

LAW AND MEDICINE: HEALTH LAW  
Fall 2005  
Professor Mayo

**Historical Overview of U.S. Health Care System**

The study of health law is virtually unique in the law school curriculum. It allows students (of which I count myself as one) to examine the impact of the entire legal system upon a single (albeit huge) industry. Our casebook does a good job of not assuming any prior knowledge about health care, but students who lack any professional or personal experience in the industry may feel somewhat overwhelmed by terminology at the beginning of the semester.

This assignment is intended to bring the entire class up to a level playing field in terms of its knowledge of fundamental developments and issues – economic, political, social, legal, scientific, and medical – in the health care sector. The following essay is a lightly edited version of the first chapter of another casebook: RAND E. ROSENBLATT ET AL., *LAW & THE AMERICAN HEALTH CARE SYSTEM* 4-36 (1997) & SUPP. 2001 at 1-5. Some of the economic and statistical data are a bit out of date, but our casebook provides current information on the same subjects.

Time permitting, class discussion will focus on three time periods: 1887-1910, 1935, and 1965, as well as on identifying the major players in the development of health care law and policy.

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**I. THE RISE AND CRISIS OF PROVIDER-DOMINATED HEALTH CARE**

*The Pre-Modern Period.* Given the current high social and economic status of the medical profession, it is remarkable that throughout most of western history, the task of caring for the ill and injured was seen as relatively low-status work. To be sure, there were famous physicians in virtually every historical period, some of whom, such as Moses Maimonides in 12th century Spain and John Locke in 17th century England, were famous philosophers as well. But the vast majority of healers were unsung local people, many of them women, either not formally trained or organized as a profession, or belonging to relatively low-status groups such as apothecaries or barber-surgeons. *See, e.g.,* PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982), which serves as a source for much of this section.

Similarly, large hospitals filled with advanced technology are a recent development. Before the late 19th century, most medical care -- even surgery -- was delivered in the patient's own home. The home was correctly regarded as far safer than hospitals, and the best place to receive nursing care from the patient's own relatives. The

few American hospitals -- only 178 in the entire country in 1873, of which about a third were mental hospitals -- were designed to serve those who could not be cared for in their homes. In the cities, the most destitute were sent to public (government-owned) hospitals and almshouses, the first being the Philadelphia General Hospital in 1734. In the eyes of well-off citizens, these were places of misery and despair, whose purpose was more to control, isolate, and reform than to cure. To serve the "respectable poor," workers in urban seaports, and occasional well-to-do people in special circumstances (such as traveling), "voluntary" or private charitable hospitals were developed, the first being Philadelphia's Pennsylvania Hospital in 1752. Leading doctors were enthusiastic supporters of these ventures, because even though care for hospital patients was uncompensated, it enhanced the doctor's reputation among the well-to-do, and provided a location for medical education, for which students paid fees. Medical students and young doctors actively competed for the few training positions in hospitals as the surest route to professional success, but these opportunities were generally given to the socially well-connected, and until the late 19th century, many American doctors spent their entire careers without setting foot on a hospital ward. See STARR, *supra*; CHARLES ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* (1987)(hereinafter cited as ROSENBERG, *THE CARE OF STRANGERS*), which also serves as a source for much of this section.

*The Transformation of Doctors and Hospitals.* From around 1870 to the 1930s, American physicians and hospitals underwent a remarkable transformation. After a period characterized by numerous for-profit "medical schools" without clinical training, medical education was reorganized along the hospital-based, clinical model previously available only to the well-connected elite. As a result, many small medical schools closed and medical education became both more scientifically-based and more expensive. The social and economic status of doctors improved substantially; physicians' average income rose from about twice the earnings of unskilled workers in the 19th century to about four times that amount by 1930, and surveys reported medicine first in occupational prestige. In this same period, "hospitals moved from the periphery to the center of medical education and medical practice." By 1910, the number of hospitals had risen from 178 in 1873 to over 4,300, with 421,000 beds.

Most of these new hospitals, including the influential university teaching hospitals, were organized as private, charitable entities. While most hospitals (and doctors) did devote some of their resources to treating the poor, the amount and nature of that service was highly discretionary, and the poor were given separate and usually inferior care either in separate wards or in public hospitals owned by local government. The main function of the private nonprofit or charitable hospitals was increasingly the treatment of paying patients brought in by physicians through their private practices. Although formally governed by lay boards of trustee, this hospital came under the control of the doctors, who controlled the flow of patients and income, and determined which doctors would receive "staff privileges." Doctors were typically not employees of hospitals, but rather used hospital resources (beds, nursing staff, operating rooms) to care for their private, fee-generating patients -- who also paid the hospitals' charges. In the more sparsely settled areas of the South and West, the only hospital in a community

might be publicly owned as a formal matter, but would actually function in the same manner as a private nonprofit hospital, *i.e.*, as “the doctor’s workshop,” a place in which doctors could treat their private patients. There was no national policy, as in most European nations, restricting hospital practice to highly-trained specialists. In the United States, whether a doctor could treat his patients in the hospital, and what kinds of surgical procedures he could perform, depended on decisions by the medical staff of each hospital.

*Science, Culture, and Professional Power.* The most obvious reason for these changes was “scientific advance” or “medical progress.” The basis of modern medicine had been developing for over a century, primarily in France and Germany. Major innovations included invention of the stethoscope, ophthalmoscope, and laryngoscope (early and mid 19th century), modern clinical observation and pathological anatomy (early 19th century), the isolation of infectious organisms (bacteriology) (beginning in the 1860s and 1870s), antiseptic surgery (late 19th century), the development of antitoxins and vaccines for major diseases such as diphtheria, typhoid, tetanus, and syphilis (late 19th and early 20th centuries), and the development of X-rays (late 19th century). For American doctors and hospitals, the critical decades were the 1880s and 1890s.

Surgeons in the 1880s might drop instruments on the floor, pick them up, and after wiping them on a sleeve continue their procedure. Bandages and sutures were used without being sterilized. \* \* \* By the 1890s, the introduction of autoclaves, sterilized dressings, and the rubber glove had made surgeons more inventive and confident.

ROSENBERG, THE CARE OF STRANGERS at 148.

While the advances in antiseptic and other surgical techniques, and in the understanding of disease processes, were real, they cannot by themselves explain what happened in American medicine. First, much of the “science,” and/or the way it was applied, was questionable and later shown to be quite wrong. Because doctors could do abdominal surgery with relative safety after 1890, suddenly “appendicitis” became a common and almost certainly abused diagnosis. In 1934 in New York City, 611 out of 1,000 eleven-year olds studied had already had their tonsils surgically removed. When the remaining 389 were evaluated by other physicians for second and third opinions, all but 65 were recommended for tonsillectomies. Today, tonsillectomies are done on only a small fraction of children, but a decades-long surgical fad swept up millions of American children in its overenthusiasm. MELVIN KONNER, *MEDICINE AT THE CROSSROADS* 118-19 (1993). Similar patterns can be seen in relation to post-menopausal hysterectomies, cesarian sections, radical mastectomies, and coronary bypass surgery.

