CHAPTER

2

Health, Health Care, and the Market Economy

WHOSE RIGHT? (WHO'S RIGHT?)

After signing the Affordable Care Act (ACA) into law in March 2010, President Barack Obama declared that, in passing the act, "we have now just enshrined the core principle that everybody should have some basic security when it comes to their health care" (Obama 2010). As seen by President Obama (and by many of his supporters), Americans have a right to a basic level of health care, and ACA was the acknowledgment of that right.

Others, however, hold a very different view of the core principles of American health policy. In an opinion piece published in August 2009 in the *Wall Street Journal*, John Mackey, the co-founder and CEO of Whole Foods Markets, wrote, "How can we say that all people have more of an intrinsic right to health care than they have to food or shelter? Health care is a service that we all need, but just like food and shelter it is best provided through voluntary and mutually beneficial market exchanges . . . This 'right' has never existed in America" (Mackey 2009).

This debate over who in America has a right to health care and what level of care that right entails has been going on for nearly a century. In 1918, Dr. John Bowman, at the time director of the Board of Regents of the American College of Surgeons, wrote that "as a people we are accustomed to hospital service; we look upon that service no longer as a luxury which we may buy, but rather as an inherent right. The humblest patient is entitled to the best of medical service. In the last twenty years especially this idea has taken hold of us. We regard the right to health today much as we regard the right to life" (Bowman 1918, p. 1). Made by the leader of one of the most prestigious

groups of physicians in the United States, this statement bespeaks a commitment on the part of the medical profession and the country to approach health care as a basic right for all individuals. This was the position President Obama was supporting in asserting that all Americans have a right to some "basic security when it comes to their health care."

Those opposed to President Obama's position would instead agree with the comments of Dr. R. M. Sade, published in the *New England Journal of Medicine*, one of the most prestigious medical journals in the country: "Medical care is neither a right nor a privilege: it is a service that is provided by doctors and others to people who wish to purchase it" (Sade 1971, p. 1289). In Dr. Sade's approach, medical care is no different from any other type of commodity that is bought and sold in the open market. If you want new sneakers, you buy a pair from the shoe store. If you do not have enough money to pay for the sneakers, then you are out of luck—you do not have a right to sneakers. Neither do you have a right to medical care, suggests Dr. Sade. If you do not have enough money to pay for care, then you are out of luck.

While Dr. Bowman's remarks from 1918 offer for many a laudable perspective on the issue of who by rights should have access to health care, they do not accurately describe the direction health care in America actually took in the decades following 1918. Instead, for much of the twentieth century, the structure of our health care system was more consistent with Dr. Sade's perspective and with that of John Mackey of Whole Foods.

THE UNIQUE HISTORY OF HEALTH CARE IN THE UNITED STATES

When Dr. Bowman published his statement in 1918, the future direction and shape of the U.S. health care system was still in a formative state. By the time Dr. Sade published his remarks in 1971, the shape of our system had largely been decided through a series of political and economic choices. The history of U.S. health care during this period largely reflects the comments of Dr. Sade. With a few notable exceptions, which I address in subsequent chapters, before President Obama signed ACA, Americans did not have a right to medical care.

In 1948, as part of the founding of the United Nations, the UN General Assembly adopted a Universal Declaration of Human Rights, with "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family." Article 25 of the declaration states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care."

The United States, despite its role in founding the United Nations, did not adhere fully to the declaration, instead choosing a market approach to medical care. In ap-

proaching medical care as a market commodity that can be bought or sold, rather than as a social good that should be made available to all people, the United States adopted a policy position that was unique among developed countries. In the words of economist Uwe Reinhardt, "Americans . . . decided to treat health care as essentially a private consumer good of which the poor might be guaranteed a basic package, but which is otherwise to be distributed more and more on the basis of ability to pay" (Reinhardt and Relman 1986, p. 23).

The United States was alone among industrialized nations in approaching health care in this market-oriented way. By the end of the twentieth century, all other developed countries had adopted national health plans that assured citizens access to basic medical care. These plans ranged from fully socialized systems such as that in Great Britain to systems such as Canada's, in which all physicians are in private medical practice.*

The decision to approach medical care as a market commodity rather than a right was closely linked to a second national policy decision that was to have equally profound effects on the way health care would evolve in the United States. This was the decision made in the early part of the twentieth century to vest in the medical profession substantial authority over the organization and financing as well as the practice of medical care. At the beginning of the twentieth century, the U.S. medical profession was a complex array of practitioners from diverse educational backgrounds with a variety of knowledge and skills. There were no standards, either legal or ethical, to maintain a consistent level of quality in the way physicians practiced medicine.

In response to what was perceived as a national crisis, a prestigious commission was asked to conduct a national study of the issue of medical education and to make recommendations about a thorough restructuring of medical education, and as a result, medical practice. In 1910, the commission published its recommendations in its report, *Medical Education in the United States and Canada*, often referred to as the Flexner Report. Based on the views expounded in this report, state and local governments increasingly relied on the American Medical Association (AMA) (the principal professional association of physicians) and on the AMA's affiliated state and local medical associations to guide the restructuring of medical practice. (For a more comprehensive discussion of this period in the history of U.S. medicine, see Paul Starr's Pulitzer Prize–winning book, *The Social Transformation of American Medicine*.)

