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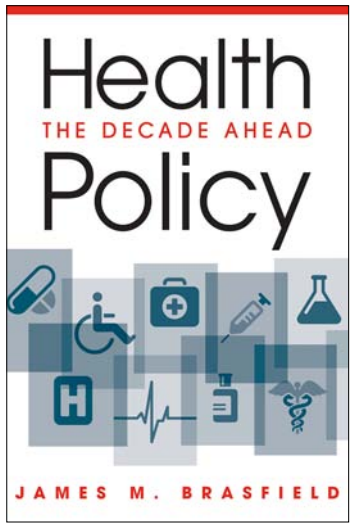
Health Policy:
The Decade Ahead

James M. Brasfield



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The Political Economy of Health Care

For most of us, the idea of a trillion dollars is just a number on a page and not something tangible. As a nation, we spent $2.5 trillion on health care in 2009.[1] It is difficult to grasp the significance of this number. But this amounts to $8,086 for each person, including children.

Throughout this book, I scrutinize the intersection of politics and economics in the health care system. In this chapter, I use summary statistics to describe the economic contours of that system and historical narrative to chronicle its development, especially in the past half-century. This intersection of the worlds of politics and economics in health care is not episodic, but a fundamental hallmark of this large and complex subsystem of our nation.

Economists and political scientists individually study the world from the point of view of their disciplinary paradigms. This book is an account of health policy from my view as a political scientist. After this descriptive introduction to the political economy of health care, I offer a useful conceptual model of the political process to serve as a blueprint for understanding how decisions made in the political arena transform the economic underpinnings of the health care system.

In the chapters that follow, I examine major public programs such as Medicare and Medicaid, assess the recent health reform endeavor, review attempts to control costs, and compare the US health care system with that of other nations. Health policy is path dependent. Current policy is in large part a function of historical developments and past decisions. I give consideration to the antecedents of current policy, but my primary focus is on the future. I devote special interest

and attention to both anticipated future problems and feasible policy options for confronting these issues.

The Health Care System in Political and Economic Terms

Advanced study in a discipline tends to influence the way we think about the world. After listening only a few minutes to a discussion, one can probably identify the discipline of the speakers by their vocabulary and perspective. In the health policy arena, participants are lawyers, academics, legislative staff, bureaucrats, and lobbyists. Each brings to the discussion a conceptual framework about the health care system and the delivery of services that was probably molded in their college classrooms years earlier. As the various disciplines become more isolated, dialogue is challenging because the vocabulary is distinctive. In these opening pages, I attempt to return to the older idea of political economy with a condensed description of the health care system in both political and economic terms.

The provision of health care services is one of the largest economic segments in the country. About one out of every six dollars of economic activity each year involves health care services. The delivery of these services is a huge industry and the livelihood for millions of Americans. Just over half of these dollars is raised and spent in the private sector. The rest passes through the national and state governments in the form of taxes collected and money spent to purchase or provide health care services.

Decisions made by the national and state governments determine which service providers receive payments, the size of the reimbursements, eligibility for services, and what types of services are offered. Almost half of all money spent in the health care system was originally collected as a tax, and legislatively established rules control many of the elements of service delivery.

A century ago a country doctor might have accepted a chicken in exchange for services from a farmer with little cash, and an urban hospital owned and operated by a religious denomination might not have expected more than a token payment from a poor patient. But today health care workers are well-paid professionals who expect and deserve a fair payment for their time and expertise.

Conceptualizing the health care service delivery system as a large business within a market economy is an authentic way to view it. Yet

it is also valid to view it as an essential community service regulated and significantly financed by public funds. It is both a business and an essential public service. Often the health policy debate begins with participants' disagreements based on the view of health care as either a business or a public service. In fact, it is both.

Basic Measures of Health Care Spending

As we explore the political economy of health care, it is useful to look at some of the basic numbers to help us understand this huge segment of the economy. It is possible to find literally thousands of explanatory numbers in tables and charts. The five basic measures below are similarly formatted each year. There is a complex reality behind them, but they portray an easily comprehendible picture of the political economy of health care.

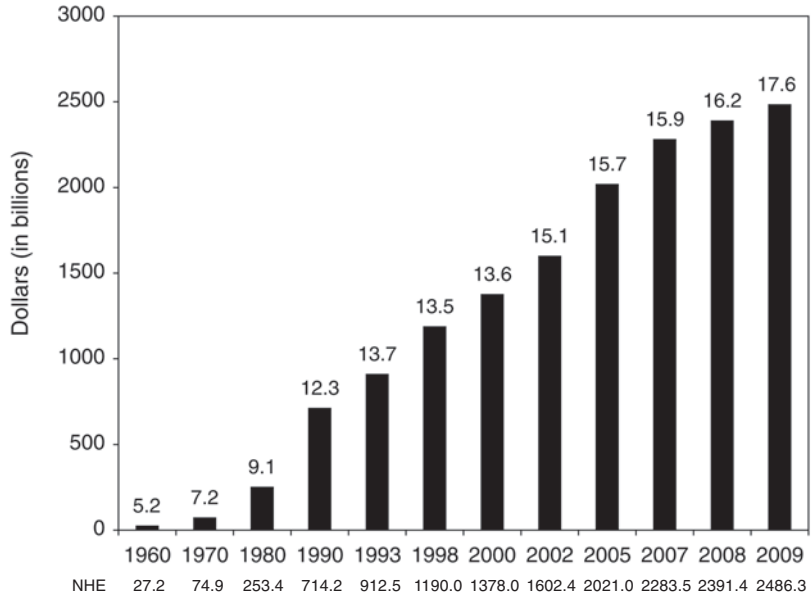
Percentage of Gross Domestic Product Spent on Health Care

As mentioned above, according to the most recent statistics on national health spending, the United States spent $2.5 trillion on health care in 2009. This was 17.6% of the US total gross domestic product (GDP) of $14.1 trillion.[2] Figure 1.1 traces how, as a society, the United States has steadily increased the share of GDP spent on health care over the past forty years, and allows us to project what future health care expenditures will consume. In 1960, the United States spent $27.5 billion, which was only 5.2% of GDP. Percentage of GDP is one of the most common comparative measures used in the health policy literature. Is the chart in Figure 1.1 a sign that health care expenditures are out of control, or does it reflect on a national preference and concern about individual health versus other individual spending?

