The Sociology of Health, Illness, and Health Care

A Critical Approach

FIFTH EDITION

Rose Weitz
Arizona State University

WADSWORTH
CENGAGE Learning™

Australia • Brazil • Japan • Korea • Mexico • Singapore • Spain • United Kingdom • United States

CHAPTER 8

Health Care in the United States

Todd Bigelow/Aurora/Getty Images.

Health care in the United States is a system in crisis. Consider, for example, Kim's story:

> *Born in Chicago and raised in the city's housing projects, Kim had few advantages in life other than having a father in the U.S. military. Though he did not live with the family, he did list her on his health insurance policy until she turned eighteen. At that point, his plan would no longer cover her.*
>
> *After high school, Kim went to community college to study early childhood education. Like many students, she assumed that her degree would lead to a permanent job and benefits. Since graduating from community college, however, she has been working part-time at a day care center. She would like to work full-time, but the center isn't hiring full-time employees. She also works part-time at a Walgreen's drugstore. Though she isn't thrilled with the work (which doesn't utilize her college training), she would agree to work full-time, except that Walgreen's isn't hiring full-time employees either. Kim explained that she tried working more hours there after her boss told her that she would need to work full-time for twelve weeks in order to be eligible for insurance. But when she approached the twelve-week mark, her hours were cut, making her ineligible for insurance....*
>
> *Kim knows that she has serious health problems and that it is dangerous for her to go without medical care and medication. Since late childhood, she has had diabetes. She needs to take insulin and Glucophage, and she must test her blood sugar several times each day. The medicine and testing equipment cost far more than she can afford on her minimum-wage salary (she earns about $1,000 a month), and she has not been to the doctor for longer than she can remember. [As a result, she says,] "I haven't been taking my medicine like I was supposed to, because I couldn't afford it...."*
>
> *Untreated diabetes not only makes her feel worse day by day but also hastens the onset of the serious complications the disease can cause. Because she is unable to monitor and manage her blood sugars and get recommended preventive care, she is at high risk for premature blindness, heart disease, limb amputations, and kidney failure. Standard medical treatment aims to prevent or at least significantly forestall such outcomes, but Kim does not see a way to access standard treatment. (Sered and Fernandopulle, 2005: 137–138)*

In desperation, Kim went to a diabetes clinic she had used while still insured and asked if she could arrange for a reduced fee. The answer was no. She then applied for Medicaid, the federal program for health care for the poor, but was told that she earned too much to get on the program unless she was pregnant.

The most basic element in any nation's health care system is how it provides and pays for health care. As Kim's story illustrates, the United States—unlike every other industrialized nation—has no mechanism for guaranteeing health care to its citizens. Nor, despite this chapter's title, does it really have a health care system. Instead, an agglomeration of public and private health care insurers (such as Medicaid and Aetna), health care providers (such as doctors and nurses), and health care settings (such as hospitals and nursing homes) function autonomously

in myriad and often competing ways. This chapter begins by looking at how people obtain health care in the United States, and at the two current crises in U.S. health care: rising costs and declining coverage. It then explores why the United States lacks a national health care system before addressing the prospects for health care reform.

HEALTH INSURANCE IN THE UNITED STATES

The Birth of Health Insurance

For most of U.S. history, most Americans paid for their health care out of pocket. The upper class could buy any health care they wanted, the middle class could afford most needed health care, the poor mostly went without, and few questioned the system. But during the Great Depression of the 1930s, millions of middle- and upper-class Americans lost their jobs, savings, and the ability to pay for medical care. As a result, many doctors and hospitals faced potential bankruptcy. In response, the American Hospital Association and the American Medical Association (AMA) founded the nation's first major insurance programs: **Blue Cross** to cover individuals' hospital bills and **Blue Shield** to cover medical bills. These two plans (collectively known as "the Blues") continue to play an important role in the U.S. health care system, currently insuring about one-third of all Americans (Blue Cross and Blue Shield Association, 2008).