Moreover, many of the advances in health outcomes in the 19th and early 20th centuries occurred not because of hospital science but because of public health science -- improved, scientifically-informed sanitation, water supply, nutrition, vaccination, public health education, and isolation of the contagiously-ill. Indeed, “one of the most dominant ideas in nineteenth-century medicine had been that social conditions foster disease . . . .

[Public health workers] repeatedly showed that people living in bad social and economic conditions were much more vulnerable to the great infectious scourges that still assaulted the modern world.” KONNER, *supra*, at 82.

In the United States these insights were largely subordinated to safeguarding the authority and income of doctors in fee-for-service, private practice of medicine, and of hospitals that supported such practice. The dominant “cultural style” of American medicine became that of the “scientist-clinician,” but “science” was defined in ways that supported medicine as a private business, and avoided criticism of social and economic conditions. The shift is nicely captured in Charles Rosenberg’s description of New York’s Hospital for the Ruptured and Crippled:

James Knight, the leading spirit in [the hospital’s] founding and its surgeon-in-chief from 1863 to 1887, was a physician who assumed a holistic -- and paternalistic -- attitude toward his patients and the hospital’s work generally. He placed little emphasis on operative procedures and a great deal on diet, exercise, fresh air, bandages, and appliances. Knight saw local lesions [dysfunctions, deformities] as aspects of more general conditions, just as he saw the child as potential citizen of a larger society and concerned himself with his little patients’ moral education and future job prospects. Knight lived in the hospital and served as father of an extended family. By 1887, Knight had become an anachronism. He was succeeded by Virgil Gibney, a youthful and energetic orthopedist. Numbers of operations increased rapidly and lengths of stay decreased. Gibney himself lived outside the hospital. The surgeon was no longer content to guide and monitor, to negotiate a multi-dimensional path to physical and social health. Aseptic surgery had far more to offer many patients than the bandages, regimen, and braces of mid-century, but the new-model surgery construed its responsibilities in increasingly narrow and procedure-oriented terms.

ROSENBERG, *THE CARE OF STRANGERS* at 149-150.

The tragedy of this change is that patient well-being depends on the kinds of science represented by both of these physicians. The “new” surgeon of 1887, Dr. Gibney, was surely right that particular dysfunctions or deformities may be corrected or improved through surgery or other specific treatments. Nor should Dr. Knight be idealized; his science (about the general causes of deformities) may have been wrong, and his social theories and values subject to disagreement and debate. But his general perspective has enduring value; actual health outcomes depend not exclusively on a surgical or medical “fix,” but also on how the patient is going to live and function after leaving the hospital. By defining this as outside the province of medicine, the scientist-clinicians of the late 19th and early 20th centuries set the stage for one of the major policy conflicts of our own time: immense expenditures for sophisticated surgery, drugs, and diagnostic tests, and an astonishing inability to address the political, social, and behavioral causes of most illness and injury.

The turn of American medicine away from the social context of health, and

toward individualistic, procedure-focused services delivered by thousands of for-profit businesses (the solo practice of medicine) and formally charitable but actually profitable larger businesses (private, nonprofit hospitals), was not the work of a small group of ill-intentioned people. Although not inevitable and certainly contested, it was rather a whole society and culture expressing itself -- a culture with immense faith in treating nature and human beings as "others," organized into the "rational" and hierarchical form of modern for-profit industry. *See, e.g., STARR, supra*, at 146; ROSENBERG, *supra*, at 5-11; KONNER, *supra*, at 20-23, 33, 81-85. The full implications of this faith -- that medicine should be "industrialized" under entrepreneurial management -- are now being realized in the development of integrated managed care systems discussed below. But between 1880 and 1980, the medical profession was remarkably successful in persuading Americans that the proper form for health care was the small and medium-size business, *i.e.*, physician-controlled practices and hospitals. In order for this to occur, however, one more ingredient was necessary: money dedicated to funding the private practice of medicine on a fee-for-service basis and the costs of doctor-controlled hospital services.

*The Rise of Private Health Insurance: 1930-1980.* By drastically lowering middle class incomes, the Great Depression undermined the traditional system by which patients directly paid hospitals and doctors at the moment they received services. Some system was needed to spread these costs over time and over a larger number of people. Broadly speaking, three types of solutions were possible: (1) governmentally-owned and managed health care systems; (2) governmentally-mandated health insurance; and (3) private, voluntary health insurance. The first two options were and are fiercely opposed by the medical profession and hospital industry, by deep anti-government values pervasive in American society, and by the fragmented American political structure that makes any major political reform very difficult to achieve. The result was that governmental health care systems have been restricted to desperately inadequate ones for the poor in large cities, prisoners, and Native Americans, and much better ones for two powerful groups with a special relationship to the federal government: the armed services and veterans. For the same reasons, governmentally-required insurance was adopted in 1965 only for the elderly (Medicare) and for about half the population below the poverty line (Medicaid). National health insurance for the whole population was prominently, but unsuccessfully, on the national political agenda in 1948, 1974, and 1994. *See* Sven Steinmo & Jon Watts, *It's the Institutions, Stupid!: Why Comprehensive National Health Insurance Always Fails in America*, 20 J. HEALTH POL., POL'Y & L. 329 (1995).

*Three Forms of Private Health Insurance.* The third option -- private, voluntary health insurance -- has existed in the United States since the 1930s in three quite different forms, classically known as indemnity benefits, service benefits, and direct services. Under an indemnity plan, the patient pays doctor and hospital bills and then seeks reimbursement from the plan to which premiums were previously paid. In other words, the benefit that the policyholder receives from the insurance company is money or an "indemnity." In service benefit plans (typically Blue Cross and Blue Shield), the plan persuades providers -- hospitals and doctors -- to "participate" in the plan, that is, to accept the plan's payments for services. Providers render services to plan members, and then receive payment for their services directly from the plan. From the policyholders'

perspective, the plan benefit is not money, but the health care service itself. In direct service plans, the policyholder also receives services, but this time from the same organization to which the monthly premium is paid. In its purest form, the plan owns hospitals and clinics and employs the doctors and other providers on salary. In reality, the types of ownership and compensation arrangements have been much more varied.

Historically and practically, the three different models of private health insurance have diverged around two major issues. The first is the conception of the “product” they are providing. Indemnity plans are selling “insurance,” that is, financial protection against a relatively rare and financially overwhelming event. These plans thus expect the patient to pay out-of-pocket for routine, preventive, and minor medical care, and often restrict insurance benefits to major financial hazards such as hospitalization. In contrast, direct service plans conceive of their product as “prepaid health care,” *i.e.*, as a way for the patient to budget rationally, through monthly premiums, for both the normal and major costs of care. In theory, direct service plans have a financial incentive to keep their patients healthy, and therefore encourage (with low or no out-of-pocket costs) the use of preventive and routine care. For this reason, direct service plans were and are often known as “health maintenance organizations” (HMOs), or, because they necessarily involve groups of providers, as “prepaid group practice.”

A second major difference among the private insurance models has to do with choice of providers. Indemnity plans, in their classic form, have no financial or other relationship to providers. As long as the provider is a licensed physician or hospital, the patient can choose whatever provider she or he wishes and will be reimbursed for at least part of the bill. Direct service plans are at the other extreme; in return for comprehensive coverage at the specified price, the patient must receive services only from the plan’s own physicians and hospitals (except in cases of out-of-territory emergencies). On both of these dimensions (breadth of coverage and choice of provider), service benefit plans can follow either the indemnity or direct service model, or can blend features of both.