The rise in the sovereignty of the U.S. medical profession was based on a some-

* Until 1994, there was a second developed country that continued to approach medical care as a market commodity. In that country, those citizens without the ability to pay for it had little, if any, access to care. As a result of a major restructuring of the country's government in 1994, the country adopted the policy of health care for all as a basic right, leaving the United States alone in treating it as a market good. That other country is South Africa.

what idealized view of physicians. Consistent with the increasing legitimacy of science and technology common during that time, physicians were typically seen as altruistic agents who possessed valuable scientific knowledge and technical skills (Parsons 1951, 1975). Their role as social agents was guided by a code of medical ethics that placed the utmost importance on acting at all times in the best interest of the patient. They could be trusted to make decisions on behalf of the patient in a paternalistic manner, acting always as a disinterested agent on the patient's behalf. This view of the medical profession led state and local governments to vest considerable authority in physicians and their professional organizations over medical education and the practice of medicine.

In 1938, Dr. Irvin Abell, then president of the AMA, spoke to a special meeting of the AMA's House of Delegates, reminding physicians of this professional responsibility. "The medical profession by principle and tradition is committed to the idea that the prime object, the standard of value and the social reason for its existence are all one thing—the service it can render to humanity" (Abell 1938, p. 1192). Part of this obligation of service, Dr. Abell explained to the assembled physicians, was "the fundamental tenet of the American Medical Association that the poverty of a patient should demand the gratuitous service of a physician" (p. 1193). Beyond this obligation to treat the poor without charge, however, Dr. Abell stated the AMA's position that "the individual physician has a right to determine the conditions of his service" (p. 1193).

While this view of physicians as agents of reason, worthy of our trust to act autonomously on behalf of patients, exerted substantial influence over governmental policy toward medical care, a historical examination of the ways in which physicians' professional organizations actually exerted the authority delegated to them offers a very different picture (Freidson 1970). While physicians were granted this authority because of their specialized knowledge and skills, they often used this power to further their own ends. In this view of physicians as agents of power, the medical profession is seen as using its control over knowledge to limit entry into the profession and to maintain political sovereignty over the system of medical care. The power of the medical profession has been used to support and protect the role of the individual physician as self-interested entrepreneur. Those interests were best served by establishing and maintaining the policy principle that medical care was, as described by Dr. Sade, "a service that is provided by doctors and others to people who wish to purchase it" (Sade 1971. p. 1289) under "conditions of . . . service" determined solely by the physician, as Dr. Abell described (Abell 1938, p. 1193).

By creating and maintaining a system that approached medical care as a market commodity, physicians were able to establish their right to charge a separate fee for each service they provided, and to base that fee on whatever the market would bear. In 1934, the AMA established the explicit policy that once the fee for the medical service was set, "the immediate cost should be borne by the patient if able to pay at the time of

service" (American Medical Association 1934a, p. 2200). Except for the poor, patients were purchasing medical care from their physician as a market commodity, and as is typical of market exchanges, were expected to pay for it at the time the service was rendered. Thus the name applied to the system of medical care that predominated throughout much of the twentieth century: fee-for-service.

In making medical decisions in a fee-for-service system, physicians were simultaneously looking out for the needs of the patient and for their own financial interests. As medical science and medical technology evolved and expanded, more care came to be perceived as better care. More care also generated higher fees. Both the perceived quality of care and the physician's income went up as the physician did more for the patient. This system of dual loyalties, while seemingly good for patients, can also place the physician in the role of an imperfect agent when making or recommending treatment decisions on the patient's behalf (Freidson 1970). In deciding whether a patient does or does not need additional care, the financial incentive might push the physician to provide care that otherwise might not be seen as medically necessary.

CONCEPT 2.1

Two policies established early in the twentieth century had major effects on our system of care and contributed to our current problems:

1. Approaching medical care as a market commodity
2. Granting sovereignty to the medical profession over the organization and financing of medical care

These alternative views of the medical profession, as agents of reason or as agents of power, are described in Table 2.1. As we proceed in our examination of health care in the United States, we will find that neither view offers a fully accurate description of the U.S. medical profession. Physicians act neither as agents of pure reason nor as agents of pure power. Medicine in this country has instead evolved as a blending of the two models.

For much of the twentieth century, our health care system and the medical profession's authority over it were stable and noncontroversial. Only in the last few decades, as the rising cost of health care and the growing number of uninsured Americans have commanded the public agenda, has there been a full examination of the effects of approaching medical care as a market commodity and sanctioning the use of medical

TABLE 2.1. Two Ways to Look at the Medical Profession in the United States

Physicians as Agents of Reason (see Parsons 1951, 1975)	Physicians as Agents of Power (see Freidson 1970)
Authority of physicians based on:	Authority of physicians based on:
Specialized knowledge	Control of knowledge
Technical skills	Limited entry into profession
Professional ethics	Sovereignty over system
Physicians are seen as altruistic healers	Physicians act as self-interested entrepreneurs
Physicians adopt a paternalistic approach to patients	Physicians face conflicting loyalties in their dealings with patients
Physicians act as unbiased agents for their patients	Physicians act as imperfect agents for their patients

knowledge as a source of political and economic power. Nonetheless, these two policies have had profound impacts on the development of our health care system and have differentiated our system from those of other industrialized countries.

THE COST OF CARE—NOW AND IN THE FUTURE

In 1970, people in the United States spent a total of $73 billion, or an average of $341 per person per year, on all types of health care combined. The total national expenditure on health care in 1970 represented 7.1 percent of the gross domestic product (GDP). At that time, people talked about a national health care expenditure of 7 percent of GDP as representing a "crisis" that needed to be addressed urgently.

