plan to the president, the complexity of the plan, the president's wife, who chaired the entire reform effort, the inability of Democratic lawmakers to forge a united front in Congress, relentless Republican opposition to the proposal, various interest groups' opposition to the plan, and the failure of the American people to rally around the proposal and urge their representatives to support it.

But, none of the above factors taken individually can explain the failure of the *Health Security Act*. A more plausible explanation is that all of the above factors, and the environment that gave rise to them, led to the failure of the plan. In other words, the fragmentation of political power in the country creates many opportunities to veto reform proposals; the remarkably decentralized, more permeable, and less manageable nature of Congress (Peterson 1993, p. 395) makes meaningful reform less likely to pass; the lack of cohesiveness in the health policy community makes it difficult to achieve policy change; the fact that health care now accounts for more than one seventh of the US economy means that even more interests have something to lose if meaningful comprehensive reform were to pass—in other words, health care reform involves concentrating the costs of the reforms on a few groups who have a very strong incentive to fight proposed changes; the nation's debt burden makes it difficult for government to finance health care reform; and the independence of members of Congress and the ability of reform opponents to use the media

Table 9.1 Essential features of the 1993 Clinton reform plan

Structural features	Expected effects
1. Creation of health insurance purchasing networks or alliances	Was expected to give buyers more bargaining power and control over the costs of insurance premiums
2. Universal coverage	To ensure continuous insurance coverage or what the president called “health security” for Americans. To discourage cost-shifting from the uninsured to those with insurance coverage
3. Employers pay a substantial portion of their employees’ health insurance costs; employees would pay up to 20% of insurance premium costs; 75 cents per pack of cigarettes tax; limits on tax deductions for premiums beyond a predetermined amount	The so-called employer mandate; employee share of the premium costs sought to control the utilization of services by consumers, thereby making them more cost conscious when seeking treatment; cigarette tax was expected to raise revenues to fund the plan and, hopefully, to discourage tobacco consumption; limits on tax deductions for insurance premiums was expected to discourage the high cost insurance or the so-called Cadillac plans
4. Standard acute-care package, plus prescription drugs, and some dental and mental health benefits and in-home care	To prescribe a defined benefit package; planned rationing rather than economic rationing, in order to limit the open-endedness of health insurance; mental health benefits were expected to eliminate the known deficiencies in mental health coverage; prescription drug coverage was expected to provide a benefit that was, until then, not provided by Medicare; in-home care was expected to discourage unnecessary hospitalizations or institutionalization
5. A national board sets limits on national and regional spending for health care; limits on how much private insurers could raise premiums; and administrative and malpractice reforms	To establish a global budget for health care rather than continuing with the prevailing pay-as-you-go practice; administrative reforms were expected to ease the paperwork burden on all health care stakeholders, especially health providers; tort reform
6. Limits denials or exclusions from health coverage or the charging of excessive premiums because of poor health status	To discourage experience rating and the practice whereby insurance companies selectively recruit or market to a disproportionately healthy population; ensures continuous and uninterrupted health insurance coverage for those with catastrophic illnesses
7. Medicare was to remain as currently set up unless a State chose to give beneficiaries the general policies that were available through health alliances. Medicaid beneficiaries were to be covered through policies issued by health alliances, except those who required long-term nursing care	To allow the Medicare program to compete with the newly created health alliances; to remove the stigma associated with Medicaid

Source: Adapted from O’Hanlon and Rich (1993)

to their advantage create serious obstacles to reform (Steinmo and Watts 1995, p. 362). These are exactly the arguments we have made in Chap. 3 of the book.

Because of the terrorist attacks on the United States on September 11, 2001, and the subsequent wars in Afghanistan and Iraq, which occupied much of the agenda of the George W. Bush administration, I did not expect much in the form of domestic, especially health policy, expansion from the George W. Bush administration. He did, however, introduce some movements toward privatization and means-testing in Medicare. For example, as was discussed in Chap. 2, the *Medicare Modernization Act* of 2003 was passed and signed into law. This program, which became officially effective on January 1, 2006, represented a major expansion of the Medicare program at a time its finances were being seriously scrutinized. Medicare Part D was discussed in more detail in the previous chapter. The imperfection in the law, or the so-called “doughnut-hole,” was fixed by the *Affordable Care Act* of 2010.

Prior to the Obama administration’s launching of its national health care reform initiative, state governments, notably Hawaii and Massachusetts, attempted reforms in their jurisdictions. Since data cited in Chap. 7 show that these two states had the lowest uninsurance rates in the country between 2008 and 2009, it is instructive to briefly look first at what happened in these states before we examine the politics of the national health care reform launched by President Obama. We begin by briefly looking at Hawaiian health care reform.

Hawaiian Health Care Reform

Similar to the Clinton reform plan discussed earlier, the Hawaiian health care reform model relies on the employer mandate. The measures that have been put in place seek to expand access to care and to create a health care environment that promotes health promotion and disease prevention. Perhaps, this partially accounts for why the state’s life expectancy is said to be the highest in the nation and infant mortality among the lowest (Dukakis and Roseman 1992, p. 11).

The process of broadening access to health care in Hawaii has progressed gradually. First, the state passed its *Prepaid Health Act* (Prepaid) in 1974. Prepaid mandates employer-based health insurance for all employees not covered by collective bargaining. The law operates through the two dominant insurance programs in the State—Blue Cross and Blue Shield and the Kaiser Permanente HMO. Health care benefits provided under the law must be equal to or medically substitutable for benefits provided by plans having the largest number of subscribers in the state. This provision ensures that employees covered under Prepaid do not receive a lesser form of coverage (Neubauer 1993, p. 32). The employee premium is limited to 1.5% of gross income; employers must pay at least half of the remaining cost.

In order to avoid the unintended effects of the ERISA of 1974 which, as we discussed in Chap. 7, prohibits states from requiring private businesses to provide prescribed benefits for their employees, Hawaii applied for and was granted an exemption from those ERISA provisions in 1974. It remains the only state that has

been granted such a waiver from the federal government. The waiver was granted because the state law was in effect before the federal prohibitions.

As a result of the ERISA waiver, the state set a benefit package that included medical, surgical, and maternity coverage; up to 120 days of hospitalization; outpatient benefits provided by a physician, psychiatrist, or psychologist; and diagnostic laboratory services, X-rays, and radiotherapeutic services (Neubauer 1993, p. 32). Subsequent legislation permits the legislature to mandate options into the benefit package, thereby making them eligible for third-party reimbursement. Some examples of the mandated options in the package include well-baby checkups, mammography, in vitro fertilization, and coverage for alcohol and drug abuse treatment.

The 1974 Hawaiian law still left some low-income and unemployed people uninsured. Therefore, in an attempt to further curtail the uninsurance population, a newly created State Health Insurance Program (SHIP) was adopted in 1989. The new program relied on existing provider organizations. It appealed to providers because of its ability to minimize bad debt and uncollectable or unsponsored care.

SHIP is means-tested. To be eligible for the program, the applicant would need to prove ineligibility for Medicare, Medicaid, and other federal benefits. SHIP premiums are based on a sliding scale, with those under 100% of poverty paying nothing, while self-payments increase with income. In addition, the program only provides for primary care outpatient services. High cost medical procedures are deemphasized within the program (Neubauer 1993, p. 34). SHIP also limits hospitalization to 5 days, with a dollar limit of \$2,500. Two inpatient days are allowed for maternity care, while elective surgery and high-cost tertiary care are disallowed.

As is typical of all of the United States, public and private health care costs continued to increase in Hawaii even with the reforms that were put in place. To address these cost concerns, the QUEST project was started. QUEST develops an insurance purchasing pool for Medicaid and SHIP, putting most recipients under a single insurance coverage plan. In other words, the state hoped to control costs through the promotion of managed competition for all publicly funded insurance beneficiaries, development of a comprehensive purchasing cooperative or alliance, and development of a basic benefit package common to Medicaid and SHIP beneficiaries.

Hawaii's QUEST program is still in existence and is administered by the state Department of Human Services. According to the Department of Health Web site, the QUEST program provides health coverage through health plans from the Hawaii Medical Service Association, and from Kaiser Permanente and Aloha Care, for eligible Hawaii residents who have difficulty getting a traditional health plan (Hawaii Department of Health 2011).

Massachusetts' Health Care Reform

Unlike Hawaii, the Massachusetts health care reform plan is based on the individual mandate. Enacted in 2006, the law mandates that nearly all residents of the state obtain a state-government regulated minimum level of health insurance coverage.

Free health care, called Commonwealth Care, is provided for residents who earn below 150% of the federal poverty level (FPL) who are not eligible for Medicaid. Additionally, the law also partially subsidizes health insurance for those earning up to 300% of the FPL.

Prior to passage of the Massachusetts' health insurance reform law, a fund of approximately \$700 million, known as uncompensated or free care pool, was set up to partially reimburse hospitals and health centers who cared for the uninsured. The monies in the pool were derived from annual assessments on insurance providers and hospitals, as well as from state and federal sources. The reform plan was expected to limit the costs of providing indigent care in the state (Wikipedia 2011).

Since the Obama administration's national reform plan has elements that are identical to the Massachusetts' model, and especially since the federal plan has drawn far more criticism than the Massachusetts' plan, it is necessary to examine relevant elements of the Massachusetts' plan in order to be able to make adequate comparisons with the *Affordable Care Act*. Table 9.2 shows some of the essential features of the Massachusetts' reform plan and their expected effects.