*The Struggle Over Private Health Insurance.* The early 1930s saw a number of experiments in all of these forms. Individual hospitals, small groups of doctors, unions, and companies offered service benefits or direct services to groups of employees in return for modest monthly premiums. The AMA reacted with intense hostility, declaring in 1934 that “the immediate cost [of medical care] should be borne by the patient if able to pay at the time the service was rendered.” In other words, the doctors wanted to deal financially only with individual patients. Indemnity insurance was acceptable because indemnity insurance companies had no or minimal dealings with doctors, but service benefit and direct service plans were not acceptable because they were organized, institutional sources of payment, capable of questioning the price and nature of doctors’ services. For similar reasons, the AMA insisted that any payment plan must be open to any physician who wished to participate. Although justified as protecting the patient’s freedom of choice, this position actually restricted choice by allowing only one kind of health insurance (the kind that made no selection among providers), and repressed the possibility of consumer choice among organized plans that selected providers.

While the AMA's position did not prevail completely, it had a major influence on the way private health insurance developed. Driven by financial desperation in the 1930s, the American Hospital Association (AHA) promoted service benefit plans for hospitals, eventually known as Blue Cross. In most states, special legislation was enacted establishing Blue Cross plans as nonprofit entities, exempt from the normal taxes and financial reserve requirements imposed on commercial insurance companies. The AHA was careful to accommodate physician sensibilities as much as possible, as well as the interests of its own hospital members. Blue Cross plans did not cover physician services, and did not attempt to select providers -- any licensed hospital that agreed to Blue Cross's rates would be reimbursed for services to Blue Cross members. Moreover, the danger to hospitals -- that their prices and services might be questioned by an institutional payer -- was minimized by putting Blue Cross plans under the control of the hospitals themselves, as a requirement of state law and/or as a condition of using the Blue Cross symbol, which until 1972 was owned by the American Hospital Association.

By the late 1930s, physicians too found themselves under strong pressure in many states to agree to some form of medical insurance, in order to forestall efforts by employers and unions to develop direct service plans, and by some state governments that were considering government-mandated insurance. The result was a mixed indemnity and service benefit plan known as Blue Shield, in which doctors typically agreed to accept plan payments for lower-income patients (*i.e.*, service benefits), but retained the right to charge middle- and higher-income patients more (*i.e.*, a form of indemnity benefits). Like the hospitals and Blue Cross, the state medical societies were careful to retain control over Blue Shield, including the crucial provision that any willing doctor could participate in the plan.

By 1940, the Blues had enrolled 6 million Americans (4.5 percent of the population), and commercial insurers (primarily life insurance companies), having seen the viability of health insurance, covered 3.7 million people (2.8 percent of the population) with indemnity benefits. The Blues were also distinguished by their policies of "open enrollment," (anyone could purchase coverage) and "community rating" (a single premium for all individuals, another single premium for all families). Commercial insurance companies practiced "underwriting" (exclusion of high risks) and "experience rating" (varying premiums according to the cost experience of different employee groups). Direct service plans (HMOs) placed a strong third, with 2.3 million enrollees (1.7 percent of the population), but their expansion was limited by harsh, often illegal AMA tactics such as denying hospital privileges to any doctor who practiced with an HMO and expelling such doctors from medical societies.

As **Table 1** indicates, the decade from 1940 to 1950 saw an explosive growth in American private health insurance, from 9.1 percent of the population in 1940 to 50.3 percent of the population in 1950. The Blues' enrollment rose over 500 percent, from 4.5 percent to 25.5 percent of the population, and commercial insurance companies did even better, rising from 2.8 percent to 24.3 percent of the population. HMOs expanded by only about 100 percent, leaving them a far distant third with 2.9 percent of the population.

There were several reasons for this dramatic change. First, World War II had enormously increased industrial employment and workers' real incomes. Second, the wartime and postwar economic boom, coupled with the growing strength of industrial unions, gave organized labor increased bargaining power. Third, employment-based health insurance was a valuable alternative to wage increases, because it was exempt from wartime wage controls and from federal income tax. Fourth, both the Blues and commercial insurers wanted to sell coverage to employee groups, because they tended to be relatively healthy and to involve far lower marketing costs.

The triumph of provider-dominated private insurance was not inevitable. Many western European countries (notably Great Britain) enacted governmental health programs and health insurance after World War II. In 1944, President Roosevelt had asked Congress to enact an "economic bill of rights," including a right to adequate medical care. President Truman proposed national health insurance legislation in 1945, and made it a major theme of his stunning 1948 re-election victory against three formidable opponents. But Truman, the unions, and liberal Democrats could not prevail against entrenched Southern conservatives in Congress, and against a massive negative publicity campaign mounted by the well-financed AMA and insurance industry lobbies. The issue was also heavily affected by Cold War rhetoric, in which any expansion of governmental functions was branded as "socialism" and "communism."

Given legislative failure to enact national health insurance, its potential supporters turned to solutions that fit with American ideology and masked the role of government. The middle class continued to buy private insurance, and the unions also turned to private insurance as a fringe benefit of collective bargaining. As Americans' real incomes rose and became increasingly subject to federal income tax, the exclusion of employment-based health insurance from taxation in the 1954 Internal Revenue Code became a major but hidden government subsidy for the well-off and the well-organized.<sup>1</sup> As **Table 1** indicates, private health insurance, increasingly dominated by commercial insurance, flourished in the next decades, covering 67.8 percent of the population in 1960, 77.4 percent in 1970, and 81.1 percent in 1980.

[Table is on next page]

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<sup>1</sup> Another well-organized group, veterans, had access to free and improved government health care not only for service-connected injuries, but for all medical care to the extent the Veterans Administration had the capacity to treat them. The linkage of health care with veteran status effectively legitimated a large-scale federal health program for millions of working class (and predominantly white) males. Much more modest efforts for other groups (such as pregnant women and children) had been routinely castigated by the medical profession and others as "socialism."

**Table 1**  
**The Rise (and Partial Decline) of Private Coverage:**  
**Population Covered by Private Health Insurance**  
**and Percentage Insured, 1940-1990**  
**(in millions of people covered\*)**

Type of Coverage	1940	1950	1960	1970	1980	1990**
Blues	6.0	38.8	58.1	75.1	86.7	70.9
Commercial Insurance	3.7	37.0	69.2	89.7	105.5	86.7
Self-insured and HMOs***	2.3	4.4	6.0	8.1	33.2	86.2
Net Total Private****	12.0	76.6	122.5	158.8	187.4	181.7
Total Population	132.5	152.3	180.7	205.1	231.2	253.7
Percentage of Total Population with Private Coverage	9.1	50.3	67.8	77.4	81.1	71.6

*Sources:* Randall R. Bovbjerg, Charles C. Griffin, & Caitlin E. Carroll, *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L., MED & ETHICS 141, 144 (Table 2) (1993), reprinted with permission from the American Society of Law, Medicine & Ethics, drawing on HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA, (Washington, DC: HIAA, 1992), Table 2.2, page 25; DEPARTMENT OF COMMERCE STATISTICAL ABSTRACT OF THE UNITED STATES, (Washington, DC: U.S. Government Printing Office, 1992), Table 2, page 8.