In 2009, people in the United States spent $2.5 trillion on health care, or about $8,200 per person (Sisko et al. 2010). This level of expenditure represented 17.3 percent of GDP, more than twice the amount of GDP apportioned to health care in 1970. The rate of increase in health care costs slowed somewhat in 2008, rising only 4.4 percent to 16.2 percent of GDP, the lowest rate of growth in health care costs since we began keeping track of costs in 1960 (Mitka 2010). The federal government estimated, however, that health care costs had risen 5.7 percent in 2009, to 17.3 percent of GDP. Based on the continuing increase in the cost of health care in the face of the falling GDP that characterizes a recession, this 1.1 percent increment in the percent of GDP going to health care represented the largest annual increase since we began keeping track in 1960. Without taking into account the effects of ACA, federal analysts also predicted continued future growth in national health care expenditures, with health care consuming 19.3 percent of GDP by 2019 (Truffer et al. 2010).

Economist Victor Fuchs has pointed out that, over the years, health care costs have risen an average of 2.8 percentage points faster than GDP. If this gap continues, Fuchs suggests, the percentage of GDP going to pay for health care can be expected to double every twenty-six years (Fuchs 2010). Fuchs argues that there are "distinctive institutional features of health care and their consequences" that "distinguish health care from other goods and services" (p. 1859) Fuchs suggests that market competition alone cannot change this long-term pattern. Instead, we will need to rely on a combination of "government regulation and self-regulation [of the medical profession] through professional ethics" (p. 1860).

Where does all this money for health care come from and where does it go? Figures 2.1 and 2.2 show the sources of the money that pays for health care and the principal categories of national health care expenditures. To gain a better sense of what these data mean, we can compare our country to other developed countries. The Organisation for Economic Co-operation and Development (OECD) compiles economic and other statistics from thirty-three of the world's leading developed countries. Table 2.2 shows national expenditures on health care for a selection of OECD countries. In 2008,

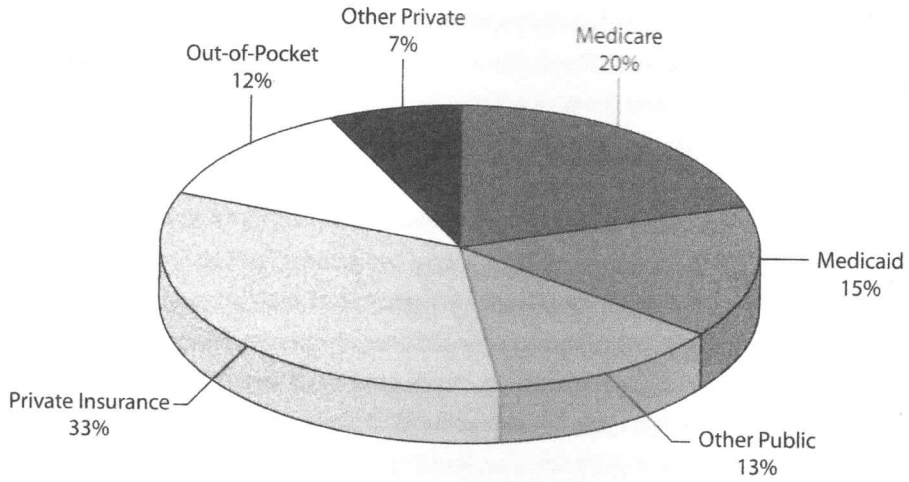

FIGURE 2.1. Health Care Expenditures in the United States, 2008: Where the Money Came From.
Source: Data from U.S. Centers for Medicare and Medicaid Services

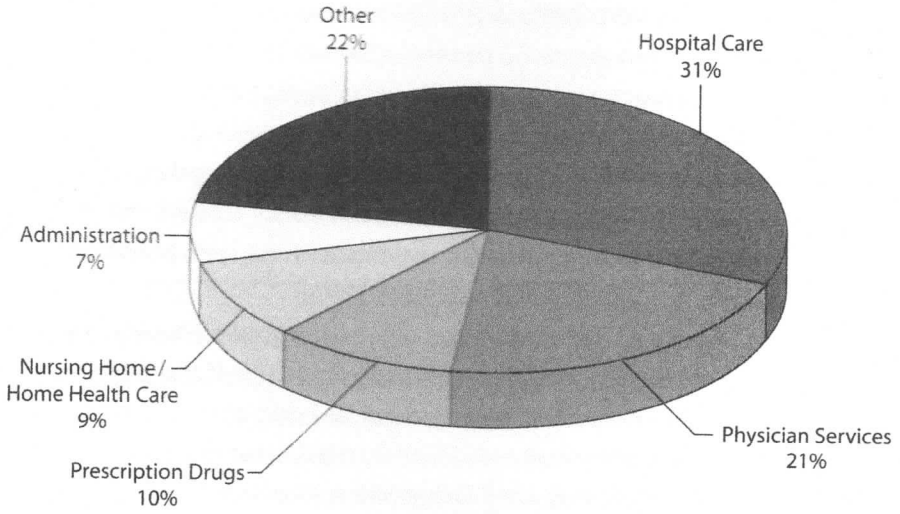

FIGURE 2.2. Health Care Expenditures in the United States, 2008: Where the Money Went.
Source: Data from U.S. Centers for Medicare and Medicaid Services

the United States reported to the OECD that it spent 16 percent of GDP on health care. This was by far the highest expenditure in the world. The closest countries to the United States were France, with a total expenditure of 11.2 percent, and Switzerland, with an expenditure of 10.7 percent.