A legal challenge, *Fountas V. Dormitzer* (Docket No. 2008-121) was filed in Essex Superior Court challenging the fine imposed on individuals for failure to get insurance, as well as the fine imposed for a failure to provide the required information on a tax return as to whether one has insurance (Wikipedia 2011). The specific questions raised were that the fine should not be collected through the state income tax return without any charges ever being filed and guilt determined in a court of law. Second, imposing a fine for failure to provide information was said to be in violation of the US Constitution's 5th Amendment's protection against self-incrimination. This protection is also provided for by Article 14 of the Massachusetts' Bill of Rights. Incidentally, none of the legal challenges to the law succeeded.

The 2010 report issued by the Commonwealth Health Connector claims that Massachusetts now has a 98% insurance coverage rate, the best in the nation. The report also claims that nearly 400,000 residents are newly insured; nearly all children (99.8%) and seniors (99.6%) have health insurance (Health Connector 2011). Additionally, the report claims that racial and ethnic disparities in health coverage have been significantly reduced. Additional success claims can be found on the agency's Web site and appear to be supported by the data cited in Chap. 7, which show that Massachusetts had the lowest uninsurance rate in the nation between 2008 and 2009. The federal reform plan closely mirrors the Massachusetts' plan.

The Barack Obama Administration

President Obama succeeded President G.W. Bush and moved to secure reform of the US health care system as he promised during the 2008 presidential election campaign. About 2 months after he took office in January 2009, Obama called a health care summit in the White House, thereby initiating a debate about the merits of the health care system and the need for change (Hacker 2009, p. 4). As in the previous

Table 9.2 Some essential features of the Massachusetts' reform plan

Structured features	Anticipated effects
1. Individuals, except those who have a waiver for religious reasons or those the Insurance Connector certifies as unable to afford insurance, must obtain insurance	Individual mandate. Seeks to decrease the number of uninsured persons and limit the cost of indigent care
2. Penalty on those who do not have coverage and do not have a waiver	Forces those who can afford insurance to obtain it. Raises revenues to implement the reform plan. Discourages free-riding and cost-shifting
3. Establishes Commonwealth Health Connector Authority (Connector)	Serves as a clearinghouse for insurance plans and payments. Administers the Commonwealth Care Program for low-income residents. Offers health insurance plans for purchase by defined populations. Sets premium subsidy levels for Commonwealth Care and defines affordability for purposes of the individual mandate
4. Firms with 11 or more workers that do not provide "fair and reasonable" health coverage to their workers pay an annual penalty. Additional Free Rider Surcharge can be assessed to the employer	Generates revenues for the Commonwealth Care Trust Fund to pay for Commonwealth Care and other health reform programs. Additional surcharge is applied when an employer does not arrange for a pre-tax payroll deduction system for health insurance, and has employees who get care from the uncompensated care pool
5. Beginning in July 2007, Connector offers reduced benefit plans for young adults up to age 26, who do not have access to employer-based coverage	Increases coverage to the young uninsured people who are no longer eligible to be on their family plans. Buys time for young adults to gain employment that is likely to provide health benefits
6. Provides health coverage to senior and disabled legal immigrants not eligible for federal Medicaid. Expands Medicaid and CHIP coverage for children of low-income parents and restores Mass Health (Medicaid and CHIP) optional benefits, such as dental care and eyeglasses	Increases Medicaid optional benefits to include vision and dental care; increases the number of people with basic insurance coverage. Expands the percentage of children covered by Medicaid and CHIP
7. Merges the individual or nongroup insurance market into the small group market	Allows individuals to obtain lower group insurance rates. Increases premium costs for small businesses that dominate the small group market
8. Formation of a "Health Care Quality and Cost Council"	Development and issuance of quality standards and publication of provider performance

Sources: Adapted from Mass.Gov. (2011); The Henry J. Kaiser Family Foundation. (2007); and Meyer and Pervez (2006)

cases reviewed, the debate was intense and generated heated arguments and charges of “socialism,” “rationing,” “government take-over of the health care system,” and “death panels” to kill seniors in order to contain high health care costs.

The 2008–2009 national health care reform debate was highly charged and partisan, even though the problems afflicting the health care system appear to be nearly universal, affecting all sorts of people and groups, businesses, and regions of the country. To be certain, some people and groups are less affected than others, but the people and groups that are less affected have neighbors, friends, and associates who are seriously disadvantaged by the failures of the health care system. Put differently, the problems of the health care system affect Republicans, Democrats, Independents, Libertarians, etc., alike, but there has not been any bipartisan approach to solving the problems.

The White House summit on health care reform convened by the Obama administration on March 5, 2009, included Democratic and Republican leaders in Congress, major interest group representatives, including labor unions, physicians’ groups, and insurers. The representation at the summit was broadened with the hope of getting many people and groups to support the legislation the administration would eventually introduce. The strategy was a bold attempt to achieve the bipartisanship and change Obama had promised during the presidential campaign.

The strategy of Congressional Republicans was total opposition to the Obama administration’s health care reform plan. According to Jacobs and Skocpol (2010, p. 40) they reasoned that if they opposed the administration’s economic recovery plan, and any subsequent health reform legislation, it was possible to both please their core conservative base and position themselves to be the only alternative if voters remained unhappy in a recession through 2010 and 2012.

With the Republican strategy in place, the battle for health care reform had begun. The media coverage was divided between reform supporters and opponents. Negotiations and deals were made in Congress, while reform sponsors and detractors commissioned television and radio commercials to press home their points of view. The House of Representatives passed a comprehensive health care reform law on strict party lines, the *Affordable Health Care for America Act* (H.R. 3962), with a provision or amendment restricting abortion, on November 7, 2009.

The Senate version of health care reform legislation, the *Patient Protection and Affordable Care Act* (PPACA) (H.R. 3590), was passed on December 24, 2009. The next round of talks and negotiations were on how to reconcile the House and Senate measures. However, the anticipated reconciliation process was complicated by the election of Republican Scott Brown in January 2010 to fill late Senator Edward Kennedy’s seat. This election essentially deprived Democrats of the filibuster-proof majority they enjoyed in the Senate. The new tally was 41 Republican and 59 Democratic Senators.

The Scott Brown victory in Massachusetts did not turn out to be as damaging to Democrats as had been anticipated. In fact, according to Jacobs and Skocpol (2010, p. 111) “in due course the Brown victory in Massachusetts spurred Democrats to cut out the incessant posturing and cooperate to finish comprehensive health reform in a bolder and better form.” The authors further add that the “all or nothing”

mindset gave way to “something rather than nothing.” The public option that was in the House-passed bill was dropped to ensure that there was agreement with the Senate bill.

The last attempt at bipartisanship was a televised summit of Republicans and Democrats held at Blair House, the official state guest house for the President of the United States, on February 25, 2010. Republicans were encouraged to go to the summit with their own plans on how to extend health insurance coverage to millions of the uninsured and control rising costs. The summit did not yield concrete Republican proposals. Their total opposition strategy was intact. It appears that they went to the summit in order not to convey to Americans the impression that they were uncooperative, or that they were not seriously engaged in finding solutions to the acknowledged national problems in the health policy arena.

Unlike in 1994, the Democratic majority in Congress in 2010 did produce a policy majority for health care reform. On March 21, 2010, the House of Representatives passed the health care reform bill approved by the Senate on December 24, 2009. In addition, a companion or so-called “sidecar” bill, the *Health Care and Education Reconciliation Act* (H.R. 4872), which involved changes in the Senate bill that were agreed upon in advance by the Democratic leadership in both chambers, also passed. Using a procedure known as “reconciliation,” the Senate passed the *Health Care and Education Reconciliation Act* by a simple majority on March 26, 2010 (Jacobs and Skocpol 2010, p. 114). Therefore, national health care reform, some important features of which are discussed below, became a reality when President Obama signed the PPACA and the *Health Care and Education Reconciliation Act* into law on March 23 and 30, 2010, respectively.

The Patient Protection and Affordable Care Act of 2010

The PPACA was designed to ensure that most Americans have access to quality, affordable health care. It currently contains at least nine titles, each addressing the following components of reform: quality, affordable health care for all Americans; the role of the public programs of Medicare, Medicaid, and CHIP; improvements in the quality and efficiency of health care; prevention of chronic disease and improvement of public health; the health care workforce; transparency and program integrity; improvements in access to innovative medical therapies; community living assistance services and supports; and revenue provisions (Senate Democrats 2011). Table 9.3 summarizes the important provisions of each of the above nine titles.

Table 9.3 is as close as we can come to giving a comprehensive, title-by-title summary of the PPACA of 2010. We do not want to belabor the point by trying again to analyze each of the nine elements or titles of the law. Rather, in the next few pages we shall attempt to analyze the anticipated effects of the law on some of the problems of the health care system identified in Chap. 1. Specifically, we shall look at the expected effects of the legislation on access to care, costs, quality, and on the health disparities among the population.