Annual Rate of Increase in Health Care Spending

There has been a consistent pattern over the past fifty years: health care expenses rise faster than general inflation. From 2008 to 2009, health care expenses rose 4.0% (the lowest single increment in forty-eight years) while inflation was 2.7%. Figure 1.2 shows the differential between the annual increase in health care spending and the Consumer Price Index (CPI) over the past decade. This pattern has

Figure 1.1
National Health Care Expenditures
as Percentage of Gross Domestic Product (1960–2009)



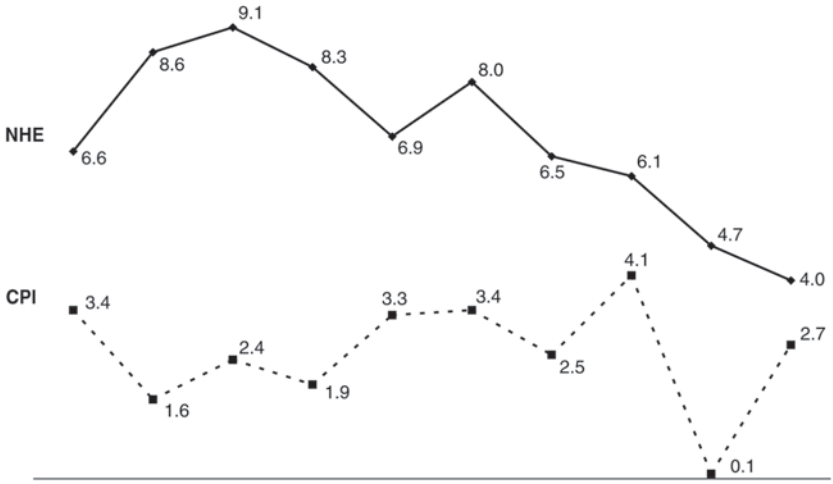
Source: Centers for Medicare and Medicaid Services, National Health Expenditure Data, www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.
Note: NHE = national health care expenditures in billions of dollars.

persisted for more than thirty years. If the increase were equal to the general rate of inflation, the health care expense trajectory would flatten. Cost control victory will be achieved when health care expenditures rise at the same rate as other segments of the economy.

Percentage of Total Health Care Spending Raised by Taxation

Americans do not like to pay taxes, and some perceive any spending of government appropriations for health care services as socialism. In 2009, $1.08 trillion (or 44%) of $2.5 trillion spent on health care was public spending. In 1970, public funds accounted for 38% of total spending. In 2009, public sector spending increased 10% over the previous year.

Figure 1.2
Annual Increase in National Health Care Expenditures and Consumer Price Index (2000–2009)



% Increase:	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
NHE	6.6	8.6	9.1	8.3	6.9	8.0	6.5	6.1	4.7	4.0
CPI	3.4	1.6	2.4	1.9	3.3	3.4	2.5	4.1	0.1	2.7

Source: Centers for Medicare and Medicaid Services, National Health Expenditure Data, www.cms.gov/NationalHealthExpendData/downloads/tables.pdf; US Department of Labor, Bureau of Labor Statistics, Consumer Price Index, www.bls.gov/cpi/tables.htm.

Notes: NHE = national health care expenditures in billions of dollars. CPI = Consumer Price Index.

Governments paid more than half of the costs for hospitals and nursing homes. Depending on one's political perspective, when public spending for health care passes 50%, it will be an occasion for joy or alarm.[3]

The Share of Health Care Dollars Spent for Hospital Services

The rate of growth and the ultimate percentage of dollars spent for hospital services is a key system measure. Hospital care accounted for 31% of all health care expenditures in 2009, down from 38% in 1970. Tests and even some surgeries may be conducted at outpatient centers, but the greatest expenses per person are still incurred during

hospital stays. This is the largest category of health care expenses and, therefore, it is a critical element.

Private Insurance Premiums as a Share of Total Health Care Spending

Since 1990, private health insurance premiums have consistently been about one-third of total health care spending. In 2009, private insurance premiums represented 32% of all health care expenses and increased 1% over the previous year. In 1970, private insurance was only 21% of health care expenses, Movement up or down from this number in subsequent years will signal a shift in the way that the health care system is financed.

Basic Ideas Offering Insights into a Complex System

These five measures do not tell the whole story, but over time they provide a quick snapshot for understanding the basic political economy of health care. When attempting to understand a large and complex system, it helps to focus on a few major concepts to understand how the system is organized and how it functions.

Next I propose five big ideas in the political economy of the health care system and show how each individually contributes to our understanding. Taken together, the five offer insights into the complex health care system.

A Few Individuals Account for a High Share of Total Health Care Expenses in a Given Year

Becoming very ill and thus incurring high health care costs in a given year is similar to winning the lottery; many people pay into the system, but there are only a few big beneficiaries. Patients with cancer or patients who have had a heart attack are not likely to see themselves as "winners," but the cost of their care is very large compared to the average person's yearly health care expenses. A huge health care bill would bankrupt a typical family without the protection of health insurance. The same principle applies to homeowners' insurance in the case of a fire, but that seems to be less abstract than health insurance.

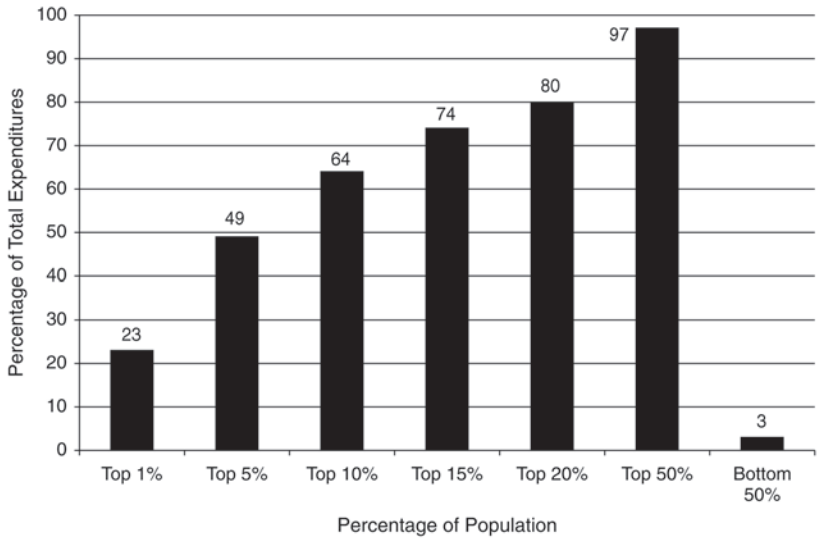
In a classic 1992 article, M. L. Berk and A. C. Monheit document the concentration of health care expenditures. In a given year, a high

share of total expenditures is spent providing care for a few individuals. Subsequent examinations find this continuing to occur in general as well as in particular programs such as Medicare.[4] Figure 1.3 is based on a Kaiser Foundation analysis with 2004 as the base year. It reflects all health care expenses in that year.

The explanation of Figure 1.3 is simple. In a given year, 50% of the population incurs 97% of the total health care expenses. The other 50% of the population generates 3% of the total costs. At the other end of the illustration, 1% of the population accounts for 23% of the total health care expenses in that year. Assume that you are an insurance company executive. Which of these groups would you prefer to be in the pool of people you insure? If you opted for the 50% who will incur only 3% of the costs, you pass the basic insurance executive test.

