THE CHANGING FEDERAL ROLE IN U.S. HEALTH CARE POLICY

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Part I
The Evolving Federal Role in the U.S. Health Care System

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1 GENERAL COMMENTS ON THE U.S. HEALTH CARE INFRASTRUCTURE AND DELIVERY SYSTEM

Health care in the United States at the end of the twentieth century occupies a completely different place in the economy, in the mind of the public, and in its impact on the government at all levels than it did either 100 years ago, at the beginning of the twentieth century, or at the beginning of the country in the late 1700s, when the U.S. Constitution was adopted. Health care in the United States is now a multibillion dollar industry, one that consumes 15 percent of the GDP (gross domestic product) of the country each year.

Moreover, that figure has been rising steadily over the past 30 years. The number of physicians, nurses, and other health care providers has increased to the point that some experts question whether the country has an oversupply. Modern hospitals have increased in size and complexity and have been described as modern temples of healing, although their role as the center of health care delivery is changing as the health care system itself changes. In fact, there are now questions whether the central role of the hospital as the linchpin and citadel of delivery of health care in the United States will hold as the new century begins (Stoeckle, 1995).

Citizens view health care as essential to their lives, and it is an unusual day when there are no articles in major national newspapers that relate to some aspect of health. Local television news shows run separate features on health care, because these are popular topics of discussion among their viewers. Most Americans today have grown accustomed to the medical

miracles of penicillin and polio vaccines, as well as the rapid advances in the treatment of heart problems.

Many experts now agree that the U.S. health care system has had great successes, especially in the area of technology (Botelho, 1991; Todd, Seekins, Kirchbaum, and Harvey, 1991). The United States has achieved one of the most technologically advanced medical care systems in the world, and much of this technology is generally available to affluent and middle-class consumers of health care services. These achievements in technology are one of the reasons why the United States is now also an international leader in medical education, with physicians coming from all over the world both to receive the most advanced and sophisticated training, and to learn how to incorporate the newest equipment and technology into the practice of medicine (Todd et al., 1991).

This book focuses on the changing federal role in health care policy in the United States, and pays special attention to the changes in the Reagan-Bush years and the failed attempt at major health care reform during the first term of the Clinton presidency. Prior to a discussion of specific aspects of federal legislation and the role of the federal government in the delivery of health care, Part One of the book presents salient features of the U.S. health care system and its infrastructure. The first chapter focuses on more general comments about the system and perceptions of past and current problems, as well as the role of technology. Chapter 2 continues describing salient features of the U.S. health care system by exploring issues of costs of care, providers of care, and the increasing attention being paid to the development of a continuum of care. Part Two focuses on the federal legislative process and its outcomes, looking at the past as well as at the situation immediately prior to the election of President Clinton. One chapter focuses on the health policy process; another focuses on the history of federal involvement in health care and health policy, and upon basic federal health-related legislation through the Carter administration. The third chapter in this section focuses upon the Reagan and Bush years and the limited and reactive types of changes in health care policy at the national level that were enacted in that 12-year period, with greater focus on those more recent reforms. Part Three examines the current situation in health care policy, with a more detailed examination of the attempt at major health care reform in the first term of Clinton's presidency and various explanations for why that attempt failed. In the last chapter, the more modest changes in the health policy arena that were successfully passed during the initial term of the Clinton presidency are discussed, as is the issue of the future of health care in the United States and the role of government. This chapter also discusses how current health care issues and concerns may or may not set the stage for a changed federal role in funding and delivery of health care services in the next century.

THE CHANGING IMAGE OF A "CRISIS" IN HEALTH CARE

Despite the recognition of the advances in modern medicine and the important advances in medical technology and training for health care providers within the United States, most of the public does not necessarily view the U.S. health care system as perfect or as nonproblematic. In fact, public perceptions of health care overall and of the role of government in health care are fraught with recognition of diverse problems such as barriers to care, lack of health insurance for many people, and discussions of a "crisis" in health care delivery. The first two years of the Clinton presidency, and part of the political campaign leading up to that election in 1992, included wide public debate over health care and the proper role for the federal government in the provision and funding of health care services. Much of this debate was predicated on the question of whether there was a crisis in health care that necessitated comprehensive reform of our financing and delivery system. The failure of this campaign will be discussed in more detail in Chapter 6 of this book.