Every year, the U.S. government publishes predictions of where health care costs will go in the future. If current government projections through 2019 are accurate, by that time nearly $1 of every $5 in the entire national economy will be spent on health

TABLE 2.2. National Health Care Expenses as a Percentage of GDP for Selected Countries, 2008

Country	Percentage of GDP
Canada	10.4
France	11.2
Germany	10.5
Greece*	9.7
Japan*	8.1
Sweden	9.4
Switzerland	10.7
United Kingdom	8.7
United States	16.0

Source: Data from OECD.
*Data are for 2007.

care. The difference between the share of our economy going to health care and what other developed countries spend will be even larger than it is today. This investment in health care will be at the expense of other sectors of the economy, such as education and national infrastructure. We will have less money available for schools, for roads and other forms of transportation, and for investing in the capital and technology necessary for continued expansion of the economy.

Beyond the effects on the U.S. economy in general, health care expenditures in the range of 20 percent of GDP will have severe consequences for government as well. Recall from Figure 2.1 that in 2008 governments at all levels—federal, state, and local—were responsible for a combined 48 percent of all health care expenditures (Medicare, Medicaid, and other public expenditures). Following the enactment of ACA, government expenditures will rise to more than half of all health expenditures. Governments rely on taxation to obtain revenue. Unless tax rates change, tax revenues generally rise at the same rate as GDP. As described above, however, historically the cost of care has risen more rapidly than GDP—especially during times of recession, when health care costs have continued to rise even in the face of a shrinking economy.

Consider the effect on governments of health care expenditures continuing to rise faster than GDP, and therefore faster than tax revenues. More than half of future increases in health care costs that are over and above the rise in GDP will have to come from government sources. *For every dollar that health care costs go up faster than GDP, government sources will pay more than half.* This is an important concept to understand.

How will government come up with the money to pay for this rise, given that *tax revenues increase only as fast as GDP increases?* There will be two options:

1. Increase tax rates to cover the increased cost of care.
2. Borrow the needed money, thus adding to government debt.

Neither option is palatable to politicians or the American public. Either would have a severe, long-term, destabilizing effect on the U.S. economy. Chernew and colleagues

CONCEPT 2.2

If the rising cost of health care as a percentage of GDP is not slowed, there will be substantial effects on our economy.

- Investment in other sectors of the economy will shrink.
- The federal government will have to either raise taxes or go increasingly into debt.
- State and local governments will face increasing budgetary strain; many will reduce health benefits to their least well-off residents.

have written about "The Specter of Financial Armageddon" if nothing is done to change this pattern (Chernew, Baicker, and Hsu 2010). Governments will face a serious dilemma if a solution is not found to the rising cost of health care.

This dilemma will be especially difficult for state and local governments, which typically are forbidden by law from engaging in deficit spending. To maintain health care expenditures at this level, growing faster than GDP growth and thus faster than the growth in state and local tax revenues, state and local governments have to either raise taxes or divert funds away from other programs such as education. This is why many states, facing an increasing crisis in their attempts to keep up with health care spending, are instead considering reducing the amount of care they pay for. Because those who receive the care paid for by state and local governments are typically the least well-off members of our society, this means that any cuts in state and local spending on health care will be felt disproportionately by those who can least afford to pay for care on their own.

What's Causing the Rising Cost of Health Care?

To fully appreciate the implications of the rising cost of health care in this country, we need to have a better grasp of its causes. Simple inflation is, of course, one reason—both prices in general and medical prices in particular tend to rise with time. Typically the price of medical care will rise faster than prices in general, contributing to the rising share of GDP devoted to care. Even when one adjusts for price inflation, however, the cost of health care measured in constant dollars continues to go up at a rapid rate.

Three general forces contribute to this increase in the cost of care:

1. The U.S. population increases over time.
2. The number of people receiving treatment for a specific illness may go up for reasons not associated with increases in the population. (This is referred to as the "treated prevalence.") Either the illness is becoming more common, or more people with the condition may seek treatment (for example, mental illness).
3. The cost of treating a specific illness may go up independently of the number of people who have that illness. This will typically be due to new, more advanced (and more high-tech) treatments becoming available, replacing older, less expensive (and more low-tech) treatments.

A study published by researchers at Emory University differentiated between these three causes of rising costs in health care (Thorpe, Florence, and Joski 2004). They looked at the increase in the cost of care for the non-institutionalized U.S. population between 1987 and 2000. Controlling for inflation, health care costs increased about 3 percent per year during this period. As a proportion of GDP, health care rose from 10.5 percent to 13.3 percent during this period.

The researchers found that ten specific illnesses accounted for nearly half of this rise in the cost of care; five of these conditions accounted for more than 30 percent of the rise. They then estimated how much of the rise in the cost of care attributable to these five conditions could be assigned to each of the three possible forces described above. They found that increases in the cost of treating a specific disease, caused by the increased costs of newer, more high-tech treatments, were the largest source of the rising cost of care.

GROWING CONCERNS ABOUT THE QUALITY OF HEALTH CARE IN THE UNITED STATES

Beyond the rising cost of health care in the United States, it is also important to consider the quality of that care. To what extent can we be assured that the increasing amounts we spend on our system of health care provide us with care that is of the highest available quality? This question pertains both to the care provided by physicians and other health professionals, and to the care provided by hospitals and other health care institutions.