Let us do a quick math exercise. Remember that in 2009 total health care spending in the United States was $2.5 trillion. If we count only the money actually spent on personal health care services excluding such items as research, the figure is "merely" $2.3 trillion. If we divide this latter number evenly among the population of 312

Figure 1.3
Concentration of Health Care Expenditures in the United States (2004)



Source: Kaiser Family Foundation, Data Spotlight, www.kff.org/charts/112706.htm.

million, the average expenditure per person is $7,371. Yet the health care expense lottery allocates high costs to only a few individuals.

One percent of the population is 3 million people, and 30% of the expenses is $690 billion or $187,000 per person. Thus, the most expensive 1% of the population generates an average cost of $221,000 each. The least expensive 50% of the population spends $56.3 billion at an average cost of $442 per person.

Neither individuals nor health insurance companies know for sure who is going to win this lottery each year, but demographics and past history may offer clues. The older a person is, the greater are his or her chances of having a serious health problem, and if he or she has a history of heart disease or cancer, the future risk is even larger. If the insurance risk pool has 100,000 people, there are going to be a few with large expenses, but most with minimal costs in a year. If there are ten people in the risk pool, one person with large expenses will consume the entire premium collected from the group plus substantially more. Small risk pools are much less attractive to insurance companies.

Studies of subgroups such as Medicare and Medicaid recipients show similar patterns, even among older people. The top 5% of the Medicare population generated 43% of the total costs, and the bottom 50% incurred 4% of the total. For Medicaid, the top 1% of enrollees accounted for 26% of all expenditures.[5]

All insurance is based on the principle that, in a given year, most of those who pay premiums will collect little or nothing in benefits. Our houses do not burn down, our cars are not totaled, and we live through the year. We purchase insurance to protect ourselves against unexpected high losses. We are part of a health insurance system out of fear that we may be the unlucky lottery winner this time. For those in between the top 1% and the bottom 50%, health insurance also helps pay routine health care expenses and covers the costs of serious, but less than catastrophic, expenses. As I discuss the various facets of health policy in the pages ahead, keep in mind the yearly concentration of expenses. It is an idea important to most of the policy discussions.

Health Care Expenses Have Grown Faster Than Inflation for a Half-Century

The Committee on the Cost of Medical Care (CCMC) carried out the first national calculation of health care expenses in 1929. It found a total of $3.6 billion, which was 3.5% of the gross national product

(GNP). Seventy-eight years later, we spent $2.5 trillion or 17.6% of (GDP). There were enormous changes in the health care system and its technology in these decades. Since 1961, national health expenditures have grown faster each year than inflation in the Consumer Price Index (CPI), which grew between 1.5% and 4% most years. Health expenses grew 1.5 to 3.0 times the CPI in most years. General inflation and population increases account for part of the annual growth, but intensity of medical services provided and price of those services are clearly important contributors to health care cost inflation.[6]

In 1960, health expenses were 5.2% of GDP. Five dollars of every $100.00 of economic activity was spent for health care. Today $17.60 of each $100.00 is spent on health care. A Congressional Budget Office study projected health care spending to be 50% of GDP in 2082.[7] This seems fanciful, but it would have seemed impossible to think in 1929 that the 3.5% would grow to 16% in less than eighty years.

As long as health expenses grow faster than inflation, people will continue to spend a higher percentage of their total wealth for health services. They may prefer to spend money for physicians, hospitals, and other health care services rather than on consumer goods, education, or alternative uses of their resources—this is a choice. At some point, however, society will become dissatisfied with the share of individual income that is directed to health care. Already public opinion polls show growing dissatisfaction with rising health care costs.[8] It is impossible to have a policy discussion about health care without the subject of cost increases quickly becoming a point of debate. Rising health care costs permeate the following pages of this book.

If Public Spending Equals Socialism, Are We Almost There?

In the recent health reform debate, critics often alleged that new government initiatives would lead to "socialized medicine." For close to a century, this has been the effective cry of those who prefer the status quo. Responding with a dictionary definition of "socialism" is not an appropriate rejoinder. Over the years, public spending for health care services has risen both absolutely and relatively. In 2009, spending by all US government entities for health care was 44% of the total.

Part of the public funds spent for health care is clearly socialized medicine by any definition. The Veterans Administration spent $33

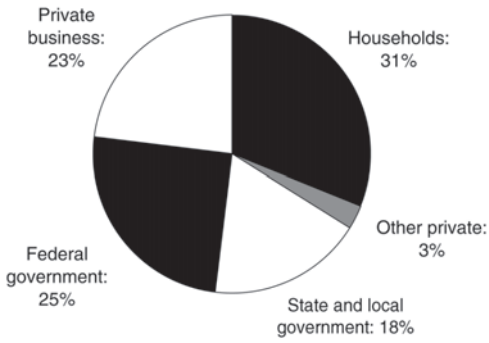
billion providing health services to veterans. This is about 5% of the total public funds. The Defense Department spent a similar amount for military health care. In 2009 Medicare accounted for $502 billion, which is about 40% of public expenditures, and Medicaid was smaller at $374 billion, including both federal and state funds. In 1960, 25% of health spending was from the public sector. That quickly jumped to 40% after the enactment of Medicare and Medicaid in the mid-1960s. By the mid-1990s, public spending had increased to 45% of total spending. The recent health reform legislation will add new public expenditures in a few years; at that point, the government share will creep past 50%. Whether this constitutes socialized medicine depends on political philosophy, not policy analysis.[9]

Most of the public funds used for health care are paid to those who provide services and goods, not public agencies or employees. A physician in private practice with Medicare patients, a community hospital receiving Medicaid reimbursement for services to a poor person, and a privately owned pharmacy dispensing drugs for Medicare recipients are all paid with funds collected through the tax system. Typically, this is not defined as socialism. But with greater public funding comes pressure on public agencies to limit total spending. Fraud or the appearance of fraud in public programs inevitably leads to bureaucratic rules that often have unintended consequences and diminish administrative flexibility.

Public tax dollars also come with legal constraints requiring fairness and equal treatment. Greater public sector participation in the funding and delivery of health care services carries both positive and negative consequences. A vigilant press enforces impartial policy rules benefiting the disadvantaged. Americans have tended to prefer a mixture of public and private institutions to deliver social services such as education. The evolution of the health care system reflects this penchant for the mixture of both public and private institutions for the delivery of services.

There are many ways to slice the total health care spending pie. Figure 1.4 breaks down expenses by sector showing the public and private pieces. The household component is composed of out-of-pocket costs, premium cost sharing, and Medicare premiums paid by recipients. Private businesses pay a significant share of employee premiums as well as Medicare tax. This slice includes only actual services and supplies, excluding such items as medical research. The government share is 40%.