But the notion of a crisis—very important in the 1992 presidential election—partially arose from the results of the special senatorial election held in November 1991 to fill the Senate seat of Pennsylvania Senator John Heinz, who died in a plane crash in April 1991. In that campaign, Harris Wofford was the Democratic candidate for the Senate against the popular former governor of the state, Dick Thornburgh, the Republican candidate. Wofford made the issue of health care reform and improved access to health care a keystone of his campaign, and used many television spots stating, "If criminals have a right to a lawyer, I think working Americans should have the right to a doctor" (Johnson and Broder, 1996). In what was described by many political observers as a stunning upset, Wofford defeated Thornburgh by a 55 to 45 percent margin, setting the stage for a renewed focus on health care in the presidential campaign of 1992—first among the Democratic primary challengers, and then in the race of Clinton versus Bush in November 1992.

The Wofford-Thornburgh senatorial race was one example of recent open public discussion about a "crisis" in health care. These concerns about a crisis in U.S. health care are not new, however. Each decade for the past thirty years has been characterized by at least some discussion of a "health care crisis," making this a most overused phrase. The exact explanation for the health care crisis has varied over time, from a crisis of access and affordable care for the elderly in the 1960s (which was partially resolved by the creation of the Medicare program), to a crisis of rapidly rising costs in the 1970s and 1980s, to crises about lack of enough generalist physicians and lack of health care in rural areas, among many other possible sources of problems.

Certainly a major crisis that has been discussed for decades is the issue of access to health care services, and suggestions for the resolution to this crisis have often involved government, at the same time, and have frequently included the opposition of some health and medical groups. The Committee on the Costs of Medical Care was created in the late 1920s, on the eve of the Depression. Its report called for a massive reorganization of the fee-for-service medical care system, and urged some version of national health insurance. When the committee report was issued in the fall of 1932, the American Medical Association (AMA, the largest association of physicians of various specialties across the United States) condemned the report and raised such fierce opposition that Franklin Roosevelt was forced to remove medical benefits from his first Social Security bill (Johnson and Broder, 1996; Starr, 1982). By 1943, during World War II, liberal Democrats with the backing of organized labor introduced the first compulsory national health insurance bill. Both the preoccupation of President Roosevelt and the continued opposition of the AMA, joined this time by the nation's pharmaceutical and insurance industries, led to the defeat of this legislation (Johnson and Broder, 1996).

A few years later, President Truman introduced health insurance legislation and made its lack of enactment a major issue in the 1948 presidential campaign. After Truman's upset victory, the AMA launched a major campaign against a national health insurance bill, warning that such legislation would lead to federal control of health care. The AMA again lined up powerful allies, including groups outside the health care industry such as the U.S. Chamber of Commerce and the American Farm Bureau.

One effort that actually led to major federal legislation was the passage of Medicare and Medicaid in 1965. Although the AMA continued its tradition of opposition to any major government role in paying for or providing health care services, the landslide victory of Lyndon Johnson over Barry Goldwater, creating large Democratic majorities in both the House and the Senate, was responsible for the passage of this major legislation that dramatically increased access to health care for the elderly and the poor in the United States.

Although various more modest pieces of legislation were passed in the United States in the decades following 1965, most did not focus on access to care. By May 1991, the AMA and many other health groups had become convinced about the growing importance of the problem of access. In that year, the Journal of the American Medical Association (JAMA), as well as the specialty publications of the AMA, published special issues focused on caring for the uninsured and underinsured. One of the articles pointed out that a national commission on medical and ethical problems in 1983 had concluded that society has a moral obligation to ensure that everyone in the United States has access to adequate medical care (Menken, 1991; President's Commission, 1983). By this standard, the author concluded that

the health system of the United States is failing. One major policy question is whether there is a public consensus that the conclusions of the commission (that everyone should have access to adequate health care) are correct. Even if there is a public consensus that everyone should have access to adequate health care, a further issue is the definition of "adequate."

While such definitions differ, most agree that having no health care insurance makes a person much less likely to be able to afford needed health care services. Although estimates of the number of those uninsured in the United States vary slightly from one expert to another, and change somewhat from year to year, many experts agree that from 33 to 40 million Americans are uninsured and are thus, at times, unable to receive needed health care services. Many of these people without health insurance are currently working—but in jobs that do not provide health care insurance coverage. Some of the others are family members of working people, whose employers provide insurance coverage only for the employee, with no option for family members.

Another way to think about definitions of adequate care is to compare what people in America spend versus those in other countries. In this area, as a nation, the United States is a large spender for health care services. The United States spent more per capita on health care in 1994 than did any of the other 26 richest nations in the world. In that year, U.S. spending on health care was $3,516 per capita, or 14.3 percent of the gross domestic product (GDP). The next closest nation to the spending patterns in the United States was Switzerland, which spent 9.6 percent of GDP, or $2,294 per person (Montague, 1996).