The underlying purpose of the Blues was to protect hospitals' and doctors' incomes by ensuring that middle-class Americans would be able to afford medical care. As a result, the plans had little incentive to control what kinds of care were given, to whom, or at what costs. Doctors and hospitals were free to provide Blue Cross/Blue Shield members with whatever treatments they thought were needed, at whatever price they thought was reasonable. Patients were required to pay their bills up front, and then had to request reimbursement from the Blues. Because patients were billed a fee for each office visit, test, or other service received, these plans are considered **fee-for-service** insurance.

But although the primary concern of the Blues was protecting doctors' and hospitals' income, these plans still had to make sure that their own bills did not outstrip their incomes. To do so, the Blues sold their insurance only to people likely to be healthy (such as workers at major businesses) and covered members' expenses only until pre-set yearly or lifetime limits were reached. They also relied on **community rating**. Under community rating, each individual pays a "group rate" **insurance premium** (or yearly fee) based on the average risk level of his or her community as a whole. Even if one individual in a community racked up high bills, those bills would be covered by the insurance premiums paid by the many healthy members of the same community.

The 1930s also saw the rise of a very different type of health insurance program, **health maintenance organizations (HMOs)**. Unlike the Blues, the early HMOs, such as Kaiser Permanente and the Group Health Cooperative of Puget Sound, were founded not to protect the incomes of doctors or hospitals but to provide affordable health care. These plans also used community rating. But unlike the Blues, which reduced their costs by avoiding unhealthy members, HMOs reduced

costs by requiring HMO members to use only HMO doctors, keeping members healthy through preventive care, monitoring doctors' behavior to avoid unnecessary care, and paying doctors on salary rather than through fee-for-service billing.

The Government Steps In

Although the Blues, HMOs, and other insurance plans enabled most Americans to pay for health care, by the 1960s it became clear that many poor Americans, as well as middle-class retirees, could not do so. Reflecting in part the rise of the civil rights movement and of the belief that government should use its power to improve Americans' lives, Congress in 1965 authorized two new health insurance programs, **Medicare** and **Medicaid**. Medicare covers health care for virtually all Americans over age 65, as well as for some permanently disabled persons. Medicaid, which covers close to 20% of Americans, provides coverage to poor children as well as to adults who are *both* very poor and either aged, blind, disabled, pregnant, or the parent of a dependent child.

Both Medicare and Medicaid were established as fee-for-service insurance, and doctors and hospitals remained free (at least initially) to charge whatever they felt reasonable for their services. But once these two programs began, millions more Americans could afford those services, since the government was paying the bills. As a result, the initiation of these two programs dramatically increased the profits that could be made in health care.

The Rise of Commercial Insurance

Recognition of the profits to be made in health care led commercial insurance companies to enter the field in large numbers. Whereas initially the Blues and HMOs were all nonprofits, **commercial insurance** programs by definition are organized on a for-profit basis and so must focus on earning a profit for their investors. To do so, they use **actuarial risk rating** rather than community rating. Under actuarial risk rating, insurers maximize their profits by charging people different premiums based on their predicted health risks and by refusing to insure those with high health risks. For example, commercial insurers typically charge higher premiums to those who have allergies, back strain, kidney stones, or ulcers and typically deny coverage to those who have diabetes or ulcerative colitis or who work as airline pilots or in construction. At the same time, commercial insurers charge exceptionally low rates to low-risk individuals. As a result, these insurers have lured many low-risk individuals away from nonprofit insurers, leaving the nonprofits with a sicker clientele overall. To avoid having to raise their rates for all members to cover the bills of their sicker members, many nonprofit insurers have switched to actuarial risk rating. Meanwhile, many local Blue Cross/Blue Shield plans have themselves become for-profit concerns and have adopted actuarial risk rating.

The Managed Care Revolution

By the 1980s, the amounts spent by government and insurers to cover health care costs had soared (as the next section discusses in more detail). This led to the explosive growth in **managed care**. Managed care refers to any system that controls costs through closely monitoring and controlling the decisions of health care providers.