Table 9.3 Overview of each of the titles of the PPACA of 2010

Title	Major provisions
1. Quality, Affordable Care	Beginning in 2010, eliminates lifetime and unreasonable annual limits on benefits; prohibits rescissions of health insurance policies; assists those who have no insurance due to preexisting conditions; requires coverage of preventive services and immunizations; extends dependent coverage up to age 26; develops uniform insurance coverage documents; caps insurance company nonmedical and administrative expenditures; reforms the consumer appeals process; creates a mechanism to support coverage for early retirees; assists Americans in identifying coverage options; and simplifies the administrative process in order to lower health system costs Beginning in 2014, puts an end to medical underwriting and preexisting condition exclusions, with premiums varying only by family structure, geography, actuarial value, tobacco use, participation in a health promotion program, and age (by not more than three to one); health plans must provide essential benefits, which include cost sharing limits; no out-of-pocket requirements can exceed those in health savings accounts (HSAs); and deductibles in the small group market cannot exceed \$2,000 for an individual and \$4,000 for a family; coverage to be offered at four levels with actuarial values defining medical loss ratios or how much the insurer pays: platinum—90%; gold—80%; silver—70%; and bronze—60%. Lower-benefit catastrophic plan offered to individuals under age 30 and to others who are exempt from the individual responsibility requirement Creates, by 2014, state-based and state-administered health insurance exchanges for the individual and small group market; states may receive a waiver to opt out of this requirement if they provide coverage at least as comprehensive as that required under the PPACA; large employers will be phased into the exchanges in 2017; only qualified health benefit plans meeting specific criteria can be sold in the exchange; insurers may sell policies outside the exchange New, refundable tax credits to be available for Americans with incomes between 100 and 400% of the federal poverty line (FPL) (about \$88,000 for a family of four in 2010). Credits to be calculated on a sliding scale beginning at 2% of income for those at 100% FPL and phasing out at 9.8% of income at 300–400% FPL. Out-of-pocket maximums (\$5,950 for individuals and \$11,900 for families) are reduced to one third for those with income between 100 and 200% FPL, one half for those with incomes between 200 and 300% FPL, and two-thirds for those with income between 300 and 400% FPL Beginning in 2014, the individual mandate goes into effect. Those without coverage will pay penalties of \$95 in 2014, \$350 in 2015, \$750 in 2016, and indexed thereafter. For those under 18, the penalty will be one half the amount for adults. Exceptions are made for religious objectors, those who cannot afford coverage, taxpayers with incomes less than 100% FPL, Indian tribe members, those who are granted a hardship waiver, individuals not lawfully present, those incarcerated, and those not covered for less than 3 months Those who already have coverage can keep them; employers with more than 200 employees must automatically enroll new full-time employees in coverage. Penalty imposed on employers with more than 50 full-time employees who do not offer coverage and have at least one full-time employee receiving the premium tax assistance

(continued)

Table 9.3 (continued)

Title	Major provisions
2. Role of Public Programs	Medicaid eligibility is expanded to low income patients with the federal government assuming much of the cost of the expansion. States may expand this Medicaid eligibility as early as January 1, 2011. Beginning on January 1, 2014, all children, parents, and childless adults who are not entitled to Medicare and who have family incomes up to 133% FPL will become eligible for Medicaid States are required to maintain income eligibility levels for CHIP through September 30, 2019. Between 2014 and 2019, states would receive a 23% increase in the CHIP federal match rate, subject to a 100% cap State-run Web sites will allow individuals to apply for and enroll in Medicaid, CHIP and insurance exchange States may offer community-based attendant services and support to disabled Medicaid beneficiaries who would otherwise require care in a hospital, nursing facility, or intermediate care facility for the mentally retarded States' disproportionate share hospital (DSH) allotments are reduced by 50% once a state's uninsurance rate decreases by 45% (low DSH states would receive a 25% reduction). Further DSH reductions to occur as uninsurance rates continue to decline but by no more than 65% compared to a state's fiscal year 2012 allotment Better coordination of care among the federal and state governments for Medicare and Medicaid dual eligibles
3. Quality and Efficiency of Health Care	Improvements in the quality and efficiency of US medical care services for everyone, especially for those enrolled in Medicare and Medicaid; linking of payments to better outcomes; information made available to consumers about patient outcomes resulting from different approaches to treatment and care delivery; the HHS secretary is to establish a national strategy to improve health care service delivery, outcomes and population health; the President will convene an Interagency Working Group on Health Care Quality to collaborate on the development and dissemination of quality initiatives consistent with the national strategy Establishment of a new Center for Medicare and Medicaid Innovation within the CMS to research, develop, test, and expand innovative payment and delivery arrangements; increased Medicare provider fees in rural areas and immediate relief granted to areas harmed by geographic adjustment for practice expenses; extension of Medicare bonus payments for ground and air ambulance services in rural and other areas; extension of the outpatient hold harmless provision so that small rural hospitals and sole community hospitals can continue to receive rural adjustments through fiscal year 2010; reinstatement of the cost-based reimbursement for lab services provided by small rural hospitals from July 1, 2010, to July 1, 2011. Rural Community Hospital Demonstration Program extended for 2 years, and expansion of the eligible sites to additional states and hospitals; attempts will be made to improve the payment accuracy for home health, hospice, imaging services, and power-driven wheelchairs; improvements in Medicare Advantage payments; MA plans will be prohibited from charging beneficiaries cost sharing for covered services greater than what is charged under fee-for-service; drug manufacturers to provide a 50% discount to Medicare Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. The initial coverage limit in the Standard Part D benefit will be expanded by \$500 for 2010

(continued)

Table 9.3 (continued)

Title	Major provisions
	The law creates an independent, 15-member Medicare Advisory Board to develop proposals to improve program quality and reduce costs, except that it cannot make proposals to ration care, raise taxes or beneficiary premiums, or change Medicare benefit, eligibility, or cost-sharing standards. The Board's proposals shall take effect when Medicare costs are projected to exceed certain targets, unless Congress takes some other measure to achieve the same level of savings
4. Prevention of Chronic Disease and Improving Public Health	To better orient the health care system toward health promotion and disease prevention, a new interagency prevention council will be supported by a new Prevention and Public Health Investment Fund; barriers to accessing clinical preventive services to be removed; new programs to be established for the operation and development of School-Based Health Clinics and oral health care prevention education campaigns. The elimination of co-payments or deductibles for Medicare annual wellness visits and development of personalized prevention plans To provide States with an enhanced match if the State Medicaid program covers any clinical preventive service recommended with a grade of A or B by the USPSTF (see Table 6.1, Chap. 6), or adult immunization recommended by the Advisory Committee on Immunization Practices without cost sharing; to require Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco consumption; to encourage states to provide incentives for Medicaid beneficiaries to adopt programs promoting healthy lifestyles The law authorizes all states to purchase adult vaccines under contracts with the Centers for Disease Prevention and Control (CDC). The CDC will provide grants to states and large local health departments to conduct pilot programs to evaluate chronic risk factors in the 55- to-64-year-old population. Federal health programs will be set up to collect and report data by race, ethnicity, primary language, and any other indicators of health disparity
5. Health Care Workforce	The law is expected to encourage innovations in health workforce training, recruitment, and retention, and to establish a new workforce commission. Provisions of the law will help increase the supply of health care workers, who will be supported by a new workforce training and education infrastructure Establishment of a national commission to review health care workforce and projected workforce needs and to provide information that will help lawmakers and the administration to align workforce resources with national needs Modification of the federal student loan program; Nursing Student Loan Program is to be increased. A loan repayment program is established for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents, who work in Health Professional Shortage Areas, Medically Underserved Areas, or with a Medically Underserved Population. Significant improvements and additions are to be made to the National Health Service Corps scholarship and loan repayment program, including the establishment of a Ready Reserve Corps within the Commissioned Corps, for service in time of national emergency New support for workforce training is established in several areas of medical care

(continued)

Table 9.3 (continued)

Title	Major provisions
6. Transparency and Program Integrity	New requirements and systems are set up to combat fraud and abuse in public and private health programs, including the reporting of information that may suggest the existence of conflicts of interest Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to implement a compliance and ethics program; standardized complaint forms will be developed for the use of nursing home residents in filing complaints with appropriate state officials A private, nonprofit entity (the Patient-Centered Outcomes Research Institute) is established to provide for the conduct of comparative clinical outcomes research. New penalties for ethical violations will include exclusions from participation in federal health programs
7. Improving Access to Innovative Medical Therapies	The law establishes a process under which the Food and Drug Administration (FDA) will license generic biological products. No approval of generic applications until 12 years from the date on which the reference product was first approved. If the FDA approves a generic product as being interchangeable to a reference product, the Department of Health and Human Services (HHS) cannot make a determination that a second or subsequent biological product is interchangeable to that same reference product until 1 year after the first commercial marketing of the first interchangeable product The law makes provisions for more affordable medicines for children and underserved communities
8. Community Living Assistance Services and Supports	The law establishes a new, voluntary, self-funded long-term care insurance program—community living assistance services and support (CLASS) program—for the purchase of CLASSs by individuals with functional limitations. The HHS Secretary will take steps to ensure program integrity and solvency. No taxpayer funds can be used to pay benefits under the program
9. Revenue Provisions	To generate revenues to fund provisions of the law, the PPACA levies a new excise tax of 40% on insurance companies and plan administrators for any health coverage plan with an annual premium that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage (the so-called Cadillac Plans). The tax applies to self-insured plans and plans sold in the group market. Threshold adjustments are made for the 17 highest cost states, for retired individuals age 55 and older, and for plans that cover employees engaged in high risk professions; employers must report the value of their contributions to each employee's health insurance coverage; conforms the definition of qualified medical expenses for health savings accounts (HSAs), flexible spending accounts (FSAs), and health reimbursement accounts (HRAs), to the definition used for the medical expense itemized deduction; increases penalty for HSA withdrawals prior to age 65 that are not used for qualified medical expenses; limits the amount of contributions to health FSAs to \$2,500 per year; imposes specified fees on pharmaceutical manufacturers, medical device manufacturers, health insurance providers, and on elective cosmetic surgery. Limits the deductibility of executive compensation for insurance providers under certain conditions; increases the hospital insurance tax on high wage workers; provides special tax benefits to Blue Cross Blue Shield (BCBS) organizations that have a medical loss ratio of 85% or higher, and establishes a new small business employee benefit Cafeteria plan to be known as Simple Cafeteria Plan

Source: Adapted from Senate Democrats (2011)

In discussing the anticipated effects of the PPACA, we are very mindful of the fact that most of the measures that are proposed to address these vexing health system problems will not go into effect for a few years. Additionally, it will take many more years before the full impacts of these measures can be fully identified and measured. In fact, much will depend on whether the provisions of the law can be implemented as intended or whether interest groups will be successful in frustrating the law's implementation. With these points in mind, we begin by looking at the expected effects of the legislation on access to care.