*Notes:* \* For 1940-1970, figures are for U.S.; for 1980-90, U.S. plus Puerto Rico and U.S. possessions.

\*\* For 1990, the table omits hospital indemnity coverages (e.g. paying \$100/day during hospital stays), which are typically bought from commercial companies to supplement other coverage. These were previously included. In 1990, 14.3 million people (5.7 percent of the population) had such coverage, and including them might raise the net percentage covered by some amount, to the extent that these indemnity purchases did not have other coverage.

\*\*\* Includes mainly HMOs prior to the 1980s. In 1980 and before, this category was called "other" and was dominated by HMOs: subsequently, an increasing share constitutes self-insured or -administered plans (In 1980, HMOs enrolled 9.1 million; in 1990, 33.1 million (see Department of Commerce 1992, cited above as source for the table)).

\*\*\*\* "Net Total Private" eliminates duplication of multiple coverage from different sources.

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*How Hospitals and Doctors Came to Be Paid.* In the 1950s, the last critical piece of provider-dominated health insurance fell into place: the methods of paying hospitals and doctors. Hospitals had historically established "charges" for different services with total discretion and no uniform pattern. Spurred by temporary World War II government

reimbursement programs, Blue Cross began shifting in the 1950s from “charges” to “reasonable costs” as a basis for paying hospitals. In theory, “costs” were less arbitrary than “charges” because a hospital had to verify that it had actually spent various amounts that constituted the “cost” of care. But as defined and implemented by the hospital-dominated Blue Cross plans, “costs” meant virtually any expense at all, and there was no effort to use the term “reasonable” to impose any discipline on hospital expenditures. In a similar way, doctor-controlled Blue Shield allowed physicians to set their own fees, and typically paid a percentage of average fees for particular procedures in particular areas. Although commercial insurance companies were not controlled by hospitals and doctors, their acceptance of “patient choice of provider” meant that they had little bargaining leverage over particular providers. Moreover, commercial insurers had to track Blue Cross and Blue Shield reimbursement rates fairly closely if their enrollees were to have comparable access to providers. Finally, although insurance policies issued by both the Blues and commercial companies typically limited benefits to “medically necessary” procedures, both types of companies rarely questioned the judgment of an individual physician about whether a service was indeed medically justified.

By 1960, the system of provider-dominated health financing was firmly in place. Patients could choose whatever provider was willing to accept them, with relatively low or no out-of-pocket costs. There was no serious, independent review of doctors and hospitals regarding which patients they chose to serve, or for quality or volume of care, and private insurers would pay doctors and hospitals pretty much what they asked. Although from 1950-1960 real health care costs per capita had risen at 3.6 percent per year, considerably faster than the 1.5 percent annual growth in real per capita Gross National Product (GNP), health care costs still represented only 5.3 percent of GNP by 1960. *See Table 2.*

None of the major interest groups had an incentive to challenge the system. Providers were of course pleased with unfettered autonomy and open-ended payment. Without paycheck deductions or tax consequences, most employees mistakenly experienced health insurance as “free,” or as “paid for by the company.” (In fact, economists agree that workers actually pay for health insurance through foregone wages.) Employers and unions enjoyed the employee loyalty that flowed from generous health benefits, and the costs, though rising, seemed bearable and not easily subject to control. Commercial insurers found they could pass on increasing costs through higher premiums, and in any event no one company had the market power or expertise to challenge the prevailing system. The insurers that often did have a significant market share -- the Blues -- had no motivation to challenge providers because they had been established and controlled by the providers themselves. Government had little incentive to get involved, because it was not paying many of the bills. Nevertheless, by delegating vast discretion and open-ended financing to thousands of hospitals and hundreds of thousands of doctors, the system constituted an inflationary time bomb held delicately in check by eroding traditions of self-restraint and charitable care. These restraints were abandoned after an historic shift to a new governmental role in health care financing.

*The Evolution of Government's Role in Health Care.* As discussed above, the

United States made the choice after World War II not to enact national health insurance, and to rely instead on private health insurance supplemented by locally-financed charitable care. Nevertheless, the medical and hospital establishment, along with business, labor, and scientific and academic leaders, did want the federal government to fund medical research (through the National Institutes of Health (NIH)) and hospital construction (through the Hill-Burton Act). Following the pattern of private health insurance, both federal programs turned over large amounts of money to researchers and hospitals without significant governmental control.

The next major expansion of the federal role in health care occurred in the 1960s, and again many factors were involved. Labor unions and other liberal groups shifted their efforts away from trying to enact national health insurance and focused on governmental insurance for the aged. This was politically astute, because the absence of private health insurance or retirement health benefits for the aged created a powerful social need that the market could not fill. Moreover, the growing number of senior citizens was increasingly vocal and politically active, with the result that the 1964 Democratic Party platform made health insurance for the aged one of its major priorities.

The upshot, after very complex political maneuvering, was the enactment in 1965 of two landmark pieces of federal legislation: Medicare, Title 18 of the Social Security Act, providing federal hospitalization (Part A) and medical (Part B) coverage for persons over 65, and Medicaid, Title 19 of the Social Security Act, providing federal matching funds for state medical assistance programs for the poor. Both programs were strongly influenced by the American tradition in health care of incremental reform, *i.e.*, of building on existing systems and accommodating powerful groups. Both programs are discussed in detail in our casebook, and only a few key features will be noted here.

Medicare Part A (hospital insurance for the elderly) ended up tracking, and even expanding, Blue Cross' system of passively paying hospitals for "reasonable costs." Indeed, even though Medicare Part A was a wholly federal program, paid for by its own payroll tax, the function of processing claims and paying hospitals was subcontracted to local private insurance companies, often Blue Cross. *See* JUDITH M. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* (1977); SYLVIA A. LAW, *BLUE CROSS: WHAT WENT WRONG?* (2d ed. 1976). Medicare Part B (medical insurance for the elderly) tracked the coverage, co-payment, and reimbursement patterns of Blue Shield. Unlike Part A, Part B was not financed by payroll taxes, but rather by a combination of premiums and co-payments paid by the elderly, and general federal tax revenues.

Medical assistance or Medicaid was financed and structured very differently than Medicare. Medicare represented an expansion of the social security system, financed and administered entirely by the federal government. Medicaid, in contrast, was structured as an extension of the cash welfare system which, since 1935, had been run in significant part as a federal-state partnership. Under this system, each state set its own eligibility, coverage, and reimbursement rules within federal guidelines, and then was eligible for federal matching funds for each state dollar spent under the program. The federal Medicaid law required the states to pay hospitals on the basis of "reasonable costs," but

left the states much more discretion about paying doctors and other providers. The states also had discretion to define income eligibility, and could only receive federal funds for low-income persons in specified cash welfare “categories,” such as the aged or one-parent families. The result of these options and restrictions was that Medicaid only reached one half or less of families with incomes below the federal poverty line. *See generally* ROBERT & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF THE MEDICAID PROGRAM (1974); Rand E. Rosenblatt, *Dual Track Health Care -- The Decline of the Medicaid Cure*, 44 U. CINN. L. REV. 643 (1975).