Figure 1.4
Health Care Expenditures by Source of Funds (2009)



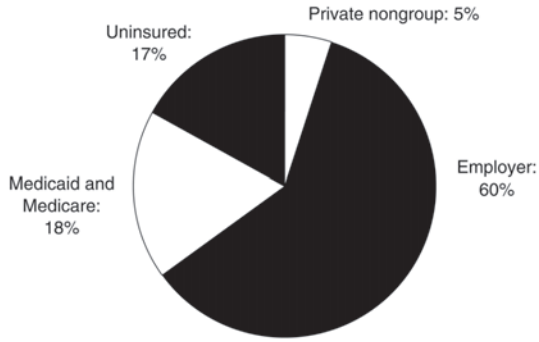
Source: Centers for Medicare and Medicaid Services, National Health Expenditure Data, www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.

Employment-based Health Insurance Declines

Employment-based health insurance began in the 1930s. Today, as Figure 1.5 illustrates, 60% of the working-age population obtains health insurance through the workplace. This includes workers and their dependents in approximately equal numbers. In 2008, 160 million people had employment-based insurance. Another 16 million purchased individual policies, and 40 million had coverage through Medicaid. Medicare was the source of insurance for 7 million, and an equal number were part of the military health care system.

Employment-based health insurance is declining. The recent high point was 2000, when 68.4% of the population had employment-based insurance. This percentage has dwindled to 59% in 2009. Individually purchased insurance has also declined from 7.5% to 5.2% since 1994; this represents an absolute decline in the number of people who were covered by individual policies from 17.3 million to 13.8 million. During the same period, the number of people covered by Medicaid increased from 29.1 million to 37.6 million, which represents 14% of the non-elderly population. Various studies have identified reasons for the employment-based insurance decline, which include decline in the number of companies offering insurance, growth in part-time positions, and increased employee cost sharing with more employees declining coverage.[10]

Figure 1.5
Sources of Health Insurance Coverage



Source: US Census Bureau, Current Population Reports, "Income, Poverty, and Health Insurance Coverage in the United States: 2009," www.census.gov/prod/2010pubs/p60-238.pdf.

There are two slightly different measures used to generate conclusions about private health insurance coverage. One relies on surveys that ask participants about the source of their health insurance coverage. The other asks companies about whether or not they offer coverage and how many employees decline coverage that is offered. Depending on which measure is used, the results differ slightly.

Figure 1.5 is based on survey research. It shows that 60% of the non-elderly population (almost all older Americans are covered by Medicare) are workers with employment-based health insurance or the dependents of workers. Public programs cover 18%, with 5% purchasing individual policies. This leaves 17% uninsured. These are 2008 statistics, but the numbers do not shift radically from year to year.

Individually purchased policies declined from 7.5% in 1994 to 5.0% in 2008. Public coverage, especially Medicaid, increased to 18% after a low of 10.5% in 1999. The uninsured climbed from a low point of 15.6% in 2000 to 17.4% in 2008.[11]

In 2000, health insurance was offered by 69% of all companies. This dropped to 60% by 2008. Large companies (those with more than 200 workers) almost always offer health benefits, with 98% doing so in 2008. This has not changed over the past decade. Today, only 46% of small firms (three to nine workers) offer coverage. This dropped from 58% of small firms in 1999.[12]

The larger the firm, the more likely it is to offer health insurance. In 2008 78% of firms with ten to twenty-four workers offered coverage as did more than 90% of those with more than twenty-five workers. Workers at small firms are those least likely to have employer-offered health insurance. Firms with a higher proportion of low-wage or part-time workers are less likely to offer insurance. Less than one-third of workers are part time, but only 30% of firms offer health benefits to part-time workers. Those not offered coverage tend to work for small firms, work part time, or work for low wages. There are industry variations, and those employed in manufacturing are much more likely to be offered health insurance than those in retail. About 80% of all workers offered insurance by their employer actually take the coverage; this is consistent across all firm sizes.[13]

From the two types of data about employment-based health insurance, we can draw a few conclusions about the political economy of health care. First, the major decline in employer-offered health insurance is found in small businesses. Large employers have been offering and continue to offer health insurance to full-time workers. When the economy declines, small firms are less likely to offer health insurance.[14] As structural changes occur in the economy, they contribute to a decline in the offering of health insurance. Fewer workers are employed as a consequence of the global financial crisis of 2009–2010, fewer high-wage manufacturing jobs exist, and more people are forced to work part time out of necessity rather than choice. In some families, one spouse works at a job with health insurance and covers the rest of the family as dependents. For one-worker households, the risk is greater. The decline in coverage by employer-sponsored insurance is real, but unlikely to plummet in the decade ahead because the decline is concentrated among low-wage and part-time workers in small firms. Employment-based coverage is in danger for a growing segment of US workers and their families.

Those Outside the Financial System Are Sicker

Since half the population spends relatively little on medical care, does it really matter whether or not one has health insurance? A variety of evidence suggests that it does. The Institute of Medicine recently published a report drawn from a large number of studies. It concluded that, "in sum, despite the availability of some safety net services, there is a chasm between the health care needs of people

without health insurance and access to effective health care services. This gap results in needless illness, suffering, and even death."[15] The report analyzed dozens of individual studies, and found significant evidence to support the contention that individuals without health insurance have less access to care and, consequently, are less healthy. Most of the studies focused either on children or adults. The health consequences differed for each category.

Uninsured children are less likely to have a usual source of care than those whose families have private insurance or public coverage. A usual source of care is associated with immunizations and well-child care in addition to the monitoring of developmental milestones and asthma care. Children with a usual source of care also receive more timely diagnosis of serious problems. Children with special needs who have health insurance are more likely to see specialists.[16]

A 2009 study at Johns Hopkins Children's Center examined data from 1988 to 2005 covering hospitalizations of over 20 million children. It found that uninsured children experienced a 60% increased risk of dying. The authors concluded that this was not the result of differential treatment once in the hospital, but a result of delayed entry into the medical system despite a life-threatening condition.[17] In a review of studies of adults without health insurance, the Institute of Medicine found they were:

- Less likely to receive preventive services
- More likely to forgo visits with physicians or delay effective therapies despite chronic conditions
- More likely to be diagnosed with late-stage cancer, to be undergoing treatment for hypertension, and to have worse glycemic control of diabetes
- More likely to have poorer health outcomes[18]

In their analysis of access to health care services, the Kaiser Commission on Medicaid and the Uninsured found that the uninsured were five times less likely to have a usual source of care, seven times more unlikely to have preventive care, and twice as likely to go without care or prescription drugs because of cost.[19]

The relationship among disease, health insurance coverage, and economic status is complex. Some have argued that these studies do not prove that lack of insurance is the direct cause of serious illness or death.[20] This is technically correct, but the association between lack of health insurance and less access to care is clear. The studies demonstrate

that, when access to routine care is constrained by financial limits, more serious conditions go undetected and untreated for a longer time.