Public opinion polling data, as well as general discussion of social and health care issues in the society, both provide evidence that the public consensus on this problem has changed just over the decade of the 1990s. Before discussing the changing views of the role of government in health care that the public has held, as well as specific issues such as technology, costs of care, and the growth of different methods and approaches for the delivery and receipt of health care services, it is helpful to cover some major aspects of the current system of health care in the United States. Included in this discussion is a brief contrast between the system in the United States and the systems in selected other countries.

PRIMARY, SECONDARY, AND TERTIARY CARE AND LINKAGES TO REGIONALIZED VERSUS DISPERSED MODELS

One classic description of systems of health care involves the distinction among primary, secondary, and tertiary levels of care (Dawson, 1975; Grumbach and Bodenheimer, 1995). Primary care involves treatment for

most common health problems, as well as preventive care. Examples of common ailments would include sore throats, sprained wrists, and infected ears. Screening for hypertension, and vaccinating babies and children are examples of preventive care. Secondary care is that provided for more specialized problems and would include surgery to set a broken leg, or care for an older patient who develops acute renal failure. Tertiary care is reserved for the most specialized and unusual health care problems; it is not the type of care that can be provided by most full-service hospitals, but rather it is care that different specialty facilities may provide. Thus, in one city, there may be a hospital that provides open-heart surgery as the most advanced, newest treatment, while a different facility may provide the setting and most accessible equipment for neurosurgery. In a different city, a university hospital may well provide a complete range of tertiary care.

An understanding of these three different levels of care helps in describing contrasting models for the delivery of health care, both at a national and at a local level. One often-discussed distinction is that between a regionalized model of care versus a dispersed model of care (Grumbach and Bodenheimer, 1995). One model that can be used is based at a national level on regionalization and at a community-wide level on a distinction between a person's usual, more typical care versus the need for more specialized services. In this regionalized system, personnel and facilities will be differentially assigned to tiers of care that correspond to the primary-secondary-tertiary care structure (Grumbach and Bodenheimer, 1995). Patients will flow across the levels of care as needs dictate.

While the health care systems in most countries often embody elements of both models, some countries' systems more closely resemble one or the other. The model of regionalization closely resembles the organization used by the British National Health Service (and does not resemble the model for health care overall in the United States at present). Many other countries, such as those in Scandinavia and some of the developing nations in Latin America, have adopted this type of approach to the delivery of health care services.

At a more community-based level, the model is applied by some health maintenance organizations (HMOs) within the United States, especially those that operate with a closed panel of physicians who work full-time for the plan in a group practice approach. In those types of HMOs, patients must obtain all of their care from within the closed panel of physicians, and they generally begin with a generalist physician who provides the primary level of care and some limited secondary care. Within the same building, there may be some specialists with the plan who provide some types of secondary care. More complicated secondary and tertiary care will be referred to other physicians within the plan, or, in some cases, to outside physicians who contract with the group for the most advanced tertiary care.

The alternative model of care is often described as a dispersed model (Grumbach and Bodenheimer, 1995), which gives greater choice to patients and caregivers, whether it is applied at a national or local level. Within a national level of care, this model describes a system without explicit regionalization, so that one community may have five different facilities providing highly technical specialized care (such as the newest procedures to treat heart disease, for example) in contrast to a community probably having only one or two such centers in a regionalized model. In fact, in the regionalized model, many smaller towns and rural areas would not have any tertiary care available within the community, with probably only the more general secondary care. In the dispersed model, if a community could generate enough funds and attract the appropriate physician, a small town might still have available more advanced cardiac services, for example. At the community-wide level, the dispersed model allows patients to pick for themselves among various providers of care. It also allows providers greater freedom, in that they are generally able to refer to other specialists as they see the need develop, and to use for referrals a physician or group of physicians with whom they have developed a professional relationship, whether or not any special payment and fee arrangements have been worked out.

This alternative or dispersed model is a better description of the current operation of the U.S. health care system overall. It also describes best how patients who are not part of managed care or HMO models in the United States obtain their health care services within the community in which they live. The dispersed model thus represents the way most people in the United States have obtained their health care in the past, although, given the growth of managed care, more people are beginning to experience a model of care that incorporates some elements of the regionalization model. In the dispersed model, patients are not required to have a primary care physician who must make decisions about seeking care at higher levels, which is the way the regionalized model operates in Great Britain and the way some HMOs operate within the United States.