The goal of both programs was to end the largely separate and inferior system of health care for low-income people that was practiced in big city public hospitals and in the charitable wards of private hospitals. Both programs assumed that giving patients a source of payment -- symbolized by the Medicare and Medicaid cards -- would be enough to integrate the elderly and the poor into “mainstream” medical care. While this worked reasonably well for the middle-class elderly, it did not solve the problems of access and quality in inner cities and rural areas, nor did it overcome racial discrimination. Moreover, because Medicaid was linked to welfare eligibility and funding, the program was chronically underfunded, thereby insuring that doctors would still have financial disincentives to treat the poor.

Even with these limitations, Medicare and Medicaid made a tremendous contribution to access to and quality of care for the elderly and a significant percentage of low-income families. For example, the elderly and the poor, whose greater health needs should generate greater health utilization, had used much less health care per capita than the well-off before 1965. After 1965, utilization rates gradually evened out, although many still faced financial and other access barriers. Moreover, as the private health insurance system began to collapse in the 1980s for reasons discussed below, the federal and state governments began to expand Medicaid incrementally to cover childbirth and other targeted services. Indeed, in the 1990s some states reported that services for 30 to 40 percent of all childbirths were being paid for by Medicaid.

These achievements came, however, at a high financial price. The Medicare and Medicaid programs created, at the federal level, an unprecedented open-ended budgetary commitment to pay for a large range of hospital and medical services whenever providers deemed them to be “medically necessary.” Given traditionally weak governmental and insurer oversight, the inflationary time-bomb already set ticking by private health insurance was now ready to explode.

*The Crisis of the Provider-Dominated System.* The social consensus supporting the provider-dominated health care system began to unravel around 1970. The system, or more accurately, the fragmented, multifaceted set of subsystems, has resisted comprehensive reform, but its internal coherence and external support (by government, business, and other important groups) have been seriously eroded. The reasons lie in sharply rising costs, often dubious quality, and diminishing access. Much of this book examines the legal mechanisms through which our society is trying to respond to these problems.

*Costs.* The enactment of Medicare and Medicaid coincided with the beginning of a spectacular escalation in national health care spending. The annual rate of growth in medical costs had been 3.2 percent in the seven years before Medicare, and 7.9 percent in the five years afterward, about 50 percent higher than the rising inflation rate of the general Consumer Price Index in the same period. Per capita annual health spending had risen from \$142 to \$198 from 1960 to 1965, then climbed to \$336 per capita by 1970. Per capita expenditures on hospitals had risen about 8 percent annually in the 15 years before 1965, and 14 percent annually thereafter. In 1965, health care had absorbed 5.9 percent of the Gross National Product (GNP), compared with 6.2 percent for education and 7.5 percent for defense. By 1970 the three sectors were at the same percentage of GNP (about 7.3 percent), with health on a steep upward trajectory of 6.5 percent annual growth in real health care dollars per capita, compared with an annual growth rate in real GNP per capita of less than 2 percent. *See Table 2.*

**Table 2**  
**The Rising Tide of Medical Costs:**  
**Health Care Spending as a Share of GNP**  
**and Growth in Health Spending and GNP, 1929-1990**

<b>Time Period</b>	<b>Health care share of GNP at end of period (percent)</b>	<b>Annual growth in real health care dollars, per capita (percent)</b>	<b>Annual growth in real GNP per capita (percent)</b>
1929	3.5	---	---
1929-1940	4.0	1.4	0.0
1940-1950	4.5	4.0	3.1
1950-1960	5.3	3.6	1.5
1960-1970	7.3	6.5	2.5
1970-1980	9.1	3.8	1.7
1980-1990	12.2	4.4	1.7
1990-2000 (estimated)	18.1	3.4	1.2

*Sources:* Randall R. Bovbjerg, Charles C. Griffin, & Caitlin E. Carroll, *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J. L., MED. & ETHICS 141, 142 (Table 1) (1993), reprinted with permission from the American Society of Law, Medicine & Ethics, drawing on Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, JOURNAL OF ECONOMIC PERSPECTIVES 6 (1992):3-21, Table 1; Sally T. Burner, Daniel H. Waldo, and David H. McKusick, *National Health Expenditures Projections through 2030*, HEALTH CARE FINANCING REVIEW 14 (1992): 1-29, Tables 3, 4, and 7 (for 1990-2000).

One reaction to these statistics has been to blame Medicare and Medicaid for health care inflation, as if government were uniquely unable to insist on efficient and proper use of its funds. But as discussed above, the truth was that hospitals and physicians had pressured government to channel its money through mechanisms (such as

“reasonable cost”) and institutions (such as Blue Cross and Blue Shield) developed and controlled by the private sector itself. Medicare and Medicaid were indeed responsible for extending insurance coverage to the elderly and some of the poor, who legitimately needed a considerable amount of care, and this undoubtedly increased effective demand and utilization. However, the nature and amount of that care, and its price, were not controlled by government, but largely by hospitals and physicians.

Many factors contributed to steeply rising costs. Advances in health care technology shifted from antibiotics in the 1940s and 1950s to complex surgical and diagnostic procedures in the 1960s and thereafter. New procedures involved expensive new equipment and highly trained technical support staff. Hospital employees -- nurses and other workers -- had long been paid substandard wages and now wanted to catch up. Nevertheless, careful international comparisons show that the extraordinary rate of cost increase in the United States cannot be primarily explained by volume of service, aging of the population, sophisticated technology, or malpractice litigation. The principal reason why the United States began spending, and continues to spend, much more per capita than any other nation, is the provider-dominated financing system itself, which allows doctors and hospitals considerable power to set their own prices.

The cost-based payment system for hospitals sent hospitals a clear message: the higher your costs, the more you will be paid, both by government and private insurers. Backed by strong cultural and professional beliefs in the value of high-technology medicine, and the need to compete for prestigious physicians with lucrative practices, it was inevitable that hospitals would increase their costs exponentially. With guaranteed reimbursement, there was no need to wonder whether patient flow would fully utilize the next piece of new equipment; if the equipment were underutilized, the price per patient would just be higher, and the costs would be covered.

Physician reimbursement reinforced these trends. The charge structures adopted by private insurance and Medicare strongly favored surgical procedures and in-hospital care, with no controls on volume of services billed. Physician fees remained high and rose higher, even when procedures such as cataract surgery were simplified, and pre- and post-operative functions were delegated to separately compensated technicians. Specialists such as cardiologists and radiologists had average incomes twice as large as primary care physicians, and a busy cardiac surgeon estimated the average income of his peers in 1979-80 as over \$500,000 per year, almost 10 times the average primary care physician's income and 25 times the median family income at that time. Not surprisingly, these numbers sent a strong signal to medical students to specialize in high-income fields, regardless of patients' actual needs for cardiac surgery as compared to primary care.

*Quality.* Many expert observers of the system have begun to doubt that the expense yields proportionate benefits. There was and is no national system for evaluating the efficacy of new medical procedures and technology (except for drugs) before they are widely disseminated. Later, after millions or billions have been spent, many studies have found a significant amount of services to yield little or no measurable benefit. A large proportion of the resources are being spent on patients in the last year of their lives. Some

analysts estimate that roughly one-third of health care expenditures -- a staggering \$330 billion in 1994 -- are medically unnecessary. Moreover, the methods for measuring efficacy are matters of intense controversy.