Most commonly, managed care organizations (MCOs) monitor and control costs through **utilization review**, in which doctors must obtain approval from the insurer before they can hospitalize a patient, perform surgery, order an expensive diagnostic test, or refer to a specialist outside the insurance plan. Those doctors who keep costs down are typically rewarded financially by MCOs. In addition, MCOs typically organize panels of doctors, pharmacists, and administrators to create lists (known as **formularies**) of the most cost-effective drugs for treating specific conditions. Doctors who work for an MCO must get special permission if they want to prescribe a drug that is not on the MCO's formulary. Although the terms *HMO* and *managed care* are often used interchangeably, HMOs represent only one form of managed care, and most fee-for-service insurers now also use managed care. Most Americans who have private insurance, and many who have government insurance, now belong to some form of managed care plan.

The ascendancy of MCOs led to many questions regarding their impact on health and health care. However, research suggests that there are few significant differences between MCOs and other insurance plans in access to care, quality of care, or patient satisfaction (Mechanic, 2004; R. Miller and Luft, 1997). Perhaps the more important issue, though, is not the impact of managed care per se but the impact of the for-profit motive. Importantly, although both for-profit and nonprofit MCOs use managed care to control costs, the former do so to generate profits, while the latter do so to free the funds needed to improve services for their members. One major study found that for-profit MCOs scored lower than nonprofits on all fourteen indicators of quality of care, including rates of childhood immunization, mammograms, prenatal care, and appropriate treatment of persons who had diabetes or heart attacks (Himmelstein et al., 1999). (This chapter's ethical debate, Box 8.1, discusses how profit incentives similarly affect pharmacists' services.)

The Backlash Against Managed Care

Despite evidence suggesting that managed care makes little differences in either patient outcomes or patient satisfaction, there has been a substantial backlash against the managed care revolution. A string of legislative and legal moves—often framed as "Patients' Bills of Rights"—have pressed insurers to drop some of the less popular aspects of managed care. For example, legislators have opposed the early release of women from hospitals soon after giving birth (labeled "drive-by deliveries" by the media) even though in general, early release is safer because it reduces women's chances of contracting an infection in the hospital. Similarly, legislators have fought to get patients access to experimental treatments, although patients are more likely to be harmed than helped by them. In addition, even in the absence of legislative pressure, the need to keep both consumers and contracted doctors happy has led insurers to scale back the use of formularies and utilization review (Bodenheimer, 1999).

Why has this backlash been so effective? The answer lies in American culture, media, and politics (Mechanic, 2004). A central theme in American culture is an emphasis on individual autonomy and independence. (In contrast, the countries of northern and western Europe have a far stronger emphasis on community and social solidarity, leaving them far more willing to support social ventures such as universal health care.) By its very nature, managed care reduces individual choices for

BOX 8.1 | ETHICAL DEBATE: PHARMACISTS AND CONFLICTS OF INTEREST

In the same way that the interests of doctors and patients clash when doctors have a vested economic interest in referring patients for particular tests at particular laboratories, many pharmacists now have a vested economic interest in selling certain drugs rather than others (Kolata, 1994).

In 1992, Merck Pharmaceuticals bought Medco, a nationwide drug supply company that buys drugs from manufacturers and sells them at discounts to its 38 million U.S. members through pharmacies. Since then, two other major pharmaceutical companies, SmithKline Beecham and Eli Lilly, have bought drug supply companies.

Since Merck bought Medco, it has offered cash commissions to pharmacists who convince customers to buy Merck products rather than competing drugs. For example, if a customer who belongs to Medco brings in a prescription for an ulcer medication not produced by Merck, the pharmacist may tell the customer that, under their Medco coverage, they can purchase a similar and equally effective drug more cheaply. The pharmacist then offers to call the customer's doctor to request that the doctor approve switching drugs. What the pharmacist will *not tell* either the customer or the doctor is that Merck makes the recommended drug and that the pharmacist will benefit financially from this switch.