The Evolving Practice, Delivery, and Economics of Medicine

> Those who cannot remember the past are condemned to repeat it. —*George Santayana*

The next few pages provide a sprint through a century of history that traces the evolution of the organization, delivery, and economics of medicine in the United States. If we jump into a time machine and travel back to the dawn of the twentieth century, many things are familiar. Trains are running, houses are being built, and even baseball games are being played much as they are today. But the practice and organization of medicine in 1900 would be almost unrecognizable.

The beginning of the twentieth century marked the culmination of significant changes in American life. The practice and economics of medicine would never be the same again. The Civil War was both a demarcation and a contributory cause. The material demands of war propelled the nascent Industrial Revolution forward, especially in the north. The US economic engine steamed ahead into the twentieth century, and with it came the economic base for medical revolution. The establishment of land grant colleges and the expansion of science education at major private institutions created the scientific base on which twentieth-century medicine was built. The forty-year span from the Civil War to the turn of the century saw a prodigious change in the understanding of biology and physiology first in Europe, and then in North America. The rapid advance of transportation and communication technology enabled people and ideas to move across national borders and vast land expanses faster than at any time in history. The convergence of these economic and technology developments propelled the rapid advance of the scientific foundation of medicine, and the diffusion of new insights and applications across the country.

To make this historical summary less complex, the story unfolds in five eras:

- The era of the general practitioner: 1900–1920
- The era of the community hospital: 1920–1950
- The era of the medical center: 1960–1980

- The era of the health maintenance organization (HMO) and managed care: 1980–2000
- The era of market redux: 2000 to the present

Of course, real life does not offer sharply distinctive timelines; no newspaper headline on January 1, 1920, hailed the beginning of a new era. But retrospectively, this helps us to understand the critical intersection of major events as they lead to system changes.

The Era of the General Practitioner: 1900–1920

In 1912, Harvard professor Lawrence Henderson asserted, "for the first time in human history, a random patient with a random disease consulting a doctor chosen at random stands a better than 50/50 chance of benefitting from the encounter."[21]

These first two decades of the twentieth century encompassed the revolutionary developments in medicine that had taken place over the previous four decades. A middle-aged practicing physician in 1900 would have been perhaps forty-five years old, born five years before the beginning of the Civil War, and received his medical education in about 1880. This education typically consisted of an apprenticeship with an experienced physician, and a short time spent at a small proprietary medical school. The physician's office, not the hospital, was the nucleus of a general medical practice in a small town.

After the birth of that average 1900 physician, medicine underwent a meteoric transformation. The era of the general practitioner was in essence the end of the predominant place of this role in US medicine. The surgeon was about to replace the general practitioner as the central player. These first two decades of the century were essentially the transition from the general practitioner to the surgeon as the embodiment of medicine.

In the middle years of the nineteenth century, the use of ether, nitrous oxide, and finally chloroform allowed the surgeon to conduct operations of greater duration and complexity without the patient undergoing excruciating pain. English surgeon Joseph Lister in 1867 pioneered antiseptic techniques and the subsequent broad acceptance of aseptic (sterile operating field) approaches that drastically reduced fatal infections associated with surgery. Finally, German physician Wilhelm Roentgen discovered the principle of the X-ray in 1895, which allowed physicians to peer into the thoracic cavity without an

incision. Together, these techniques rendered all types of surgery safer and more feasible, especially abdominal intervention. The Mayo brothers performed 54 abdominal surgeries between 1889 and 1892, but 612 in 1900. By 1905, the number had risen to over 2,000.[22] However, in this first decade of the twentieth century, the average physician was not a surgeon, did not live in a major urban area, and was not wealthy. Health insurance did not exist. Despite the growing urban middle class, the typical family income did not provide enough of a surplus to afford high physician fees.

Organizationally, physicians were separating into specialists and general practitioners. Despite the prominence of the Mayo Clinic group model, the typical physician was a solo practitioner dependent on individual fees. The new surgery specialists were likely to have had at least part of their education in Europe, and were exposed to a more science-based approach to medicine.

The Carnegie Foundation–sponsored Flexner Report of 1910 was a devastating critique of US medical education, especially the proprietary schools. Most quickly closed their doors. The Johns Hopkins Medical School with its European-style scientific approach to education became the national model. Across the country, physicians educated after 1915 experienced a more rigorous and scientific medical school education. The best of these graduates were more likely to gravitate toward surgery and other emerging specialties.

The average small-town general practitioner in 1900 probably did most of his work in the office or at in-home visits called "house calls." His community was likely in the process of raising money to build a local hospital. In 1904, there were 1,500 hospitals in the nation.[23] A century earlier, there had been two hospitals in the United States.[24] Most were established after 1880. Prior to the growth of surgery, the typical hospital was an asylum maintained by local governments or religious denominations for sick people who were poor or without families to provide care. The emerging new surgical techniques required an institution capable of achieving the necessary sterile environment and providing X-ray machines and recuperative nursing care essential for successful operations. The professionalization of nursing, which began in the latter part of the nineteenth century, also advanced exponentially. Without the emergence of this group of health professionals, the emerging hospital would not have been possible.

Individual physicians developed about half of these proprietary institutions. This form predominated in the South and West. In the

Northeast, religious groups, private philanthropy, and local government were the most likely sponsors. Before the twentieth century, hospitals were often free because their sponsors perceived them as charities and their "customers" were unable to pay for services. At the turn of the century, as middle- and upper-middle-income Americans began to routinely have more surgery, hospitals became commonplace. With expanded use, capital and operating costs escalated. Fees were charged. Surgery patients became the mainstay of the typical hospital with an average length of stay around three weeks.[25]

World War I hastened the further development of hospitals as major medical schools sent physicians to Europe with the expeditionary force, and field hospitals were established to treat the wounded. After the war, the lessons learned from this experience contributed to the continued expansion of the role of hospitals in the practice of US medicine. By the end of the second decade of the twentieth century, the era of the general practitioner was drawing to a close. The physician continued to be the dominant figure in the practice of medicine, but surgery was emerging as the preeminent focal point of medicine. The use of hospitals in the decades to follow had profound implications for the organization and financing of medical care.

The Era of the Community Hospital: 1920–1950

The 1920s was a decade of prosperity and modernization in America. One of the prominent features of urban middle-class prosperity in the 1920s was the emergence of the community hospital as a symbol of modern health care delivery. New hospital construction occurred everywhere at a scale that would not be seen again until the 1950s. The glittering new community hospitals moved away from the older ward layout to private and semiprivate rooms. Special facilities for operations, X-ray, and physical therapy were essential parts of the modern hospital. By the 1930s, most births were taking place in hospitals. Obstetrical services represented about one-fifth of the patients, and tonsillectomies about one-third. Appendicitis cases and accidents were also major causes of admission with about 10% each. These four areas represented about 60% of all admissions.[26]

Although many hospitals made lines of credit available to patients, daily hospital costs nearly doubled in the decade of the 1920s. Middle-class Americans consumed higher levels of hospital service, and even they were beginning to feel a financial pinch when

hospitalization was necessary. Insurance companies adopted the premise that the decision to enter a hospital represented "moral hazard" and, thus, was uninsurable. Insurers had no method to assess risk and, therefore, had no basis for establishing a premium.