Anticipated Effects on Access to Care

Prior to the passage of the Affordable Care Act, about 83% of legal, nonelderly Americans had health insurance coverage, while the remaining 17% were without coverage. After passage of the legislation, the Congressional Budget Office (CBO) estimates that about 32 million working age Americans and their dependents, who have no health insurance under current law, will now have coverage. That would leave about 23 million nonelderly residents, about one third of who will be illegal immigrants, uninsured. Put differently, under the PPACA, the proportion of legal nonelderly residents with insurance coverage is expected to rise from about 83% currently to about 94% (CBO 2010, p. 9)

Concerning the dynamics of coverage, the CBO estimates that about 24 million people would purchase their health care coverage through the new insurance exchanges proposed to be set up. Additionally, it is estimated that there would be about 16 million more Medicaid and CHIP enrollees than the number projected before passage of the law. Furthermore, between six and seven million people would be covered by an employment-based plan under the law, who would not be covered by such a plan under current law, largely because the individual mandate would increase workers' demand for employment-based coverage.

Additionally, the CBO estimates that between eight and nine million other people, who would be covered by an employment-based plan under current law, would not be offered such coverage under the PPACA. The firms that would choose not to offer coverage as a result of the reform measure would tend to be smaller and lower-wage employers whose employees would be eligible for subsidies through the proposed insurance exchanges. It is noteworthy that some workers who would not have employment-based coverage because of the reform plan would also not be eligible for subsidies (CBO 2010, p. 10).

Still, on the dynamics of coverage, the CBO estimates that between one and two million people who would be covered by their employer's plan, or as dependents of employees under current law, would instead obtain coverage through the exchanges. Although workers with an offer of employment-based insurance coverage would generally be ineligible for exchange subsidies under the PPACA, there are provisions to make exceptions for workers whose employment-based insurance offers are thought to be unaffordable.

Anticipated Effects on Costs

About half of the \$965 billion in new spending under the law is expected to be used to help individuals and small businesses with fewer than 50 employees afford health insurance coverage (CBO 2010, p. 15). For example, as reported under Title 1 in Table 9.3, new refundable tax credits will be available under the law for Americans with incomes between 100 and 400% FPL. These credits are to be calculated on a sliding scale beginning at 2% of income for those at 100% FPL, and phasing out at 9.8% of income at 300–400% FPL.

The expected decrease in costs for small businesses that currently offer health insurance to their employees should help increase their profits and competitiveness. Furthermore, the provision to establish a new Center for Medicare and Medicaid Innovation within the CMS to research, develop, test, and expand innovative payment and delivery arrangements, cannot be easily dismissed when one considers that the Medicare prospective payment system based on DRGs grew out of research commissioned by the CMS, which at the time was called the Health Care Financing Administration (HCFA).

Anticipated Effects on Quality of Care

Some of the expected improvements in the quality of care will not be immediate, but should progress as the legislation is being implemented. Similarly, some of the expected quality improvements will depend on how well providers comply with policy directives, and on how well they cooperate with those charged with the responsibility of implementing the quality-enhancing aspects of the legislation. For example, the provisions of the law charging the HHS secretary to establish a national strategy to improve health care service delivery, outcomes, and population health are futuristic. The convening of an Interagency Working Group on Health Care Quality to collaborate on the development and dissemination of quality initiatives will depend on the national strategy developed by the HHS secretary and on the cooperation of providers, especially physicians. Essentially, the question is this: Will providers implement the recommendations of the Interagency Working Group on Health Care Quality?

The health insurance reforms that mandate coverage of preventive services, immunizations, coordination of care between the federal and state governments for Medicare and Medicaid dual eligibles, better orientation of the health care system toward health promotion and disease prevention, and the provision of grants to states and local health departments to conduct pilot programs to evaluate chronic risk factors in the 55- to 65-year old population, should produce far more readily observable quality improvements (Guterman et al. 2010, p. 3). Similarly, the provision of more affordable medicines for children and underserved communities, enhanced matching rates for State Medicaid programs that cover any preventive

service recommended with a grade of A or B by the USPSTF, and the elimination of co-payments or deductibles for Medicare annual wellness visits and development of personalized prevention plans, should produce tangible and immediately noticeable quality improvements.

The *Affordable Care Act* was not specific as to the focus of the national strategy on health care service delivery to be established by the HHS secretary. This vagueness was probably due to the fact that Congress intended to leave such technical details to health care experts. When the time comes to discuss specifics of the quality strategy, discussants must not lose sight of the research cited in the introductory chapter of the book, which stresses the need for electronic medical records and other information technologies as some of the most important tools for improving diagnosis and treatment and avoiding unnecessary errors.

Anticipated Effects on Health Disparities

To the extent that some of the health disparities discussed in Chap. 7 are due to lack of access to health services, the expansion of access to an additional 32 million nonelderly Americans and their dependents will help reduce health disparities. Similarly, the establishment of new health departments and the strengthening of the existing ones should help lessen the health disparities among the minority, inner city, and economically disadvantaged populations that depend on local health departments for their health care needs.

The PPACA calls for new programs to be established for the operation and development of School-Based Health Clinics, new investments in community health teams to manage chronic disease, and for new funds for home visits for expectant mothers and newborns. These provisions are important because minority communities experience higher rates of illness and death for chronic diseases, such as diabetes, kidney disease, heart disease, and cancer. Additionally, since infant mortality and postbirth complications tend to be higher among minority and low-income groups, the provisions for expectant mothers and newborns, and for coverage of recommended preventive services, is expected to help mitigate these problems in the minority and low-income communities (Health care.gov 2011, p. 1).

The provisions of the law that are designed to increase racial and ethnic diversity in the health care workforce, to strengthen cultural competency training for all health care providers, and to use language services and community outreach in underserved communities, should help improve communications between providers and patients and, therefore, help address some of the disparities in the minority communities, particularly Hispanic communities. Additionally, the law provides new funding to collect information on how women and racial and ethnic minorities experience the health care system. The information collected in the process is expected to lead to improvements that will benefit the affected groups.

Furthermore, recognizing that some health problems are due to lifestyle and behavioral factors, the law provides funding for oral health care education campaigns.

The education campaigns are important because while people cannot be forced to change their lifestyles or refrain from engaging in unhealthy behaviors, it is important that they have the information they need to make healthy choices. Changing a few lifestyles and behaviors can have ripple effects on the people who are associated with those who choose to live healthy lives.

Criticisms and Controversies

The *Affordable Care Act* is not without harsh criticisms and controversies. This should be expected in the environments we described in the preceding chapters of the book. These criticisms and controversies are primarily from two groups of people—those who believe that the law did not go far enough and those who think that it went too far. Therefore, in the rest of this chapter, we examine the criticisms and controversies from these two perspectives or vantage points. First, we look at the arguments of those who think the law did not go far enough.

Did the PPACA Go Far Enough?

Most of those who criticize the PPACA as not going far enough point to specific things or provisions that the legislation did not address. Weissert and Weissert (2010, p. 1) argue that the legislation will do very little about the health care system's two biggest problems, costs and quality. According to them, while we are getting coverage of three-fourths of our uninsured, the bill does not contain provisions to “force physicians to follow protocols to move care more toward science and away from art, and the cuts promised in Medicare payments to hospitals and physicians are no more likely to occur in the future than they have been in the past.” Furthermore, they argue that putting coverage expansion before cost control means spending more money on an already-too-expensive system, before implementing any serious measures to cut costs.

Another important criticism of the PPACA as not going far enough involves the abandonment of the public option. To induce competition in the health insurance market, liberal Democrats in the House of Representatives wanted the government to offer its own insurance plans. These publicly supported plans were expected to keep private plans from setting their rates too high and charging very high administrative and marketing costs. Because of serious criticisms by Republican lawmakers and the health insurance industry, the public option, believed to be one of the most important tools of cost control, was dropped from the final legislation.

Critics complain about the setting up of numerous demonstration projects to devise better ways to deliver care, pay providers, connect pay to good health outcomes, and to induce efficiency and effectiveness in the health care system. The setting up of these demonstration projects, critics argue, is a demonstration of lack

of political will by the Congress to take immediate steps to address the problems that beset the health care system. Therefore, the question that arises is this: if the Congress lacked the political will to make tough choices in 2009–2010, how can we be sure that it will be able to adopt the equally tough or tougher choices that will be recommended in the future? For example, reference is made to the fact that interest group pressure caused a delay, till 2018, in the imposition of a tax on the high cost insurance or “Cadillac” plans. These sorts of things, critics argue, are very likely to happen to the portions of the plan that are slated for implementation in future years.