*Responses to Cost Escalation and the Emergence of Managed Care.* Beginning in the 1970s and gathering momentum in the 1980s, both government and private payers attempted to control costs through a variety of techniques, notably price controls, review of doctors' decisions, and financial incentives. For example, notably New York and Maryland, abandoned reasonable cost reimbursement and began to treat hospitals as analogous to public utilities, subject to prospective rate regulation. Other states, notably New Jersey, pioneered hospital reimbursement by diagnostic groups (DRGs), a method adopted by Medicare in 1982. Under this system, hospitals are paid a fixed amount per patient according to diagnosis, giving the hospital an incentive to lower costs per patient rather than raise them. Medicare also limited the inflation rate in physician charges, and in 1992 began phasing in a new physician reimbursement system that attempted to impose volume controls as well as fee limits.

Cost escalation also had a major effect on the private market. Before the late 1970s, most employers who provided health coverage bought insurance policies from commercial insurers or the Blues. But large employers began shifting to "self-funded" plans, in which the company itself assumes the financial risk of paying for care, and typically hires an insurance company to administer the benefits with unprecedented review of doctors' decisions. Employers also began to give their employees financial incentives to join HMOs or other types of managed care plans. As **Table 1** indicates, the number of persons covered by "self-funded and HMOs" rose from 8.1 million in 1970 to 33.2 million in 1980, and to 86.2 million in 1990. The federal and state governments also began encouraging Medicare patients and requiring Medicaid patients to enroll in managed care plans. At the same time, entrepreneurial and managerial control of health care increased through the growth of for-profit HMOs and hospital chains, and the pervasive restructuring of health care delivery into complex webs of profit-making firms.

Hospitals and physicians responded to the cost containment measures of the 1980s with self-interested resistance. Although hospital admissions declined 15 percent after the Medicare DRG reform of 1982, between 1980 and 1989 hospital expenditures rose from \$154 billion to \$233 billion (in 1989 constant dollars), an increase of 51 percent. Physicians' earnings rose even more dramatically; although the average number of physician-patient contacts declined 5 percent, earnings increased from \$63 billion to \$118 billion, or 87 percent. How did they do it? Part of the explanation is a large increase in the number of doctors, from 185 to 240 per 100,000 population, or 30 percent. But most of the explanation is higher fees charged by doctors, higher volume of out-patient care by hospitals, and more "intense" or "sophisticated" (and therefore more expensive) care by both types of providers. See Eli Ginzberg, *Health Care in the 1980s: Overview and Focus*, in CHANGING U.S. HEALTH CARE 1, 3 (Ginzberg *et al.* eds., 1993). While some of these increases are undoubtedly justified by higher volume and quality of service, a significant part reflects the profit motive's distortion and corruption of American health care. For example, the home infusion industry, a \$3 billion a year

market “niche” comprised of companies providing intravenous chemotherapy, antibiotics, pain control, and nutrition to patients in their homes, quickly became a hot Wall Street item, as canny investors bought up physician practices, encouraged doctors to refer patients to companies in which the doctors had an ownership interest, and charged insurance companies and government grossly inflated prices. *See* JEANNE KASSLER, M.D., BITTER MEDICINE: GREED AND CHAOS IN AMERICAN HEALTH CARE (1993).

The self-interested focus -- not to say greed -- of many hospitals and doctors was extremely short-sighted. Having disabled government from effective cost containment, and having created a hugely profitable economic sector composed mainly of small and medium-sized businesses, the providers virtually guaranteed that the next phase of health care delivery would mimic what was happening in other parts of the economy. Large organizations -- “integrated delivery systems” -- would swallow up the providers, transferring a significant part of the profit to themselves, while offering employers and government the promise of managerial “cost containment.” This is indeed what is taking place in the 1990s.

The term “managed care” has been used in many ways, but in our view it can best be understood as part of a seismic shift in the financing and organization of American health care. In this new framework, the functions of insurance and delivery of health services are integrated into a single corporate arrangement that both insures groups and delivers covered benefits through a defined network of participating providers. These corporate arrangements operate under a variety of organizational names, such as health maintenance organizations, individual practice associations, preferred provider organizations, integrated service systems, point-of-service plans, and provider networks. Some are regulated by federal and state law, while other entities are so new that they have virtually escaped government guidelines as of this point. While these arrangements differ in key respects, they share fundamental structural and legal features as well as a common mission: to hold down costs through greater direct control over the use of health care.

Most managed care organizations share the following common elements: (1) the assumption of a contractual duty to furnish covered care and services; (2) the provision of services through specified provider networks, which are themselves under contract to the managed care entity; (3) advance control over actual utilization of benefits by both providers and patients; (4) the use of financial incentives in order to influence provider practice and resource utilization; and (5) quality and cost control systems that include credentialing, practice reviews and guidelines, and the reporting of practice data which are used to control providers’ access to the market.

All of these features were present, or potentially present, in the direct service organizations of the 1930s discussed above, many of which still exist, such as Kaiser Permanente on the west coast, Group Health Cooperative of Puget Sound, and Group Health Association of Washington, D.C. But the economic, professional, legal, and cultural context of today’s managed care is quite different from that of the earlier period. The classic prepaid group practices of the 1930s were nonprofit entities with strong

commitments to consumer satisfaction. Their explicit goal was to provide doctors and patients with an alternative to entrepreneurial practice, in which a more preventive and cost conscious medical culture could develop. In contrast, the new managed care entities are generally operating in a hyper-entrepreneurial environment, with little effective restraint from the federal or state governments. This has created major issues concerning coverage decisions and quality of care.

These cost containment and market strategies have had deep ripple effects on access to care. As the federal and state governments lower Medicaid eligibility levels, increasing numbers of low-income people have become uninsured, at the very moment when low-wage jobs are expanding in number. Corporate layoffs and the shift to part-time workers without benefits have increased the number of middle class uninsured, as have a growing number of companies dropping health benefits or refusing to offer them. Rising costs have made individual and small group policies increasingly unaffordable, and intense insurance company desire to avoid high-cost patients has led to unprecedented exclusion of people with “pre-existing conditions.” As **Table 1** indicates, the percentage of the population covered by private health insurance actually fell, for the first time in 50 years, from 81.1 percent in 1980 to 71.6 percent in 1990. Moreover, increasingly tight hospital reimbursement practices, and the decline in funding for already underfunded public hospitals, has made charitable care harder than ever to obtain.

Taken together, these developments represent a crisis in the provider-dominated system that had developed from 1870 to roughly 1980. Hospitals and doctors can no longer count on setting their own prices and defining their own services -- although many have displayed remarkable ingenuity in maintaining their incomes. Doctors are increasingly practicing in settings where they have less autonomy, and face greater pressures from financial incentives, practice guidelines, and utilization management. Indeed, the highest financial rewards and power have shifted from practicing physicians to entrepreneurs, including some physician-entrepreneurs. The great university teaching hospitals, the pinnacle of modern health care, are struggling to define their future structure and role. The overlapping access crises -- for the middle class, the unemployed, low-income workers, the poor, and the seriously ill -- mean that pressure for some form of government-subsidized health insurance is likely to reappear on the political agenda. For reasons discussed below, however, the shape of a political solution is quite unclear.