In the years leading up to World War I, some labor leaders and advocates of the progressive political agenda began to argue for a social insurance idea similar to what had been established by Otto von Bismarck in Germany in the 1880s. The cash payments for sick workers were closer to what we today call disability insurance. The onset of World War I ended the discussion without any legislation being enacted. By the mid-1920s, the rapidly rising cost of hospital care created discussions about some type of a financing system to help cover hospital costs. As mentioned above, costs were rapidly becoming a concern for middle-class clients of private hospitals. Many urban areas had established free public hospitals for the poor and working class, but these were not seen as attractive options for the growing middle class.

In 1926, a group of American Medical Association (AMA) leaders from academic medicine established a committee, which led to the ultimate creation in the following year of the Committee on the Cost of Medical Care. The purpose of the CCMC was defined as providing a solution to the problem of the middle class being unable to afford modern scientific medicine.[27] Its mission was to study the subject and make recommendations. Under the leadership of its associate director, I. S. Falk, twenty-three major reports were issued over the next five years.

By the end of the 1920s, the stock market had crashed and the economy had tumbled into the Great Depression lasting more than a decade. But regardless of the economy, the cost of health care services continued to rise. In many urban communities, publicly funded hospitals were the only point of access for care. Financially strapped local governments were unlikely to be able to transform these institutions into facilities comparable to the private or nonprofit community hospitals.

In a federal political system, national policy sometimes emerges from local experimentation. The development of a health care financing system for the middle class was a noteworthy example. In 1929, a financially strapped Dallas private hospital and teachers in the local school district joined in an experiment in which the teachers paid fifty cents a month into a hospital fund. In return, they were entitled to a maximum of twenty-one days a year of care in the hospital at no cost. This arrangement soon spread to other employee groups in Dallas.

The success of the Dallas experiment led to similar arrangements in other communities. In a few years, the individual hospital plans were replaced with an association of multiple hospitals that had similar agreements with multiple employee groups. By the end of the 1930s, these Blue Cross plans had spread across the country. Meanwhile the commercial insurance industry, which had not regarded protection against hospitalization as an insurance risk, began to rethink the viability of hospitalization insurance. By 1940, these companies were seeking to gain a foothold in the group health insurance market.

Political progressives in the 1930s viewed the changing economics of health care services as a basis for again trying to place national public financing on the agenda. In 1935, a task force of the Franklin D. Roosevelt administration recommended health insurance as one of the elements of a proposed new Social Security system that also included a public pension system, unemployment insurance, and a set of welfare payments for people with disabilities and mothers with dependent children. Opposition from physicians led President Roosevelt to exclude health coverage from the Social Security legislation. This absence of a public program opened the door for expansion of group insurance through the workplace.

The key element for financing the growing expense of providing a bundle of hospital-based services was to find a mechanism for pooling large numbers of people who would pay relatively small amounts of money into a common fund. Concentration of health expenses was just as present seventy-five years ago as today. Since the government was not willing to organize this pool, the emerging Blue Cross system and commercial insurance companies began to do so with employment groups as the basis for the risk pool.

During World War II, wage controls were used to keep wartime scarcity from driving high inflation. With young men in the military and out of the workforce, employers needed to find a viable incentive to attract and keep good workers. Wage increases were severely limited, but adding or expanding health insurance for employees was not considered wages under government regulations. This became a recruitment and retention tool for wartime employers. In 1935, the National Labor Relations Act (Wagner Act) provided a statutory legal position for labor unions, especially industrial unions. The continuing Depression and then World War II kept the unions from leveraging their new legal status. By the end of the 1940s, unions were aggressively pursuing a new postwar social order in

which generous wages and benefits were obtained for workers through collective bargaining. Hospitalization insurance was one of those benefits.

In 1948, the Harry S. Truman administration revived the Roosevelt task force plan for a national health insurance plan through Social Security. The AMA vociferously opposed this effort, and the legislation never emerged from the committee stage in Congress. Physicians had also initially objected to the emerging Blue Cross service guarantee system for hospitals. Yet by the end of the 1930s, physicians had begun to establish a similar but separate system for physician payment. Soon these systems were joined for marketing and administrative purposes, and called Blue Cross and Blue Shield. For decades, the two components remained under separate internal governance despite consumers perceiving it as a single insurance system.

In the mid-1950s, the Internal Revenue Service issued new rules that treated the employer contributions for employee health insurance as taxable income. Congress reacted to the public outcry by amending the law to exclude this as income subject to tax. In the meantime, both Blue Cross and commercial insurance companies continued to thrive and expand their health insurance businesses. Both entities did sell policies to individuals, but the employer group market was the core of the business and the way that most families arranged for health insurance coverage.

By the end of the 1950s, the community hospital had become the centerpiece of US medicine. With the help of federal grants under the Hospital Survey and Construction Act (Hill-Burton) and the ability to borrow capital because of steady patient revenues from health insurance, community hospitals grew and modernized across the country. New technology and patient amenities that were inconceivable a few decades earlier had become commonplace.

Rosemary Stevens states the following about emerging technology in community hospitals in the 1950s:

> The most pervasive image of hospital technology in the 1950s was the hospital intensive care unit. Except for the smallest hospitals the great majority of American hospitals established intensive care units between 1950 and 1960. By 1960 virtually all short-term hospitals had clinical laboratories, diagnostic X-ray, and electrocardiography; over half had a postoperative recovery room and a blood bank; over one-third provided X-ray therapy; and one-fifth had a radioisotope facility.[28]

With two glaring exceptions—the elderly and poor people—the previous two decades had seen the development of a financial mechanism capable of providing medical care to the population without significant use of tax revenue for this purpose. Health insurance pools organized around the workplace provided a way to both collect money and spread risk even as the total cost of providing health care had grown exponentially.

The Era of the Medical Center: 1960–1980

In the previous era, the hospital became the central institution in the US health care system. The technology for treating illnesses and our understanding of disease and treatment advanced at an astonishing pace. By the middle of the twentieth century, life expectancy in the United States had increased significantly. In the early 1960s, most medical innovations were pioneered at major medical centers. These hospitals usually were located in major cities and affiliated with a university medical school. Their mission was to both treat complex disease and train the next generation of physicians.

Medical progress was not cheap. By the early 1960s, the percentage of GDP spent on medical care had doubled from the 3% found by the CCMC in 1929. Each year, more US workers and their families were offered health insurance and received it as an employment benefit. While this often did not cover all costs for extended treatment, it relieved fear that even routine hospital treatment would devastate the average family budget. For the poor and uninsured, public hospitals still offered an alternative, although they were increasingly perceived as inferior institutions.