There are arguments that while the law makes a very bold attempt to expand health insurance coverage, there will still be about 23 million uninsured people after the law is fully implemented. Although most of these uninsured people will be illegal immigrants, the law is silent about how they will receive care. If, as expected, illegal immigrants and the remaining uninsured in the population are still protected by the *Emergency Medical Treatment and Active Labor Act* (EMTALA) of 1986, which requires hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay, then, these people will continue to use hospital emergency rooms for their care needs, thereby reducing the effectiveness of the reforms. Moreover, Medicaid enrollees will continue to have difficulty finding primary care doctors who are willing to treat them.

Other criticisms of the *Affordable Care Act* involve comparisons of some aspects of the law with the Clinton administration’s *Health Security Act* of 1993. In a nutshell, the argument is made that the PPACA is not as bold and far-reaching as the doomed *Health Security Act*. For example, the *Health Security Act* attempted to guarantee full universal coverage, defined a national standard acute-care package, established a national board that was to impose a health care budget or to set limits on national and regional spending for health care, attempted to limit malpractice lawsuits, sought to remove the Medicaid stigma from the foreheads of program beneficiaries by proposing to disband the program, and to cover Medicaid recipients through policies issued by health alliances, and, like Hawaii, relied more on the employer mandate than the individual mandate. Finally, there are those who argue that Congress succumbed to pressures from drug manufacturers by not supporting the importation of drugs from Canada.

Those who make the above arguments seem to belong to the “all or nothing” group of reformers. They do not appear to be concerned about whether some of the features of the Clinton Plan that they would have preferred contributed to the defeat of the proposal, and whether they would have led to the defeat of the PPACA.

Did the PPACA Go Too Far?

Those who claim that the PPACA went too far are far noisier and more boisterous than those who claim that the law did not do enough to address the problems of the health system. While the law was being debated in the Congress, the opposition was civil, involving demonstrations and rallies. However, soon after the law was passed,

the outcry led to a few violent acts, incivility, and name calling. Today, opposition activities are centered on state legislatures and federal courts. The major arguments against the law are summarized below.

The *Affordable Care Act* is said to be a gross violation of the liberty of the American people. The specific provision cited as violating individual liberty involves the individual mandate or the requisition that individuals must purchase adequate health insurance coverage or pay a penalty. As was summarized in Chap. 3, the reasoning is that the federal government has no constitutional authority to force citizens to buy a product or commodity they do not want. When told that the Massachusetts' reform plan, signed into law by a Republican governor and presented earlier in the chapter, also involves an individual mandate, the law's opponents argue that the Tenth Amendment to the Constitution gives states, not the federal government, "police powers, or the ability to regulate its internal affairs and to enact whatever laws are necessary to protect the health, morals, safety, and welfare of its people" (Sidlow and Henschen 2012, p. 54).

The portion of the law that requires employers who do not offer adequate health insurance coverage, and have a least one full-time employee receiving premium assistance tax credit, to pay a fine per full-time employee, is said to be likely to result in reduced wages, job cuts, or to cause employers to rely more heavily on part-time workers. These options, it is argued, will hurt the economy by inhibiting small business growth and job creation (Nix 2010, p. 1).

Critics also argue that the proposed cuts in Medicare payment rates to hospitals and physicians will keep some providers from seeing Medicare patients. Similarly, the provisions of the law authorizing the setting up of insurance exchanges, linking payments to good outcomes, and setting up innovation projects are expected to result in more government regulation of medical practice, thereby further eroding professional autonomy and the independence of the medical profession.

Some critics have argued that one of the most important failings of the current health care system is moral hazard or the tendency for people to use more care because insurance insulates them from the true costs of care. Therefore, it is argued that the new law, which builds on the existing system, does nothing to address moral hazard. The reasons offered for this assessment are that the *Affordable Care Act* will not allow people to scale back and choose more limited insurance, to shift to catastrophic-only plans, or to rely more on self-insurance through HSAs (Goodman 2010, p. 6).

Many conservative groups do not believe that the health care market has failed as the discussion in Chap. 2 concluded. Rather, they argue that strict government regulation and encroachment on the practice of medicine are the reasons for the imperfections in the health care system. Therefore, they see the *Affordable Care Act* as still more government interference in the market that is bound to make things worse, not better.

Other perceived excesses of the *Affordable Care Act* are that the new spending envisaged under the law will grow the already-high federal budget deficit; the legislation expands already-broken public programs, such as Medicare and Medicaid, increases taxes, relies on inaccurate projections, may hurt the poor more than it helps

them, and some of the provisions of the law are nothing less than mandates on States, which undermine the federalist system upon which the country was founded. By imposing an individual mandate to purchase insurance, by regulating insurance companies that have traditionally been regulated by state governments, and by mandating the expansion of the joint state-federal Medicaid program, the law undermines or usurps states' powers (Nix 2010, p. 4). These criticisms and controversies have resulted in an unprecedented number of lawsuits and challenges to the PPACA.

Challenges to the PPACA

The National Council of State Legislatures (NCSL), in a report written by its program director, reports that in response to the federal reform law, as well as separate state reform efforts, some members of at least 45 state legislatures have proposed or passed legislation to limit, alter, or oppose some selected state or federal actions. For the most part, many of the opposing measures focus on not permitting, implementing, or enforcing federal or state mandates that would require purchase of insurance by individuals, or the imposition of fines for failing to purchase insurance; seek to keep in-state health insurance optional, and allow people to purchase any type of health services or coverage they may choose; or seek to contradict or challenge the policy provisions of the PPACA. The language used to draft these opposing measures varies from state to state, and includes statutes, constitutional amendments, as well as binding and nonbinding resolutions (Cauchi 2011). These actions appear to be symbolic because it is very unlikely that the US Supreme Court would uphold a state law or constitutional amendment that seeks to nullify a federal law.

The most serious challenges to the PPACA are the lawsuits that were briefly mentioned in the introductory chapter of the book. Virginia was the first state to file a lawsuit, in March 2010. This was followed by lawsuits filed, in no particular order, in Michigan, Ohio, the District of Columbia, and Florida.

In the first decision among the many cases filed against the *Affordable Care Act*, a federal district judge in Detroit, Michigan, ruled in favor of the federal reform law. Additional favorable decisions were reached by a US district judge in the District of Columbia; the US Sixth Circuit Court of Appeals in Cincinnati, Ohio; the federal fourth Circuit Court of Appeals in Richmond, Virginia, and by a three-judge panel of a federal appellate court in the District of Columbia. Also in Virginia, a private lawsuit by Liberty University was rejected by a federal district court (Cauchi 2011).

The unfavorable rulings against the law were rendered by federal district judges in Virginia and Florida, and by the 11th US Circuit Court of Appeals in Atlanta, Georgia. The 2-1 decision by the Atlanta-based Court of Appeals, rendered on August 12, 2011, was in favor of 26 states that had joined the lawsuit started in Pensacola, Florida. That decision, unlike the Florida federal district court decision that struck down the entire reform law, only invalidated the individual insurance mandate (Cauchi 2011).

Following the August 12, 2011 split decision by the three-judge panel of the 11th US Circuit Court of Appeals in Atlanta, the US Justice Department announced on September 26, 2011, that it would not ask the full US Court of Appeals to conduct another review of the case. Therefore, on September 28, 2011, both the plaintiffs and the Justice Department formally petitioned the US Supreme Court to take up the case during its current term, October 2011 to June 2012.

On November 14, 2011, at about the same time that the federal appellate court in the District of Columbia upheld the PPACA by a 2-1 majority, the Supreme Court announced its decision to take up the legal challenges to the law. A decision is expected in the summer of 2012. There are at least three or four possible decision choices before the Supreme Court.

The Choices Facing the Supreme Court

As things stand, we can only envisage four possible outcomes or decisions from the Supreme Court. First, a majority of the Justices could side with federal district judge Roger Vinson of Florida and declare the entire law unconstitutional. Second, a majority of the Justices could side with federal district judge Henry Hudson of Virginia, and with the 2-1 decision of the US Circuit Court of Appeals in Atlanta, and declare the individual mandate and other sections of the law, not the entire law, unconstitutional. Third, a majority of the Justices could side with the lower and appellate courts that have upheld the constitutionality of the entire law. And, fourth, the Court could rule that because the penalty for not buying insurance does not become effective until the 2014 federal income tax returns are due in 2015, nobody has been harmed and, therefore, the legal challenges to the health care reform law are premature. As we noted in the introductory chapter of the book, the future direction of the nation's health politics and policies will be greatly influenced by the decision of the Supreme Court in this case. The future focus of health policy scholars will involve analyses of the consequences and effects of the Supreme Court decision. We turn to that task in the concluding chapter.

Conclusion

The systemic problems of the health care system have generated calls and efforts to reform the system dating back several decades. Unlike in Europe, health insurance did not become a major political issue in the United States until the advent of WWI. The social, cultural, political, and attitudinal climate in America in the early 1900s could not support the types of insurance reforms that took place in Europe. Some of those early influences still prevail today. As a result, a host of reformers, including but not limited to, Theodore Roosevelt and the Bull Moose Party, the AALL, and the Harry Truman, John F. Kennedy, Lyndon B. Johnson, and William Jefferson

Clinton administrations, failed in their attempts to undertake major restructuring of the US health care system. But, even though the types of measures that have been enacted in Europe are not possible here, there have been significant accomplishments, including passage of the Kerr-Mills Act of 1960, passage of Medicare and Medicaid in 1965, and, recently, the Obama administration's passage of the PPACA. Given what we have so far learned about the environment of health policymaking in the United States, it is surprising that these various measures were enacted. It is also instructive that the enacted measures and policies have generated heated debates, controversies, and litigations. The PPACA seems to have generated more controversies and litigations than any other piece of social legislation in the history of the country. The Supreme Court's ruling on the legal challenges to the PPACA will greatly influence the future direction of American health politics and policies.