The Quality of Care Provided by Physicians

Dr. John Wennberg, of Dartmouth Medical School, first started looking in the 1970s at differences in the way physicians treat specific diseases. He found that, for a variety of conditions, there were consistent differences across geographic regions in the rates at which certain surgical procedures and other treatments were applied. Physicians in community A, for example, might use a surgical approach to prostate cancer at a certain rate, while physicians in community B might use that procedure at a substantially lower rate, relying instead on nonsurgical treatments. Wennberg and his colleagues consistently found these differences in regional patterns, referred to as "small area variations," for a wide variety of medical conditions.

Which community of physicians uses the higher-quality approach to treatment—community A or community B? That depends on whom you ask. Physicians from community A might respond that they are being appropriately aggressive in using a surgical approach, while their colleagues in community B are being too cautious. Physicians from community B, of course, might respond in the opposite way. They are

using surgery appropriately, while their community A colleagues are being too cavalier in using surgery. A principal benefit of the decades of research done by Dr. Wennberg, culminating in the publication in 1998 of the *Dartmouth Atlas of Health Care*, has been the need for physicians to confront this quality conundrum.

The answer as to which community of physicians—A or B—is using a higher-quality approach to treating their patients can be determined only by using scientific evidence from well-designed studies comparing alternative approaches to care. There is a growing consensus both among physicians and among health policy analysts that "evidence-based medicine"—that is, medical care determined by scientific research to provide optimal outcomes—should be the standard by which the quality of physician care is judged. Scientific research of this type has an especially important role to play when there are multiple alternatives available for treating a specific condition. Research that compares outcomes of alternative treatments is often referred to as "comparative effectiveness research" (CER). The federal government has charged its Agency for Healthcare Research and Quality (AHRQ) with supporting research to develop the evidence-based standards by which health care quality should be judged, and by which the effectiveness of treatment alternatives can be compared. The federal Medicare program, discussed in Chapter 6, is looking at ways to adjust its method of paying physicians to reward those who consistently practice higher-quality, evidence-based medicine.

The Quality of Care Provided by Hospitals

The Institute of Medicine (IOM) of the National Academy of Sciences saw a need to study the issue of quality in the care provided to patients in hospitals and other large health care institutions. In the 1990s, it convened a Committee on Quality of Health Care in America. This committee of national experts, drawn from industry, health care organizations, professional organizations, and universities, studied the issue of quality and delivered its report in 1999 (Kohn, Corrigan, and Donaldson 1999). The report, titled *To Err Is Human: Building a Safer Health System*, came to some disturbing conclusions about the quality of the care provided in U.S. hospitals: "At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented . . . preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS" (p. 1).

The IOM report concluded that the problems with medical mistakes are not principally due to individual human error, but rather, "are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them" (p. 2). It recommended two principal mechanisms to improve hospital safety:

1. Creating a "nationwide public mandatory reporting system," as well as additional voluntary reporting systems
2. Relying on existing oversight organizations to focus added scrutiny on the issue of health care quality

Both mechanisms have been initiated, with some preliminary but positive results.

Hibbard, Stockard, and Tusler (2005) reported on a study done in Wisconsin comparing the change in quality over a two-year period for three groups of hospitals: (1) those who received an independent report on the quality of their care with that report made public; (2) those who received an independent report on the quality of their care with that report kept confidential; and (3) those who received no report on the quality of their care. The quality in hospitals confronting public disclosure of their report increased significantly more than in hospitals receiving a confidential report. The lowest improvement in quality was in those hospitals receiving no report. This and other studies (for example, Jha et al. 2005b) suggest that a system of publicly distributed "report cards" may encourage hospitals to take steps internally to improve the quality of the care they provide.

CONCEPT 2.3

Despite spending increasing amounts on health care in the United States, substantial problems remain in the quality of our care. Efforts to improve quality focus on evidence-based medicine, rewarding high-quality care, and monitoring the quality of care through "report cards" and accreditation standards.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is the principal body nationally that monitors hospital performance directly and sets standards for hospital accreditation. In 2002, JCAHO implemented a new program of quality improvement based on standardized performance measures. Williams et al. (2005) reported that these new standards were associated with significant improvement in the quality of care for diseases such as heart disease and pneumonia.

Following the publication in 1999 of *To Err Is Human*, Congress directed AHRQ to study the issue of health care quality and to issue an annual report of its findings. The National Healthcare Quality Report for 2009 (Agency for Healthcare Research and Quality 2009) identified three main themes that needed attention in order to attain the goal of higher-quality health care:

1. "Health care quality needs to be improved, particularly for uninsured individuals, who are less likely to get recommended care."
2. "Some areas merit urgent attention, including patient safety and health care-associated infections (HAIs)."
3. "Quality is improving, but the pace is slow, especially for preventive care and chronic disease management."

AHRQ will continue to monitor the issue of health care quality, and will issue reports on a regular basis regarding our progress toward meeting established quality goals.

THE GROWING NUMBER OF UNINSURED AMERICANS

The two aspects of the U.S. health care system discussed above that make us unique in the developed world—approaching health care as a market commodity and the amount of GDP spent on health care—have led to a third characteristic of our system that is also unique: the large segments of our population living without health insurance. Health care has become so expensive that fewer and fewer people can afford basic health insurance. In 2009, 50.7 million people in this country were without health insurance for the entire year. Despite two national programs to provide health insurance to children from low-income families, this number included more than 7.3 million children (data from U.S. Census Bureau website). For those under the age of 65, more than one person in six was unable to afford insurance. California had one in five residents without health insurance; Texas had more than one in four residents without insurance. In families earning less than $25,000 per year, 24.5 percent of people were uninsured, even after taking into account government-financed insurance through the Medicaid program for poor families. In families earning between $25,000 and $50,000 per year, 21.4 percent of people were without health insurance.