*The Impact of the Market on Professional Authority: The Case of Drug Testing.*  
A dramatic example of the impact of managed care can be found in the radical transformation of testing drugs on human beings. Under the medical autonomy or professional authority model that dominated health care reimbursement until the 1980s, payers (primarily employers and government) passively paid whatever health insurers demanded. Insurers, in turn, passively paid whatever physicians, hospitals, and other suppliers such as drug companies demanded. Able to raise their prices almost at will, drug companies had little incentive to develop costly new products. To test the relatively small number of new drugs on human beings, the drug companies turned to well-respected academic research centers, whose specialists and scientists were paid on a salaried basis and where drug company studies usually had lower priority than those

funded by prestigious government grants. The entire process was further slowed down by the Food and Drug Administration (FDA) approval process. In short, whether and how new drugs were developed was shaped by a system of profitable professionalism in which drug companies, academic researchers, and physicians in private practice were largely insulated from market competition. This insulation assured reasonably high-quality drug testing on human beings, at the price of relatively slow drug innovation, monopoly profits for drug companies, and above-market incomes for most physicians. *See* Kurt Eichenwold & Gina Kolata, *Drug Trials Hide Conflicts for Doctors*, N.Y. Times, May 16, 1999, at 1, 35.

Beginning in the 1990s, this system underwent rapid change. Under pressure from employers and government no longer willing to pay for sharply rising costs, managed care insurers in turn resisted paying for constantly rising drug prices (albeit with mixed success). In order to increase profits, drug companies now had to develop new products in the fastest possible time and at the lowest possible cost. But the academic medical centers did not have the capacity and entrepreneurial culture and incentives to respond quickly to the industry's need for greatly increased and low-cost human testing. Almost overnight, a new sub-industry of "testing companies" arose, which began to pay physicians in private practice, most often family practitioners and internists in primary practice, from \$1,000 to over \$4,000 per patient to enroll their patients in trials of new drugs. While federal regulations require patients to sign a consent form reviewed by an "Institutional Review Board" (IRB), there is no governmental oversight of what physicians say to their patients or the payments to physicians, and no requirement that physicians disclose to their patients that the physician is being paid for every patient enrolled. In short, the professional autonomy model gave way to a wide-open market competition model, in which highly-trained specialists and multi-billion dollar drug companies were replaced to a significant extent by family practitioners hustling patients into trials run by start-up firms and "virtual" companies with a web of sub-contracts. As with the managed care industry as a whole, the new drug testing industry has no way to measure the quality of its testing, and its payment practices are powerful inducements to inappropriate and dangerous patient referrals and outright fraud. In short, market competition achieved a much faster rate of drug innovation and more competitive drug prices, at the cost -- to some unknown extent -- of lower quality testing and medical care, higher risk to patients, corruption of the doctor-patient relationship, and very high entrepreneurial profits with corresponding incentives for fraud and abuse. *See* Eichenwold & Kolata, *supra*; Kurt Eichenwold & Gina Kolata, *A Doctor's Drug Studies Turn Into Fraud*, N.Y. Times, May 17, 1999, at 1. Concerned that the "huge influx of money into biomedical research is creating unacceptable conflicts of interest for scientists and is eroding the public's trust in the data," the Department of Health & Human Services convened a conference in August 2000 "to consider strengthening guidelines on conflict of interest in medical research." Philip J. Hilts, *U.S. Weighs Rule Changes On Conflicts In Drug Study*, N.Y. Times, Aug. 16, 2000, at A-28.

*The Predicted Sharp Rise in Health Care Costs, 1998-2007.* In September 1998 a group of economists and actuaries known as the Health Expenditures Projection Team, associated with the National Health Statistics Group, Office of the Actuary of the Health

Care Financing Administration, published an article predicting that after five years of “near stability,” health care costs would rise significantly in the years 1998—2007. National health spending is expected to rise from slightly more than \$1 trillion in 1996 to \$2.1 trillion in 2007, accounting for 16.6 percent of gross domestic product (GDP) as against 13.6 percent in 1996. The authors believe that a major cause of this increase is the rise in real per capita income, causing increased demand in the private sector for available resources, and increases in the use and intensity of services. See Sheila Smith *et al.*, *The Next Ten Years of Health Spending: What Does the Future Hold?*, 17 HEALTH AFFAIRS (Sept./Oct. 1998) at 128; Robert Pear, *Sharp Rise Predicted in Health-Care Spending in Next Decade*, N.Y. Times, Sept. 15, 1998 at A-21. A *New York Times* editorial called these numbers “discouraging, since the projections do not even reach the years when baby boomers will begin utilizing health care intensively in the late 60’s and 70’s.” Editorial, *Rising Costs in Health Care*, N.Y. Times, Sept. 23, 1998, at A-28.

The September 1998 predictions were well founded. Health insurance premiums rose 8.3 percent in 2000, compared with 4.8 percent in 1999. See Christopher Hogan, Paul B. Ginsburg, & Jon R. Gabel, *Tracking Health Care-Costs: Inflation Returns*, 19 HEALTH AFFAIRS (Nov./Dec. 2000) at 217, 219. In 1999 the cost of all health benefits rose 6.6 percent, but the cost of prescription drugs rose 18.4 percent. *Id.* In December 2000 the *New York Times* reported that “[c]onsumers across the country will face double-digit increases in their health care costs starting next month, reflecting the biggest surge in medical inflation since the early 1990’s. Employees of large companies are predicted to pay 18 percent more or \$1,401 on average in 2001. Employers’ health care costs will rise 9.8 percent to \$4,026 per employee. See Milt Freudenheim, *Consumers Across the Nation Are Facing Sharp Increases in Health Care Costs in 2001*, N.Y. Times, Dec. 10, 2000, at 54. See also Robert Pear, *Rise in Health Care Costs Rests Largely on Drug Prices*, N. Y. Times, Nov. 14, 2000, at A-18; Robert Pear, *Health Costs Underestimated, Experts Say*, N.Y. Times, Nov. 30, 2000, at A-32.

## II. NATIONAL HEALTH CARE REFORM AND THE CLASH OF FUNDAMENTAL VALUES

*A Brief Anatomy of National Health Care Reform.* National health care reform involves a great many issues, but two appear to be central to the political outcome: who will pay for it, and how the vast sums of money that flow through the system will be controlled, contained; and allocated to different types of providers, suppliers, managers, investors, and others.

The first issue can be easily stated: an adequate family health insurance policy can easily cost \$4,000 per year or more. The median family income in the United States is around \$38,000. It seems obvious that families at this income level cannot afford a \$4,000 expense out of their own pocket, nor is it likely that their employers will buy such policies for them if they have not already done so. The only way that large numbers of currently uninsured or underinsured people will obtain private or governmental coverage is if higher-income citizens help them pay for it. The Clinton Administration estimated

the amount of the needed subsidy at around \$90 billion per year.