Review Questions

1. Not long after the passage of Medicare and Medicaid, the assumptions that Americans needed more medical care than the existing health care system could provide, and that large segments of the population lacked access to medical services, were replaced by the assumptions that the health care system was bloated and the costs too high. Explain.
2. Identify some of the major elements of the *Health Security Act* of 1993. Why was the proposal, which was greeted with much enthusiasm at the time of its introduction, not voted on in either chamber of the national legislature?
3. Why did Hawaii and Massachusetts have the lowest uninsurance rates of all the States in the country between 2008 and 2009?
4. What are the anticipated effects of the PPACA of 2010 on health care costs, access to care, quality of care, and on the health disparities among the population?
5. What are the major criticisms of the PPACA?
6. What factors account for the more serious and unprecedented opposition to the PPACA, relative to the much similar Massachusetts' reform law?
7. What are medical loss ratios and what are the effects on the insurer and the insured of setting high medical loss ratios?
8. What are the decision choices before the Supreme Court with regard to the legal challenges to the PPACA?
9. What are the likely policy implications of the Supreme Court taking any of the decision choices you identified in question 7 (these are discussed in Chap. 10)?
10. In Chaps. 1 and 3, we discussed problem framing, ideological differences between the two major political parties, dispersion of powers between the federal, state, and local governments, and a host of other issues and concepts. Which of these topics can be used to explain and analyze the unprecedented opposition to the PPACA and why? Are there any additional issues that we did not discuss which are relevant?

References

- Altmeyer, A.J. 1968. *The Formative Years of Social Security*. Madison, WI: University of Wisconsin Press.
- Blum, J. 1967. *From the Morgenthau Diaries: Years of War, 1941-1945*. Boston, MA: Houghton Mifflin.
- Brodie, M., and R.J. Blendon. 1995. "The Public's Contribution to Congressional Gridlock on Health Care Reform." *Journal of Health Politics, Policy and Law* 20(2) (Summer): 403-410.
- Cauchi, R. 2011. "State Legislation and Actions Challenging Certain Health Care Reforms, 2011. (Updated: September 29, 2011)." Washington, DC: National Conference of State Legislatures, from <http://www.ncsl.org/?tabid=18906>.
- Congressional Budget Office (CBO). "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)," March 20, 2010, 1-17 and Tables 1-7.
- Davis, K., G.F. Anderson, D. Rowland, and E. Steinberg. 1990. *Health Care Cost Containment*. Baltimore, MD: Johns Hopkins University Press.
- Dukakis, M.S., and C. Roseman. 1992. "Learning from the Aloha State." *Journal of American Health Policy* 2(1) (January/February): 11-14.
- Goodman, J. 2010. "The Most Important Feature of ObamaCare is Something No One is Talking About." *National Center for Policy Analysis*. John Goodman's Health Policy Blog, from <http://healthblog.ncpa.org/?s=The+most+important+feature+of+Obamacare+is+&x=11&y=...>
- Guterman, S., K. Davis, and K. Stremikis. 2010. "Issue Brief: How Health Reform Legislation Will Affect Medicare Beneficiaries." New York, NY: *The Commonwealth Fund Publication* 1383, Vol. 81.
- Hacker, J.S. 2009. "Yes We Can? The New Push for American Health Security." *Politics and Society* 37(1): 3-32.
- Hawaii Department of Health. 2011. "Health Care Programs: Hawaii's Quest Program." Retrieved September 18, 2011, from <http://hawaii.gov/health/disability-services/neurotrauma/key-services-medical.html>.
- HealthCare.gov. 2011. "In Focus: Health Disparities and the Affordable Care Act." Retrieved June 27, 2011, from <http://www.healthcare.gov/law/infocus/disparities/index.html>
- Health Connector. 2011. "The Top Ten Facts About Massachusetts Health Care Reform." Retrieved September 18, 2011, from <http://www.mahealthconnector.org/portal/site/connector/HealthCareReform>.
- Jacobs, L.R., and T. Skocpol. 2010. *Health Care Reform and American Politics: What Everyone Needs to Know*. New York, NY: Oxford University Press.
- _____, and R.Y. Shapiro. 1995. "Don't Blame the Public for Failed Health Care Reform." *Journal of Health Politics, Policy and Law* 20(2) (Summer): 411-423.
- Lubove, R. 1970. *The Struggle for Social Security 1900-1935*. Cambridge, MA: Harvard University Press.
- Mass.Gov.2011. "Health Care Reform." from <http://www.mass.gov/?pageID=mg2subtopic&L=4&LQ=Home&L1=Resident&L2=Health...>
- Morone, J.A. 1995. "Nativism, Hollow Corporations, and Managed Competition: Why the Clinton Health Care Reform Failed." *Journal of Health Politics, Policy and Law* 20(2) (Summer): 391-398.
- Meyer, J., and F. Pervez. 2006. "Summary of the Key Features from the Massachusetts Health Care Reform Law." Retrieved June 18, 2011, from <http://www.universalhealthct.org/.../1013444735463582904.06751627.do...>
- Neubauer, D. 1993. "State Model: Hawaii: A Pioneer in Health System Reform." *Health Affairs* 12(2) (Summer): 31-39.
- Nix, K. 2010. "WebMemo: Top 10 Disasters of Obamacare." Washington, DC: The Heritage Foundation Publication No. 2848, from <http://report.heritage.org/wm2848>.
- Numbers, R.L. 1978. *Almost Persuaded: American Physicians and Compulsory Health Insurance*. Baltimore, MD: Johns Hopkins University Press.

- O'Hanlon, A., and S. Rich. November 8–14, 1993. "Key Provisions of the Major Health Care Bills." *The Washington Post National Weekly Edition*, 13–14.
- Peterson, M. 1993. "Political Influence in the 1990s: From Iron Triangles to Policy Networks." *Journal of Health Politics, Policy and Law* 18(2) (Summer): 395–438.
- Poen, M.M. 1979. *Harry S. Truman Versus the Medical Lobby*. Columbia, MO: University of Missouri Press.
- Quirk, P.J., and W. Cunion. 2000. "Clinton's Domestic Policy: The Lessons of a New Democrat." In *The Clinton Legacy*, eds. C. Campbell and B.A. Rockman. New York, NY: Chatham House, 200–225.
- Senate Democrats. 2011. "Responsible Reform for the Middle Class." Retrieved September 18, 2011, from <http://dpc.senate.gov/healthreformbill/healthbill04.pdf>.
- Sidlow, E., and B.E. Henschen. 2012. GOVT³. Boston, MA: Wadsworth Cengage Learning.
- Skidmore, M.J. 2010. "Health Care in America, and Everywhere Else: A Review of Essay." *Poverty & Public Policy* 2(1): Article 11. DOI: 10.2202/1944-2858. 1065.
- Starr, P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York, NY: Basic Books.
- Steinmo, S., and J. Watts. 1995. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." *Journal of Health Politics, Policy and Law* 20(2) (Summer): 329–372.
- The Henry J. Kaiser Family Foundation. June 2007. "Massachusetts Health Care Reform Plan: An Update," from <http://www.kff.org/uninsured/upload/7494-02.pdf>.
- Tishler, H.S. 1971. *Self Reliance and Social Security, 1870–1917*. Port Washington, NY: Kennikat Press National University Publications.
- Weissert, C.S., and W.G. Weissert. 2002. *Governing Health: The Politics of Health Policy*, 2nd ed. Baltimore, MD: Johns Hopkins University Press.
- Weissert, W.G., and C.S. Weissert. 2010. "Why Major Health Reform in 2009–10 Won't Solve Our Problems." *The Forum* 8(1): Article 9, from <http://www.bepress.com/forum/vol8/iss1/art9>.
- White, J. 1995. "The Horses and the Jumps: Comments on Health Care Reform Steeplechase." *Journal of Health Politics, Policy and Law* 20(2) (Summer): 373–383.
- Wikipedia 2011. "Massachusetts Health Care Reform." Retrieved April 18, 2011, from http://en.Wikipedia.org/wiki/Massachusetts_health_care_reform.
- Witte, E. 1962. *The Development of the Social Security Act*. Madison, WI: University of Wisconsin Press.
- Yellowitz, I. 1965. *Labor and the Progressive Movement in New York State, 1897–1916*. Ithaca, NY: Cornell University Press.

Chapter 10

Conclusion and Future Direction of Health Politics and Policies

This final chapter of the book is devoted to summarizing the issues and perspectives we have examined in the last nine chapters. Following the summary, we utilize our understanding of the environment of health care policymaking in the country, our perception of the attitudes and beliefs of the people, at least at the moment, our educated opinions of the decision alternatives before the Supreme Court regarding the legal challenges to the health care reform law and our analysis of the problems the PPACA did not fully address, to speculate as to the likely future direction of the nation's health policy. We begin by attempting to summarize the important arguments we have made in the previous chapters of the book.