Because employment-based insurance expanded exponentially in the 1950s, the most obvious group not included in the emerging system of health finance was older people. By the late 1950s, reformers narrowed their focus for a public program to older Americans. In the early 1960s during the John F. Kennedy administration, one of the highest legislative priorities was Medicare, the proposed public health insurance plan to cover hospitalization costs for older people. Finally, after President Lyndon B. Johnson's decisive election victory in 1964, Congress passed Medicare in early 1965. Included in the legislation was a program of federal grants to the states for medical payments for the poor covered by the existing welfare program. This later came to be called Medicaid.

By the late 1960s as these two new public programs were fully implemented, both community hospitals and the increasingly important (and expensive) medical centers were receiving substantial reimbursement to cover the high costs of treatment for serious illness. The government and private insurance company reimbursements were typically made on a cost basis. It is oversimplifying to say that the hospitals sent the bill and the government or insurance company paid it, but this is an apt generalization of the process. In such a system, rising costs led to higher reimbursements. Until the end of the decade, general inflation was low, but health costs tended to rise much faster. By 1970, the United States was spending 7.2% of GDP for health care, up from 5.2% in 1960.[29]

The higher costs associated with medical centers were easily passed on to insurers and the government. Treatment based on advanced technology also became routine in the community hospitals, as recently trained physicians demanded support from hospitals for the latest technology.

By the early 1970s, federal government officials voiced concern about Medicare and Medicaid cost increases, and private insurance companies began to experience resistance to rising premiums from employers. The 1970s were characterized by oil price–driven inflation, and medical cost inflation exceeded general inflation. By 1980, health care spending was 9.1% of GDP.[30] Despite congressional attempts to contain health care inflation, no effective approach was found.

The Era of the HMO and Managed Care: 1980–2000

By the early 1980s, many community hospitals began to routinely use technology that was not available even in medical centers twenty years earlier. In 1983, Congress passed the first major reimbursement reform for Medicare, which was a prospective payment system using Diagnostic Related Groups. Congress adopted a new Medicare physician fee schedule system later in the decade.

The escalating cost of group health premiums led to new experiments with cost control measures, especially managed care. During the early 1970s, there was, for a time, the sense that integrated delivery systems featuring prepaid group practice (such as Kaiser Permanente in California) were a hopeful approach to cost control. By the 1980s, it was clear that this type of system change would be difficult to implement. Managed care was a less comprehensive reform. It featured lim-

its on the choice of physician and hospital based on reimbursement negotiations between the provider and insurance company. It also included tighter utilization control featuring preapproval for many types of procedures. Many insurance companies and state Medicaid programs implemented the managed care approach. Some of these efforts were successful, but a backlash also developed because of the insensitivity and heavy-handed application of utilization review. Employers faced with unremitting premium increases shifted more of the cost to the employee.

In the early 1990s, the William J. Clinton administration proposed comprehensive reform of the health care financing system, but there was no congressional majority for the plan. The measure died in the fall of 1994 and, in the November elections, the Democrats lost control of Congress. The window of opportunity for major reform closed.

In the boom times of the late 1990s, the number of uninsured Americans declined marginally. Jobs were more plentiful than at the beginning of the decade. Also, passage of the State Children's Health Insurance Program (SCHIP) brought working-class children and families into Medicaid despite levels of income above previous eligibility levels.

The Era of Market Redux: 2000 to the Present

As the first decade of the twenty-first century began, there was an economic downturn. The global financial crisis brought a recession bordering on depression at the end of the decade. Even during better times, the persistent rise in health care costs and insurance premiums led to calls for reform of the health care financing system. The ideological belief in the power of market reforms to solve both cost and financial access issues waned. In many metropolitan areas, hospitals became more integrated into large systems as the recent consolidation trend continued. Larger insurance companies expanded their market share as the once independent local Blue Cross companies were acquired by private companies.[31]

In any generic discussion of the health care system, there has always been a view of a single government system versus a lively marketplace of both insurers and providers. To some extent, this has always been myth. In 2010, almost one-half of all health care system revenue was raised by federal and state government taxes. The marketplace has contracted as both insurance and hospital industries have consolidated. This oligopoly confers potential bargaining power to both

hospitals and insurance companies since leading firms possess a high market share. But since both industries are consolidating, the power to negotiate favorable prices may be limited. Neither is in a position to press an absolute advantage because each ultimately needs the other.[32]

The health reform debate of 2009–2010 attempted to find the proper roles for government, employers, consumers, and insurance companies as congressional legislation sought a balance between cost control and expanded financial access for the uninsured.

This has been a quick sprint through 100 years of health care finance to provide a historical overview as preview for the chapters to follow. There has been a steady development and diffusion of medical technology. With each new breakthrough, medical science is able to work additional "miracles" to preserve, extend, and add to the quality of life. The cost of these miracles continues to strain governments, employers, and households.

Scenarios for the Future

In this first chapter, much of the narrative has outlined the historical development of the US health system. This is an important preface for the next chapters because, as we examine programs and policy issues, they need to fit into a common context. To organize this effort, I conceptualized the past century as consisting of five eras of roughly two decades each. In the three brief scenarios below, I try to anticipate possible major developments in the next decade or two. These scenarios set the stage for the coming discussions of Medicare, Medicaid, reform, and cost containment.

The scenario technique allows us to view alternative paths into an uncertain future. "Scenarios make sense of future events in the same way as historical accounts make sense of the past."[33]

Employment-based Insurance Rapidly Declines

Two out of three non-older Americans receive health insurance through group policies arranged for and mostly paid by employers as part of a benefit package. Employment-based insurance has been the key element of risk pooling since the late 1930s. There has been a decline in the past decade as union manufacturing jobs diminished, and more adults worked part time or as contract workers without benefits.

In the first scenario, employment-based insurance steadily declines over the next decade or so. It declined from a 2000 high of 68% to 56% in 2009. Let's assume a drop of 10 percentage points over the next decade. The same percentage decline over the next two decades means that, by 2030, only 40% of Americans will have employment-based health insurance.

This will result from fewer jobs that offer full benefits, coupled with employers discontinuing health insurance coverage because of escalating premium costs. Workers and their families will need to purchase individual policies, participate in public plans (if they have moderate income), or go without health insurance.

Under this scenario at some point, perhaps as the number reaches 50%, there will be political pressure on the government to take action. Since administrative and marketing costs of individual policies tend to be two to three times higher than group policies, the premium cost for the same coverage will escalate, rendering it even more expensive in the future.

If the government seeks to respond, either a broad public program (like Medicare) can be created to serve those without employment-based insurance or the government can provide expanded subsidies for the purchase of private health insurance as planned under recent health reform legislation. The existence of this type of alternative to employment-based insurance will probably lead many employers to drop their coverage and allow their workers to participate in a government plan.

Whatever the outcome that this scenario envisions, the current employment-based system significantly deteriorates because of a changing job structure and escalating employer benefit costs. The latter particularly impacts low- to middle-wage employees.