Whether one regards this or other amounts as “worth it” or not depends on many factors. Much of the money could be raised by eliminating the enormous administrative costs of our fragmented insurance system, in which hospitals and doctors must hire tens of thousands of staff to process billing for hundreds of payers. Some of the money could come from reducing the vast amount of waste, duplication, and underutilization in our currently over-built and over-equipped delivery system. But achieving these savings depends on the second reform issue: changing the financing and delivery systems. Tens of thousands of people in the insurance and health care industries would lose their jobs or otherwise be disadvantaged, so they represent a potent group opposed to these reforms.

More fundamentally, how one views a transfer of \$90 billion or more from the relatively well-off to the relatively less well-off depends on how one views society and its workings. If you believe that a civilized, moral society should not deny care to people in need because they cannot pay for it, then you will likely support the transfer. In a more utilitarian or self-referential vein, if you believe that subsidized universal coverage will generate more economic security, job mobility, and productivity, and thereby increase your own opportunities and well-being, then you may well be willing to pay higher taxes to support the transfer. If, on the other hand, you see the transfer as going from hardworking, successful people to less hardworking, less deserving people, you may see the transfer as an unjustified penalty that will only undermine work incentives. These and other aspects of our conflicting visions of society are explored below.

The second issue -- controlling and reforming the financing and delivery systems -- is already apparent. In order to raise the money to deal with the first issue, it would be very useful to deal with the second. Moreover, we know from sad experience with Medicare and Medicaid that just adding new government coverage to the existing financing and delivery system is likely to lead to increased costs and profiteering. Unfortunately, our political system has typically become paralyzed in an “After you, Alphonse” posture around these two issues. Proposals for redistribution are met with: “we must control costs first.” But costs cannot be controlled in a system with fragmented payers and millions of uninsured, the costs of whose care are covertly shifted to paying patients.

In addition, we also know from our experience with Medicare and Medicaid that simply adding government money in the “standard” amounts and forms is not sufficient actually to deliver care to traditionally underserved populations. Racial discrimination, lack of providers, cultural and language barriers, and many other factors form powerful barriers to effective access. Advocates for these groups rightly fear that national health reform that solves only the problems of the middle class will leave millions of Americans still excluded from adequate care.

The Clinton Administration attempted to address these issues with its proposed Health Security Act in 1993-94, as did a number of other congressional proposals. The Administration’s approach seemed heavily influenced by interest-group arithmetic, and

its health plan was carefully designed to appeal to many powerful interest groups. Large companies would benefit by shifting the mounting costs of retirement health benefits to the federal government. Small companies would get the price advantage of buying health insurance through large purchasing pools. The elderly would receive coverage for long-term care. Self-employed people, low-income workers and the unemployed would get lower premiums and subsidies. Employers, taxpayers, and premium payers would no longer be bearing hidden costs for the uninsured -- those costs would now be in the open, and more fairly distributed. Large insurance companies and other organizations would make profits managing the insurance and health care delivery systems. In short, the idea was to make it possible for everyone (except, controversially, millions of illegal aliens) to have the kind of health insurance coverage now enjoyed by employees of large or well-off organizations, and to guarantee that coverage against the risks of unemployment and illness.

If national health reform of this sort would have provided so many benefits, why did not Congress and the American people support it? This is a fascinating question about which there are no definitive answers. Most Republicans and some Democrats deny that this kind of reform was a good idea; they say that the American people saw that it would lead to a “government take-over” of health care and would cost too much, and therefore did not support it. It is true, as discussed above, that the Clinton plan anticipated eventual redistribution of about \$90 billion a year, and that every powerful interest group fought furiously to minimize its share of the bill. On the other hand, every other developed nation has managed to raise comparable funds through a combination of reduced administrative costs, limits on the health care system’s size and budget, and taxes. Many Americans mistakenly believe that we are somehow free of these limits and taxes now. In fact, we are facing increasing and non-accountable treatment and choice-of-provider restrictions imposed by private health care plans, and “taxes” in the form of premiums, hospital cost-shifting, and actual taxes. Moreover, the hidden costs of not insuring everyone and of a largely unregulated system -- unnecessary illness and death, distorted investment and personnel decisions by employers, distorted job-seeking decisions by workers, and many others -- radiate throughout the society and far exceed the costs of covering the uninsured.

Other analysts explain the collapse of national health reform as the result of our nation’s fragmented political structure. The byzantine congressional committee system, and the lack of disciplined national political parties, permits and encourages powerful legislators to advance the interests of well-financed and/or well-organized constituencies to the detriment of comprehensive reform. Others point to the news media’s “horse-race” reporting and interest-group advertising that misled and confused the American people, and to massive political contributions that bought influence in the political process. Still others point to strategic and tactical errors by the Clinton Administration, including a long period of drafting the plan in secret, an overly-complex statute, and failure to follow through with a coherent congressional strategy and educational campaign for the American people. In particular, the Clinton plan was understandably less than candid about its cost control and regulatory provisions, making it an easy target of fear-mongering about “bureaucracy” and “big government.”

This last issue points to what many see as a deeper explanation for the collapse of the national health reform: that many Americans have a profound distrust of government, and a related uncritical faith in what they perceive as “the private market.” This point was made vividly in the now-legendary comment by a senior citizen to a member of Congress: that she was opposed to health reform because she did not want “the government to take over Medicare.” Of course, Medicare is a government program, with far lower administrative costs than private health insurance. Yet in many people’s minds, a program that works well -- as most senior citizens believe Medicare does -- “by definition” cannot be a government program, and, conversely, a government program must by definition be a “bad” one. We now turn to examining directly the value systems and visions of society with which these beliefs are associated.

### **III. CONFLICTING VALUES IN AMERICAN HEALTH CARE**

The issues of access, quality, and costs, and of professional autonomy, government regulation, and market competition, have been profoundly affected by an underlying tension between three contrasting principles or ideals. The first, and from around 1880 to around 1980 the dominant principle, is that of professional autonomy and expertise. Under this principle, the questions of the nature of the doctor-patient relationship, what health care is, how its quality is defined, who should have access to it, and how much it should cost, are left largely to those professionals with the most expertise -- the physicians. Indeed, in their historical codes of ethics and principles of financing, the organized profession -- preeminently the American Medical Association -- asserted that these questions should be under the control of doctors themselves. How doctors answered these questions was a matter of some controversy even within the profession.

The second principle is often termed one of equality, and rests on profound moral, religious, and political traditions. This principle holds that health care should be distributed without regard to what are considered irrelevant factors, such as race, gender, income and social status. Proponents of this principle ask: when a physician or other health care provider confronts a patient seeking care, what factors should influence his or her response? As between two women in the process of childbirth, or two victims of heart attack, kidney failure, or automobile accident, do we really want doctors to deny one of them care, or provide markedly inferior care, because she or he cannot pay for it, or is considered socially less worthy?

The third principle is that of market competition. This view holds that most or all health care should be treated as a commodity; that ability to pay is a legitimate criterion of allocation, and that differing “tiers” of health care are necessary for economic efficiency and individual liberty. Proponents of this principle ask: should an individual be prevented from spending his or her own money in order to obtain the best possible treatment, because society cannot afford to subsidize similar services for everybody? Should those who want to spend less on health care be prohibited from buying limited

insurance plans, or a lower standard of care, because of a medically or socially defined ideal? \* \* \*