Is one of these models a better or more appropriate way to deliver health care services? Critiques of both approaches exist. Critics of the dispersed model, which has formed the basis for the traditional delivery of health care in the United States, argue that the system is top-heavy, with too many specialists and too few generalists. Related to this is the criticism that the U.S. system provides a focus on more advanced levels of care and tertiary facilities, rather than a focus on primary care. However, most people need primary and simpler levels of services most of the time, and these can be provided by generalists. Another criticism of the U.S. system is the lack of a clear organizational structure. How patients are supposed to figure out what type of physician to go to first, and where to find this physician, is often unclear in the dispersed model. Moreover, a

patient may consult several physicians about different problems at the same time, and if the patient does not think or remember to discuss this with the second or third physician, each may be unaware that the patient is currently undergoing treatment by a colleague. A physician could even prescribe a drug for one problem that could interfere with, or be dangerous when taken with, a drug prescribed by a different physician for a separate problem. This issue has often been described as a lack of continuity and coordination in care (Kronenfeld, 1980). Torrens (1993) describes this aspect of the private-practice, fee-for-service system of health care in the United States as an informal system, in which there is an absence of any defined structure or organization to create continuity of care across time and across provider.

Advocates of the dispersed model that has been an important traditional approach to the delivery of health care in the United States argue that pluralism is a virtue, because it promotes flexibility and convenience in the availability of personnel and facilities (Grumback and Bodenheimer, 1995). The emphasis on specialization and technology is viewed as particularly congruent with American values and expectations, since Americans prefer choice in many areas and value technology greatly. In many areas of American life, people prefer the best, the most advanced, and the newest. One way Americans have been able to actualize these preferences in the health care system has been through a dispersed model of care, even if it has led to higher costs and a less easily understood system for obtaining health care.

Critics of the regionalized model of care are fearful that such a model removes too many choices from patients and places too much power in the hands of those who determine how to regionalize the system—whether these are executives of managed care programs in HMOs within the United States or bureaucrats in a government agency. With the growth of HMOs and managed care organizations in the United States in the last five years, there has been a growth of consumer complaints about denials of care. These include denials of newer medications, denials of certain newer treatments, and denied permission to see specialists. If this model becomes more common, these complaints may proliferate and some remedies may have to be found, perhaps in greater government regulation of the managed care companies.

A more important fear about a regionalized model in the United States, which became one factor in concerns about the Clinton reform plan that was not passed in 1993–94, is that government will hold too much power over the fates of individuals. Within the United States, this concern fits neatly into one cultural paradigm of concern about "big" government and a feeling that the best government is small and at a level close to the individual. The specter of a large national health insurance agency making decisions about which doctor a patient can go to and what treatment he or

she can receive touches upon pivotal American concerns about autonomy, self-control, and freedom of choice of provider and treatment. It also raises American fears about "Big Brother," who will know too much about intimate details of the life of an individual if health care information is centralized in a large, federal bureaucracy. Moreover, the last several decades—and especially the Reagan years—have heightened the traditional American dislike of bureaucracy and created a public image of inefficient government agencies that cannot be trusted with major control over the most important aspects of a person's life. Because at times of the most serious illnesses, access to the best health care often becomes a "life or death" issue, emotions about such access being controlled by government touch many of the deepest fears of some Americans.

Advocates of a regionalized model argue that it would better help to define practitioner roles, which might lead to a more appropriate split between specialization and primary care among American physicians, a problem of long standing in the American health care system. Proponents of this model also argue that it would increase the accountability of care for the whole patient, and thus ultimately have the potential to improve the total quality of care that patients receive, since there would be a generalist physician overseeing the total provision of care.

TECHNOLOGY AND CARE

The preeminence of the dispersed model of care in the United States during the twentieth century is linked with 1) the preeminence of the biomedical model among physicians and others within the health care system, 2) the preeminence of medicine in the United States compared to many other countries in the post-World War II years, and 3) the importance placed upon technology and the development of new technology. To understand the problems of the U.S. health care system today, as well as issues that will have to be addressed in the future either by the federal government or by market-driven reorganization of care, a better appreciation of the role of technology within health care in the United States is important.

In the early twentieth century, the biomedical model became the dominant approach for the education of physicians in the United States (Starr, 1982; Grumback and Bodenheimer, 1995). Part of the push toward the adoption of a biomedical model was a result of the impact of the Flexner Report in 1910, which pointed out great deficiencies in medical education in the United States at that time. These deficiencies included a lack of science background for entering students and the absence of both laboratory science and direct clinical education for medical students. Many existing medical schools subsequently closed, and most of those remaining in operation, as well as new ones begun after the Flexner Report, became affiliated with universities and began to hire