Inflation Causes Rationing

We currently spend 17% of GDP on health care, higher than any other major industrialized country. This is an increase from 13.6% in 2000. The Center for Medicare and Medicaid Services projects this number to rise to 19.3% by 2019, if no actions are taken to restrain growth in costs.[34] This scenario assumes that no effective short-term action is taken to constrain costs. As a result businesses, households, and the government all find health care in its current form to be unaffordable.

New forms of subsidies for households or businesses will not be a practical solution because the existing tax system will not support a sufficiently high level of revenue generation for subsidies. Increases

in the out-of-pocket costs borne by households will also be unsustainable. Thus, a public rationing scheme is the logical policy choice.

This new policy could take many forms. Perhaps the most likely form is a combination of government limits on new capital expenditures (thus constraining the high capital and operating costs of new technology) along with a public reimbursement system that has utilization restrictions as well as waiting lists for services because of restrictions on providers. In this scenario, the current service-on-demand model will be replaced by one that is far less desirable.

Tinkering and Adjustment Keeps the Current System in Place

In the current mixed private-public health care system, we are currently struggling to find a set of public policies that will enable us to simultaneously expand financial protection against health care expenses and control system costs. At previous junctures in the past, the system has been tinkered with to forestall rapid cost increases and the decline of the dependence on employment-based insurance.

In the 1980s, Medicare moved its reimbursement systems away from those based on costs to prospective payment. At the same time, private insurers and Medicaid adopted managed care systems to control utilization. SCHIP was adopted by Congress in the late 1990s to address part of the problem of the uninsured with greater coverage for children, but this was not comprehensive reform. Incremental revenue and payment adjustments have been utilized by Medicare to postpone a time when revenue and reserves do not equal annual outlays in the Part A Medicare Hospital Insurance Trust Fund. Similar incremental adjustments might be made by both public and private insurance entities to stave off the worst-case problems without ever adopting comprehensive reform measures.

How we approach policy in next decade depends on how we view these scenarios. Each scenario is both feasible and plausible. As I examine the various policy issues in the chapters of this book, keep in mind these three possible scenarios.

Notes

1. Anne Martin et al., "Recession Contributes to Slowest Annual Rate of Increase in Health Spending in Five Decades," *Health Affairs* 30, no. 1 (2011): 11.

2. Ibid.

3. "National Health Expenditures Accounts: Definitions, Sources, and Methods" (Washington, DC: Centers for Medicare and Medicaid Services, Office of the Actuary, 2009).

4. M. L. Berk and A. C. Monheit, "The Concentration of Health Expenditures: An Update," *Health Affairs* 11, no. 4 (1992): 145–149. See also Anna Sommers and Mindy Cohen, "Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2006); Congressional Budget Office, *Medicare High Cost Beneficiaries* (Washington, DC: CBO Publications Office, May 2005); "Concentration of Health Care Spending in the US Population" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 3, 2011), http://facts.kff.org/chart.aspx?ch=1344.

5. Lisa Potetz and Juliette Cubanski, *A Primer on Medicare Financing* (Washington, DC: Kaiser Family Foundation, July 2009), p. 8; "Medicaid: A Primer" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2010), pp. 23–25.

6. Martin et al., "Recession Contributes to Slowest Annual Rate of Increase in Health Spending in Five Decades."

7. Congressional Budget Office, "Technological Change and the Growth of Health Care Spending" (Washington, DC: CBO Publications Office, January 2008), p. 7.

8. "Gloomy Americans Bash Congress, Are Divided on Obama," Section 3: "View of Health Care Legislation" (Washington, DC: Pew Research Center for the People and the Press, March 18, 2010), http://people-press.org.

9. Martin et al., "Recession Contributes to Slowest Annual Rate of Increase in Health Spending in Five Decades."

10. John Holahan, "The 2007–09 Recession and Health Insurance Coverage," *Health Affairs* 30, no. 1 (2011): 4.

11. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2009 Current Population Survey," Issue Brief No. 334 (Washington, DC: Employee Benefit Research Institute, September 2009), p. 5.

12. *Employer Health Benefits: 2010 Annual Survey* (Washington, DC: Kaiser Family Foundation and Health and Research Educational Trust, Publication 8085, September 2010).

13. Gary Claxton et al., *Employer Health Benefits: 2009 Annual Survey* (Washington, DC: Kaiser Family Foundation and Health Research and Educational Trust, 2009), p. 200.

14. Gary Claxton et al., "Job-Based Health Insurance: Costs Climb at a Moderate Pace," *Health Affairs* 28, no. 6 (2009): 1002–1012.

15. "America's Uninsured Crisis: Consequences for Health and Health Care," Institute of Medicine of the National Academies (Washington, DC: National Academies Press, 2009), p. 83.

16. "America's Uninsured Crisis: Consequences for Health and Health Care," Report Brief (Washington, DC: Institute of Medicine of the National Academies, February 2009).

17. Michelle Andrews, "Deaths Rising for Lack of Insurance, Study Finds," *New York Times,* Prescriptions Blog, February 26, 2010, http://prescriptions.blogs.nytimes.com/2010/02/26/deaths-rising-due-to-lack-of-insurance-study-finds.

18. "America's Uninsured Crisis," pp. 72–81.

19. "The Uninsured: A Primer" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2009), pp. 7–8.

20. Megan McArdle, "Myth Diagnosis," *The Atlantic,* March 2010, www.theatlantic.com/magazine/archive/2010/03/myth-diagnosis/7905.

21. Theodore Marmor, *The Politics of Medicare,* 2nd ed. (New York: Aldine de Gruyter, 1970), p. 3.

22. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), p. 157.

23. Rosemary Stevens, *American Medicine and the Public Interest* (New Haven: Yale University Press, 1971).

24. Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), p. 337.

25. Stevens, *American Medicine and the Public Interest,* p. 24.

26. Ibid., p. 114.

27. Joseph Ross, "The Committee on the Costs of Medical Care and the History of Health Insurance in the United States," *Einstein Quarterly Journal of Biology and Medicine* 19, no. 3 (2002): 129–134.

28. Stevens, *American Medicine and the Public Interest,* p. 231.

29. Centers for Medicare and Medicaid Services, "National Health Expenditure Data," www.cms.gov/NationalHealthExpendData/downloads/tables.pdf (accessed May 7, 2011).

30. Ibid.

31. Jonathan Cohn, "How Blue Cross Became Part of a Dysfunctional Health Care System" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 8, 2010), www.kaiserhealthnews.org/Columns/2010/March/030810Cohn.aspx.

32. William B. Vogt, "Hospital Market Consolidation: Trends and Consequences" (Washington, DC: National Institute for Health Care Management, November 2009); James Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs* 23, no. 6 (2004): 11–24.

33. Kees Van Der Heijden, *Scenarios: The Art of Strategic Conversation,* 2nd ed. (Hoboken, NJ: Wiley, 2005), p. 134.

34. Centers for Medicare and Medicaid Services, "National Health Expenditure Data."