During much of the twentieth century, little attention was paid to the issue of the uninsured. Most physicians would take care of some poor and uninsured patients for free. Physicians would often include a number of these "charity cases" in their practice, in a manner similar to lawyers taking certain cases "pro bono." As described above, the ethics of the medical profession expected physicians to provide this type of care. With the rising cost of medical care, and with the advent in the 1960s of government programs to pay for care for the poor and the elderly, the "charity patient" tradition has largely been abandoned by U.S. physicians.

Who are the uninsured? It is easy to think of them as chronically poor people who do not work and who rely on government welfare for their existence. This picture could not be further from the truth. Unemployed or homeless individuals make up only a small part of the uninsured. Seventy-two percent of adults between 18 and 64 without health insurance in 2008 worked either part-time or full-time during the year. They are the workers in low-wage jobs, often in small companies that do not offer health insurance to their workers.

A full-time worker can be uninsured for one of three reasons (Kaiser Family Foundation 2009):

1. The person works for a company that does not offer health insurance to any of its workers. (In 2009, only 60% of firms offered health insurance benefits to their workers.)
2. The company offers health insurance, at least to some workers, but the worker is not eligible for the company-sponsored plan. (In 2009, 19% of workers in companies that offered health insurance benefits were ineligible for those benefits.)
3. The company does offer health insurance and the employee is eligible; however, the worker chooses not to sign up for the plan, due to the share of the plan cost he or she must pay. (In 2009, 19% of workers eligible for health insurance benefits chose not to enroll in those benefits.)

For each of these categories, the lower the worker's wage, the more likely he or she is to be affected.

A factor that contributes to this disproportionate lack of insurance among lower-wage workers is the size of the firm employing the worker. The smaller the firm, the less likely it is to offer health insurance to its workers. Forty-six percent of firms with fewer than 10 employees offer health insurance to their workers, while 98 percent of firms with more than 200 workers do so. Accordingly, 31 percent of workers in firms with fewer than 25 workers were uninsured, while 10 percent of workers in firms with more than 500 workers were uninsured.

If one thinks of the jobs that involve low-wage workers and small firms, it should be clear that the service sector is a principal source of uninsured workers. Restaurants, small businesses, contractors, and similar types of firms often fail to provide health insurance for their workers. These types of firms play a crucial role in our economy, yet they have been hit especially hard by the rising cost of health care. Chapter 5 looks at the historical roots of our employment-based system of health insurance. We will see that the adoption of a system that relies on employers to bear most of the cost of health insurance was never fully thought out.

THE HEALTH OF OUR SOCIETY: WHAT DO WE GET FOR OUR MONEY?

The United States pays more for health insurance than any other country, both per capita and as a percentage of GDP. What do we get for all the money we spend? One would hope that paying for so much health care would make our society one of the healthiest in the world. Nothing could be further from the truth. In comparing ourselves to other developed countries, we lag far behind in most of the broad indices that measure the overall state of a society's health.

Infant mortality is one of the most common indicators used to gauge the health of a

TABLE 2.3. Infant Mortality (infant deaths per 1,000 live births) for Selected Countries, 2008

Country	Percentage of GDP Spent on Health Care	Infant Mortality
Canada*	10.4	5.1
France	11.2	3.8
Germany	10.5	3.5
Greece	9.7	2.7
Japan	8.1	2.6
Sweden	9.4	2.5
Switzerland	10.7	4.0
United Kingdom	8.7	4.7
United States*	16.0	6.7

Source: Data from OECD.
*Data are for 2007.

nation. Infant mortality measures how many of 1,000 babies born alive will die before their first birthday. Infant mortality for selected OECD countries is shown in Table 2.3, along with the percentage of GDP each country spends on health care. In 2007, the United States reported an infant mortality rate of 6.7 deaths per 1,000 live births. This placed us in twenty-eighth position among OECD countries, worse off than countries such as Hungary, Poland, and the Slovak Republic. Only Mexico and Turkey reported worse infant mortality than the United States.

It should be apparent that there is little relation between how much a country spends on health care and the health of that society, as measured by infant mortality. Even though the United States spends nearly twice as much as Japan on health care, babies in the United States still die at more than twice the rate of babies in Japan.

Another common health index is life expectancy. Life expectancy can be measured in two ways:

1. Life expectancy at birth
2. Age-adjusted life expectancy (How long, on average, can a person who is a certain age today expect to live?)

Life expectancy, like infant mortality, is often used to measure the health of a society. It is usually reported separately for men and women, because biological differences between the sexes historically give women an advantage over men in longevity. How does the United States compare to other developed countries in this statistic? The answer is shown in Table 2.4.

In 2007, male babies born in the United States could expect to live, on average, 75.3 years, while females born the same year could expect to live 80.4 years. Of the thirty OECD countries, the United States ranked twenty-fourth for both male life expectancy and female life expectancy.

In addition to measuring life expectancy at birth, additional information about the health of a society can be obtained by looking at age-specific life expectancy: for adults

who have attained a certain age, how many additional years can they expect to live on average? Table 2.5 compares the United States with the other developed countries shown in Tables 2.3 and 2.4. Using data from the OECD for 2006 (the last year complete data are available), it compares additional life expectancy in these nine countries for those who have reached age 40, age 65, and age 80.