The first chapter of the book introduced the problems afflicting the health care system and the differences in how various stakeholders define these problems. Following that, we attempted to show how ideological and political differences have impeded health care reform in the country from about 1920 to 1994. To fully understand the various factors that influence the country's health care policymaking process, we presented a select number of relevant models of policymaking and their shortcomings. Health care policymaking in the United States, relative to other industrialized countries, involves a combination of significantly different approaches and factors because of differences in values among the different countries.

Some of the problems that the health care system faces today are the result of both our past successes and failures. Advances in medical technology have led to increased life expectancies and corresponding increases in health care utilization and costs. Similarly, the lack of the necessary political will to enact national health insurance in the past has contributed to our present cost and uninsurance problems. The near total delegation of health care policymaking and implementation powers to health care providers caused serious distortions in the health care market. When these market distortions came to light, and attempts were made to correct them, the country's constitutional, political, and legal frameworks, as well as the multiple veto points they engender, impeded the reform efforts. The changes that are made from time to time are usually incremental in nature and occur under constitutionally, politically, and legally difficult circumstances. The failure of the Clinton

administration's comprehensive health care reform package in 1994, and the controversies and litigations challenging the PPACA of 2010, are very instructive in these regards.

The legal, constitutional, and political frameworks encourage interest group activities. On the one hand, the First Amendment to the Constitution guaranteeing the right of assembly and association ensures that government does not infringe on citizens' political freedom. On the other hand, it breeds interest groups that constantly lobby for the enactment of policies that benefit small constituencies at the expense of the general public. Similarly, the political parties that are the outgrowth of the political system differ significantly about what should be the role and scope of government in virtually all policy areas, including health care. The controversies and litigations that trail the PPACA are partly due to ideological differences among the two political parties about what types of reform should be enacted, who should direct the reform process, what is allowable under the federalist system, and whether the nation should employ public or market-based approaches to solve the problems facing the health care system. The political system exhibits a very strong pro-market and anti-government bias, thereby leading to the utilization of private approaches to solve public problems.

The pro-market bias dictates the methods used to solve the problems in the US health care market. policy-makers and private health care payers have been reluctant to adopt nationalized systems to address the health system's problems. Consequently, efficiency has emerged as the value to pursue. Various policies and programs, including the imposition of wage and price freezes in the health care sector, the enactment of utilization review practices, health planning and the requisition for Certificates of Need (CON), managed care practices, increased cost-sharing for the insured and the setting up of high deductible insurance plans, paying for performance, disease management, health promotion, and outright abandonment of the provision of insurance by employers for current and retired employees, have been employed to contain health care costs. These policies and programs target consumers and health care providers because they are blamed for the rising costs.

The dominance of the medical profession over all facets of health care delivery did not allow the nonmarket social institutions that were expected to address the optimality gaps in the health care market to function properly. As a result, the claim by the medical profession that it was collectively oriented and altruistic was challenged. Corporations now exercise tremendous control and influence over the health care system. While the cost containment measures that have been put in place have succeeded, to some extent, in curtailing the rate of growth in expenditures, some analysts contend that sufficient attention has not been paid to the cost-increasing effects of medical technology. Medical technology is believed to have the greatest impact on insurance-related market failure and institutional response. Furthermore, expanded health insurance is said to have interacted with the process of technological innovation and diffusion to introduce a new form of market failure, dynamic moral hazard, into the health care market. In other words, the availability of health insurance encourages the development and deployment of cost-increasing technologies.

Medical technologies are defined broadly to include the drugs, devices, machines and ultramodern facilities, computer-supported information systems, and

the medical and surgical procedures used in medical care. Medical technologies, divided into traditional social, designed social, and physical categories, have expanded significantly since the end of WWII because of a variety of demand-side and supply-side factors. These technologies affect medical training and practice, health care costs, quality of care and quality of life, and access to care. Similarly, they have raised ethical concerns concerning the utilization of medical services, as well as life-sustaining and life-terminating decisions. These concerns have led to calls to incorporate ethics into the process of technology assessment.

The growth of technology affects the physical environment, which in turn impacts the health of the population. The health status of the population is largely determined by physical, social, and economic factors, including preventive medicine, genetic predisposition, social and economic circumstances, environmental conditions, lifestyles and behaviors, and curative medical care. These determinants of health are not only affected by local and personal factors but by global and international variables as well. The global and international factors that have been found to be associated with health and health care involve international trade and finance, infectious disease epidemics, global warming or climate change, population mobility, and natural disasters and terrorism.

But, even though most of the deaths in the country are associated with social, cultural, economic, and environmental factors that can be prevented, curative medical care is an important determinant of health that cannot be ignored. Unfortunately, a large number of Americans lack health insurance, an important, if not the most important, factor that influences access to medical care. The lack of insurance causes serious health problems for the uninsured. Among many other effects, the uninsured are less likely to have a regular source of care, and to receive the recommended screenings and treatments for chronic conditions. Uninsurance is also associated with an increased risk of subsequent mortality, an effect that is evident in all socio-demographic health insurance and mortality groups.

Additionally, uninsurance contributes to some of the serious health disparities identified among the population. Some of the identified disparities include gender and racial differences in life expectancy and in age-adjusted homicide and HIV deaths; differences in behavioral risk factors and in mammography usage; racial and ethnic disparities in obesity, physical activity, and infant and maternal mortality rates; and racial and ethnic differences in the use of prenatal care. The observed differences in uninsurance rates and health status among segments of the population would most likely have been worse had it not been for the safety net programs of Medicare, Medicaid, and CHIP.

The passage of Medicare came about after many unsuccessful attempts to enact a national health insurance program for the country. Medicare was expected to be the first step toward the enactment of national health insurance. At the time the program was being contemplated, Representative Wilbur Mills decided to add a third component to the Democratic and Republican proposals. This third component, Medicaid, was to provide medical services for the poor. But, whereas Medicare is solely financed by the federal government, Medicaid is jointly financed by states and the federal government. Both Medicare and Medicaid have experienced significant cost growth.

Furthermore, the aging of the population has resulted in significant increases in the population of Medicare beneficiaries and in Medicaid nursing home expenditures.

Increased Medicare and Medicaid expenditures have caused serious concerns among State and Federal policy-makers. These concerns have resulted in various innovations and policies to control the programs' expenditures. One such cost containment effort, the repeal of the AFDC program in 1996, caused concerns that the population of uninsured children would rise, thereby resulting in the establishment of the CHIP in 1997. The safety net programs of Medicare, Medicaid, and CHIP have improved access to health care for the elderly, the disabled, the poor, and for children. However, at a time of changing beliefs about the role of government, a serious economic downturn, and large deficits and public debts, the survivability of the safety net programs is a serious concern. As a result, policy-makers and analysts on both the right and the left have called for reform. Some of the disagreements involve what form the reform should take and who should lead the reform effort. It is out of this environment that the failed Clinton administration's *Health Security Act* of 1993 and the Obama administration's *Affordable Care Act* of 2010 were launched.

Prior to the enactment of the federal government's health care reform legislation, several states, most notably Hawaii and Massachusetts, had implemented reforms in their jurisdictions to expand health insurance coverage to their citizens. Hawaii's reform plan is based on an employer mandate, while the Massachusetts' plan relies on the individual mandate. Even though most of the funds for the reform measures in the two states come from federal sources, the measures have not been nearly as unpopular and controversial as the Obama administration's reform plan.

Federal health care reform became a reality when President Obama signed the PPACA and the *Health Care and Education Reconciliation Act* into law on March 23, 2010, and March 30, 2010, respectively. Not surprisingly, the federal health care reform legislation has generated more controversies and lawsuits than any other federal legislation in recent memory. The National Council of State Legislatures (NCSL) reports that in response to the federal reform law, as well as separate state reform efforts, some members of at least 45 state legislatures have passed legislation to block some selected state or federal actions related to health care reform. The most serious challenges to the federal law are the lawsuits that have now reached the US Supreme Court. The decision of the Supreme Court concerning the constitutionality of the PPACA, as well as other issues that have become apparent throughout our discussion of the health policy environment and specific policies and programs, will significantly influence the future direction of the nation's health care politics and policies.

Future Direction of Health Politics and Policies

As we discussed in the previous chapter, there are at least four foreseeable choices facing the Supreme Court with regard to the constitutionality of the PPACA. First, the constitutionality of the entire law could be affirmed. Second, the individual mandate could be declared unconstitutional. Third, the High Court could rule that

the legal challenges to the PPACA are premature because the fines for not purchasing adequate insurance coverage are yet to go into effect. And, fourth, the entire law could be declared unconstitutional. In the next few pages, we consider what would be the likely effects of the Court adopting each of the four options.

Option 1: The PPACA Is Constitutional

The first option, finding that the law is constitutional, would be welcomed by the Obama administration and the law's supporters, but would not completely eradicate the opposition to the legislation. Rather, it would shift the efforts by opponents to block the law from the courts to the Congress and the federal agencies charged with implementing the law. Republican lawmakers and other opponents of the law would accelerate their efforts to deny funding for the legislation's implementation. They would also attempt to weaken the enabling rules and regulations that would be written to guide the implementation of the reforms. Under this first scenario, Republicans and other conservative groups would campaign tirelessly to gain control of Congress and the executive branch in the 2012 election cycle. If this were to happen, they would be in a good position to vote to repeal the entire law or some portions of it. Since some provisions of the law are very popular among the electorate, such as the requirement that insurance companies not deny people coverage because of preexisting conditions, it is more likely that they would repeal the portions of the law they find offensive, rather than repealing the entire law. Should they choose to repeal the entire law, they would have to enact another law in its place. However, the "repeal and replace" option would be risky since they would need the support of Democrats to enact new legislation if they did not have large enough majorities in both Houses of Congress.