The United States is ninth of these nine countries in life expectancy at birth. We also have the lowest additional life expectancy for both men and women at age 40. We are still in last place for men, and are eighth out of nine for women at age 65. The United States has risen to eighth place for both men and women at age 80.

It appears that a principal health benefit our society enjoys as a result of our heavy investment in health care, at least in terms of additional life expectancy, only starts to show up for our 80-year-olds. This is understandable, because the common causes of death for people in this age group—heart disease, cancer, and strokes—are often amenable to high-tech treatment. Because the United States has more health care technology available than any other country, it stands to reason that our oldest citizens should fare relatively well. At ages younger than 80, however, there seems to be little relationship between the amount we spend on health care and the health of our popu-

TABLE 2.4. Life Expectancy at Birth, in Years, for Selected Countries, 2008

Country	Male	Female
Canada*	78.3	83.0
France	77.6	84.3
Germany	77.6	82.7
Greece	77.5	82.5
Japan	79.3	86.1
Sweden	79.1	83.2
Switzerland	79.8	84.6
United Kingdom*	77.6	81.8
United States*	75.3	80.4

Source: Data from OECD.
*Data are for 2007.

TABLE 2.5. Life Expectancy for Men and Women at Ages 40, 65, and 80 for Selected Countries

Country	Men at Age 40	Women at Age 40	Men at Age 65	Women at Age 65	Men at Age 80	Women at Age 80
Canada	39.7	43.8	17.9	21.1	8.3	10.1
France	38.8	45.1	18.0	22.3	8.3	10.5
Germany	38.5	43.3	17.2	20.5	8.1	9.2
Greece	38.8	42.8	17.4	19.6	7.9	8.1
Japan	40.3	46.7	18.5	23.4	8.5	11.3
Sweden	39.9	43.7	17.6	20.8	7.6	9.4
Switzerland	40.7	45.2	18.5	22.1	8.3	10.3
United Kingdom	39.0	42.7	17.4	20.1	8.0	9.4
United States	37.6	41.7	17.0	19.7	7.8	9.3

Source: Data from OECD.
Notes: For a person who has attained the specified age, the table shows how many more years that person can be expected to live. Data are for 2006.

lation. (The reader should note that for all ages, and for both men and women, life expectancy is better in Canada than it is in the United States. This fact will be of particular relevance when we compare the U.S. and Canadian systems of health care in the following chapter.)

As we have seen so far, it is difficult to compare the quality of national health systems when different measures of quality give such disparate rankings. To reconcile some of these differences, the World Health Organization (WHO) combined eight different measures to create a single measure of the overall quality of a nation's health system. Using this combined measure, the United States ranked thirty-seventh in the world (World Health Organization 2000). Two more recent studies arrived at similar conclusions. Comparing the United States to five other developed countries in areas such as cost, access, and quality, Davis et al. (2007) found the United States last of the six. In a comprehensive review of studies comparing U.S. health care with that of other developed countries, Docteur and Berenson (2009) concluded, "on the basis of this review it is safe to say that the U.S. is not pre-eminent in quality."

CONCEPT 2.4

The United States spends more on health care than any other country in the world. Despite this high level of expenditure, we have one of the lowest levels of overall health of any developed country.

WHAT DETERMINES THE OVERALL HEALTH OF A SOCIETY?

It should by now be clear that, at the level of the society, health and health care are not the same thing. Using the above indicators, we find little if any correlation between the amount spent on the health care system and the health of a society. As the country spending by far the most, the United States still has health indices close to the worst. The only exception is in the survival of our 80-year-olds, and this difference is relatively small.

Rather than the amount of money spent on health care, other factors largely determine the overall health of a society. Principal among these factors is overall standard of living, typically measured by per capita income and the average level of education in a society. Victor Fuchs, one of the founders of the study of health economics, has repeatedly emphasized this relationship: "The basic finding is the following: when the state of medical science and other health-determining variables are held constant, the marginal contribution of medical care to health is very small in modern nations . . . For most of man's history, [per capita] income has been the primary determinant of health and life expectancy—the major explanation for differences in health among nations and among groups within a nation" (Fuchs 1986, pp. 274–76).

An excellent example of the ways in which social class and standard of living affect health independently from health care is seen in Great Britain. The Whitehall study looked at the health of people working in the British Civil Service (Marmot and Theo-

rell 1988). Because Britain has had universal health coverage and a nationalized health system since World War II, all members of the Civil Service have access to basically the same level of health care. Thus, differences in health care cannot explain differences in health.

CONCEPT 2.5

Among developed countries, there is little correlation between the amount a country spends on health care and the overall level of health of that country. The health of a society has more to do with the level of education and income than it does with health care.

The study found a clear correlation between occupational category (and therefore education) and health. There was a threefold difference in mortality between the highest and the lowest ranks of the Civil Service. Even at the upper ranks, the higher on the scale a worker was, the lower the mortality he or she faced. This was true even though all subjects of the study

- worked in office jobs
- were regularly employed
- came from a relatively uniform ethnic background
- lived and worked in greater London

These data should not be taken to mean that, in the face of the growing cost of health care in this country, there has been no improvement in overall health. Quite the contrary, data from the last forty years show dramatic increases in health. In 1960, when the United States spent 5.2 percent of GDP on health care, infant mortality was at the level of 26 deaths per 1,000 live births; now it is 6.7. Male life expectancy was 66.6 years in 1960, compared to 75.4 years now. Female life expectancy went from 73.1 to 80.7 years. It is simply that, despite these improvements in overall health, the United States still lags far behind other developed countries.