Option 2: The Individual Mandate Is Unconstitutional

If the second scenario, the blocking of the individual mandate, were to happen, the estimated 32 million working-age Americans and their dependents, who are expected to have insurance coverage as a result of the law, would remain uninsured. Additionally, the projection that there would be 16 million more Medicaid and CHIP enrollees would not materialize. The States that are opposed to the expansion of Medicaid and CHIP because of perceived strains on their budgets would feel some relief, even though they would be saddled with large numbers of uninsured children and adults. The United States would continue to have the dubious distinction of being a superpower with large numbers of its citizens without health insurance coverage. Furthermore, cost shifting from the uninsured to the insured would continue unabated, resulting in continued high insurance premium costs; and the health disparities attributable to lack of insurance would continue to increase.

In June 2010, the CBO estimated the effect of the individual mandate on the federal budget deficit. Specifically, the estimate showed that the mandate would lead to a \$252 billion decline in the federal budget deficit between 2011 and 2020. Therefore, eliminating the individual mandate would lead to a loss of the anticipated savings and to additional government payments to disproportionate share hospitals (DSHs) that treat a large proportion of the uninsured. Since disproportionate share payments do not cover all the costs incurred for indigent care, DSHs would continue to experience their usual financial stresses. Moreover, the younger and healthier individuals targeted by the individual mandate would continue to forego the buying of health insurance, resulting in adverse selection and continued increases in insurance premium costs, because of the difficulty of spreading risks from the less healthy to the more healthy (CBO 2010; Quinncommentary 2011; Gruber 2011). It is also not clear if this ruling would invalidate the Massachusetts' individual mandate.

Option 3: The Legal Challenges to the PPACA Are Premature

The prospects for this option are remote but not impossible. The understanding in judicial politics is that for people to have standing to sue, they must have either been harmed or been threatened with a harm by some individual or governmental action. If the Supreme Court were to rule that the fines for not purchasing insurance should be applied before lawsuits can be entertained, a position taken by the dissenting judge in the District of Columbia 2-1 ruling upholding the constitutionality of the PPACA, the decision would narrow the definition of standing. Ruling that the legal challenges to the PPACA were premature would not make the controversies go away. To the contrary, the ruling would merely postpone the lawsuits and disagreements until a later date.

Once the fines go into effect in 2015, new lawsuits would have to be filed. However, it is not clear whether the entire process would begin anew at the lower federal courts, through the appellate courts, to the Supreme Court; or whether the new lawsuits would go directly to the Supreme Court. Whatever happens, the primary effect of the fourth option would be to postpone the legal challenges to the reform law. In the interim, it is conceivable that the law's implementation would continue if the necessary funds were made available to the DHHS. The legal costs of the Supreme Court adopting the third option would be high for both the plaintiffs and the defendants.

Option 4: The Entire Law Is Unconstitutional

Although there is widespread opinion that this option is very unlikely, nothing can be taken for granted. Declaring the entire law unconstitutional would put us where

we were prior to the end of March 2010. Specifically, younger people would not be able to remain on their family insurance plans till age 26; there would continue to be lifetime and unreasonable annual limits on benefits; rescissions of health insurance and exclusions from coverage due to preexisting conditions would continue; insurance companies would continue to devote a larger share of their enrollees' premium payments to administrative and non-medical costs, including profits; and the demonstration projects and experiments that are expected to improve the quality of care and diversify the health care workforce would not be implemented. In brief, all the provisions of the law would be abandoned until such a time replacement legislation was enacted.

After the *Health Security Act* was defeated in 1994, it took almost 2 decades before this latest attempt at serious health care reform was initiated. And, it took more than 4 decades from the time Medicare and Medicaid were passed to the failed 1993 attempt to expand coverage by the Clinton administration. It follows, therefore, that the opportunities to achieve major reforms of the health care system seldom present themselves. Given these trends, if the entire PPACA is declared unconstitutional, one cannot predict when the next opportunity to reform the health care system will arise. Furthermore, if the Supreme Court declares the entire law unconstitutional, there would likely be serious controversies and charges of judicial activism or partisanship. These controversies can have the effect of undermining the already battered image of the Court as a neutral and fair adjudicator. Additionally, it would lead to more serious partisan battles than currently happen when there are vacancies on the High Court and other lower federal courts.

Aside from the focus on the effects of the Supreme Court decision about the constitutionality of the PPACA, the discussions throughout the book reveal additional important issues facing the health care system. The PPACA is not a panacea for all the ills of the health care system. Some of the additional issues that must be examined are discussed in the next few pages.

Additional Issues

The aging of the population and the cost problems associated with Medicare and Medicaid raise important issues for the future direction of the nation's health care policy. Medicare and Medicaid cost problems will persist and, very likely, worsen as the elderly population continues to grow. Long-term care is one of the fastest growing areas of health care spending. As was discussed in Chap. 8, Medicaid pays for most of the institutional long-term care services used by the elderly. This is so because the private long-term care insurance market is small and growing very slowly.

The *Affordable Care Act* did not address public expenditures for long-term care services. Rather, the law established a new, voluntary, self-funded long-term care insurance program for the purchase of community living assistance services and supports for individuals with functional limitations. This provision is not enough to

address the current and expected future demand for long-term care services. The need to enact some form of a public long-term care insurance program will become more urgent in the near future.

Although medical technology is said to be the single most important factor driving health care costs, there are no serious plans to check the growth of cost maximizing technologies that may not necessarily lead to better quality care, and to encourage the growth of cost minimizing and quality enhancing technologies. Moreover, the health care sector is said to invest almost 50% less in information technology than any other major sector of the economy, resulting in the use of antiquated devices and methods to store patients' medical information.

Apart from the increased costs and medical information storage issues discussed above, medical technologies have raised important ethical concerns that relate to the beginning of life and the end of life. Beginning of life issues include controversies about abortion and stem cell research, controversies that pit right-to-life groups against pro-choice groups. End-of-life issues include controversies about unnecessarily prolonging or terminating life, expensive end-of-life medical care, physician-assisted suicide, and euthanasia.

The *Roe v. Wade* 1973 Supreme Court decision, discussed in Chap. 3, did not settle the controversies surrounding abortion. Additionally, the aging of the population will raise still more questions about end-of-life medical care. A consensus as to how these conflicts should be resolved is not likely to be reached in the near future. Furthermore, while still on the topic of technological growth, it is important to stress that the medical profession must develop standards and guidelines to ascertain the practitioners and specialists that are better trained and equipped to perform the newly evolving techniques and procedures spurred by technological growth. Such an undertaking would help to improve the quality of care.

Even if policy-makers provide health insurance coverage to every resident of the United States, the disparities in health will continue to exist because of social and cultural differences among the population, unhealthy lifestyles, covert discrimination and segregation policies, low levels of education among the population, and the income gaps between the rich and the poor. The unpopularity of income and wealth redistribution and the abandonment of redistributive policies and programs, suggest that the income and wealth gradient among the population, and the resulting disparities in health, will persist.

Closely related to the issue of the rich and the poor is the conflict between the PPACA and another federal law that is still effective, the *Emergency Medical Treatment and Active Labor Act* (EMTALA) of 1986. The conflict arises because of how differently the two laws treat illegal immigrants. Whereas the PPACA denies insurance coverage to illegal immigrants, the EMTALA permits them to access emergency treatment when they need it. Additionally, it is not clear how the US-born children of illegal immigrants will be treated under the PPACA, and whether state governments will extend Medicaid and CHIP coverage to them. Even if states extend Medicaid and CHIP coverage to them, the parents may be reluctant to take them to receive care for fear of being apprehended and deported. These issues suggest the need to reform the nation's immigration laws.

One final thought. Americans want less costly, accessible, and quality health care. The pursuit of these three values creates conflicts. For example, how can we achieve quality in a health care system that is obsessed with the need to contain costs? How should we deal with the tradeoffs between costs and access? The arguments we made in the previous chapter, and in this concluding chapter, suggest that the conflicts between these three desirable values impede the development of a sound health care policy (Ginzberg 1977). Therefore, the development of sound health care policies and programs requires that we try to resolve the conflicts between the three values. Failing to do so will not make the conflicts go away, but will only postpone their resolution. To be sure, there will be no easy agreement on how to resolve the conflicts between costs, access, and quality. The key is to embrace some values that have been lacking in recent American political discourse: political coexistence, cooperation, and compromise.

References

- Congressional Budget Office (CBO). 2010. "Effects of Eliminating the Individual Mandate to Obtain Health Insurance, June 16, 2010." Retrieved August 19, 2011, from http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.p.
- Ginzberg, E. 1977. *The Limits of Health Reform: The Search for Realism*. New York, NY: Basic Books.
- Gruber, J. 2011. "Health Care Reform Without the Individual Mandate." Center for American Progress, 1-8. Retrieved October 20, 2011, from http://www.americanprogress.org/issues/2011/02/pdf/gruber_mandate.pdf.
- Quinnscmentary. 2011. "Eliminating the Individual Mandate Under Health Care Reform (PPACA)—GOA Asks the 'Experts' for Other Ideas." Retrieved October 20, 2011, from http://quinnscmentary.com/2011/03/29/eliminating_the_individual_mandate_under_heal...

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