There is substantial suggestion that improvements in the level of health in this country may be due more to lifestyle changes than to improvements in health care. Studies from 1991 (Burke et al.) and from 2010 (Wijeysundera et al.) confirmed that the substantial decline in the death rate from heart disease was related as much to improved diet, exercise, and other lifestyle factors as it was to improvements in drugs or surgical treatments.

Victor Fuchs provides an example of the importance of lifestyle issues in his book *Who Shall Live?* (1983). He cited data for Nevada and Utah, two states with roughly comparable populations in terms of ethnic background, socioeconomic status, education, climate, and availability of medical care. In the 1960s, infant mortality in Nevada was 40 percent higher than in Utah, while life expectancy in Nevada was 40 to 50 percent lower than in Utah. If income, education, and medical care cannot explain these differences, what can?

Cigarette and alcohol consumption was markedly lower in Utah, due largely to the influence of the Mormon Church. Correspondingly, death rates from lung cancer and

cirrhosis of the liver were two to three times higher in Nevada than in Utah. Lifestyle factors in Nevada and Utah, rather than medical care, seem to have explained the different levels of health in the two states.

It appears that further increasing expenditures for health care cannot be expected to result in substantial improvements in the overall health of American society. Nonetheless, there has been a strong social movement to provide increased access for the uninsured. Providing health insurance to the one-sixth of our society that is uninsured will of course add to the overall cost of health care.

There has also been an equally forceful movement to restrain the cost of medical care. Thus, for years we have faced two powerful, opposing forces: the need to expand access to health care and the need to restrain costs of care.

SUMMARY

For several decades the United States has faced three major policy challenges in the area of health care:

1. The rapidly rising cost of providing care has resulted in an increasing share of our national economy going to support our health care system. We spend more of our GDP on health care than any other country in the world, even though we trail most developed countries in measures of population health such as infant mortality and life expectancy.
2. Researchers have raised serious and continuing questions about the quality of the care provided by our doctors and our hospitals.
3. We have been confronted by a rising number of Americans with no health insurance and, as a result, seriously impaired access to care.

The roots of our three-part dilemma are nearly one hundred years old. Early in the twentieth century, our society elected to approach health care as a market commodity, available to those with the resources to pay for it. Physicians, working through their professional organizations to influence political and legal aspects of health care delivery, were able to attain a position of substantial power. They used that power for much of the twentieth century to ensure that health care remained a market good, with government playing a relatively minor role. At the beginning of the twenty-first century, we are confronting the policy consequences—cost, quality, and access—that evolved as a result of those earlier policy choices. ACA, signed into law in March 2010, was an important step in addressing these policy issues.

HOW THE AFFORDABLE CARE ACT ADDRESSES THE ISSUES OF HEALTH CARE COST, QUALITY, AND ACCESS

In an Op-Ed published in August 2009, President Obama laid out four broad policy goals for health reform: (1) expanding the availability of health insurance to those who are uninsured; (2) controlling the cost of health care; (3) making Medicare more efficient in order to reduce costs; and (4) providing consumer protections against discrimination by health insurance companies based on a pre-existing illness or condition. In his targeting the issues of health care costs and access to insurance, Obama was addressing two of the three principal policy issues facing U.S. health care. In his Op-Ed remarks he also addressed the issue of quality by promising the American people that "we will make sure that no insurance company or government bureaucrat gets between you and the care you need" (Obama 2009b)

Once it was signed into law, ACA, in combination with the accompanying reconciliation act, largely carries out President Obama's stated goals. Starting in 2014, health insurance will become available to an estimated 32 million people who previously were uninsured. This expansion of coverage will take place through a combination of reform of the private market for health insurance and a major expansion of the existing federal-state Medicaid program. I describe these changes in more detail in Chapters 5 and 7. These expansions will result in nearly 95 percent of all Americans having health insurance coverage. Those remaining uninsured will typically be those working for small companies not required under the new law to provide health insurance to their workers and those residents who are undocumented. I discuss these issues in Chapter 11.

ACA addresses the issue of cost containment in two main ways: changes to the Medicare program (discussed in Chapter 6) and new sources of tax revenues (described in Chapter 5). While there seems to be broad consensus that ACA will meet the goal of expanding health insurance coverage, there is substantially less agreement as to whether ACA will be able to meet the long-term goal of constraining health care costs. A report issued in September 2010 by the chief actuary for the federal Center for Medicare and Medicaid Services predicted that, as a consequence of ACA, national health expenditures for the period 2010–19 would increase more than if ACA had not been passed, with expenditures rising to 19.6 percent of GDP by 2019, rather than the previously predicted amount of 19.3 percent (Sisko et al. 2010). I discuss the long-term issue of health care costs in more detail in Chapter 14.

ACA addresses the issue of maintaining the quality of health care in two principal ways. The first is through an expansion of primary care services through a restructuring of the way primary care is delivered, described in Chapter 4. The second is through a major expansion of CER. CER will bring a major new focus to the issue of comparing

the costs and clinical outcomes of alternative ways of approaching the diagnosis and treatment of illness. CER, if successful, will shift the definition of "quality" in medical care from one that focuses on whether a treatment is newer or more high-tech, to one focusing on how well the treatment actually works in the context of its comparative costs. In Chapter 13 I describe CER and the related issue of whether balancing costs with clinical outcomes constitutes health care "rationing."