Because in the past pharmacists had no financial links to pharmaceutical companies, doctors generally assume that pharmacists' suggestions are both educated and impartial. Doctors, therefore, agree to switch drugs in about 80% of cases (Kolata, 1994). After several such phone calls from pharmacists, doctors may begin routinely prescribing the recommended drug instead of the drug that they used to prescribe.

Is it unethical for pharmaceutical companies to offer financial rewards to pharmacists who sell certain drugs, or for pharmacists to accept those rewards? Those who participate in these arrangements, of course, consider them merely an extension of normal business practices. Because many of the most popular drugs on the market are virtually identical to competing drugs, supporters argue, customers lose nothing by switching drugs and gain if the new drugs are cheaper. Moreover, they claim, if drugs do differ significantly, it is the doctor's responsibility—not the pharmaceutical company's or pharmacist's—to know that and to protect his or her patients. In essence, proponents argue, drugs are like any other consumer good, and so no ethical rules apply beyond the normal rules of the marketplace, such as not advertising a product's effects falsely.

Opponents of these arrangements, on the other hand, argue that such practices necessarily produce unethical conflicts of interest. A pharmacist who can earn extra money by recommending certain drugs over others is more likely to recommend that drug, whether or not it really is the best drug for the customer. Moreover, the entire transaction is grounded in dishonesty, for neither customer nor doctor knows that the pharmacist has a vested interest in selling certain products. Rather, both customer and doctor reasonably assume that pharmacists, as professionals, are bound by a code of ethics that restrains any tendency to place their economic self-interest ahead of customer welfare. These problems led the federal government in 2002 to release new guidelines that identify these practices as illegal frauds and kickbacks. It remains to be seen how much effect the guidelines will have.

Sociological Questions

1. What social views and values about medicine, society, and the body are reflected in current practices that allow pharmaceutical companies to reward pharmacists for promoting certain drugs? Whose views are these?

(*continued*)

BOX 8.1 | ETHICAL DEBATE: PHARMACISTS AND CONFLICTS OF INTEREST *(continued)*

2. Which social groups are in conflict over this issue? Whose interests are served by allowing pharmaceutical companies to enlist pharmacists in promoting drugs? Whose interests are harmed by so doing?
3. Which of these groups has more power to enforce its view? What kinds of power do they have?
4. What are the intended consequences of allowing pharmaceutical companies to offer inducements to pharmacists? What are the unintended social, economic, political, and health consequences of this policy?

both consumers and health care providers. As a result, media and political attacks on managed care resonated well with popular sentiment.

The media and politicians also found managed care an easy target simply because its size made it so visible. As we saw in Chapter 2, medical errors are rife throughout the health care system. Yet when fee-for-service doctors working outside of managed care plans are identified as dangerous, we think of them as individuals, not as representatives of the fee-for-service system. In contrast, because managed care doctors belong to huge, visible, corporations, it is far easier for opponents to generalize concern about problematic managed care doctors or clinics to managed care as a whole (Mechanic, 2004).

Similarly, the belief that more health care is better health care is long-standing in American culture. Under the fee-for-service system *without* managed care, doctors have an incentive to provide as much treatment and testing as their patients' insurance or budget will cover, leading at least in some circumstances to dangerous overtreatment (Leape, 1992). For example, mortality rates are *higher* in geographic regions where Americans receive more extensive medical care, apparently because the extra medical treatment is more dangerous than helpful (E. Fisher et al., 2003). Yet because of our belief that more is better in health care, the public rarely questions whether the ease of access to care under the fee-for-service system might be dangerous.

With the rise of managed care, the inherent financial incentives of the health care system have reversed, so that now doctors can increase their incomes by *restricting* the treatments they provide or the drugs they prescribe. Because this system goes against the American cultural belief that more health care is better, it is far easier for patients to see the dangers of undertreatment inherent in managed care than the dangers of overtreatment inherent in fee-for-service medicine without managed care. Similarly, although the time doctors spent with each patient actually *increased* slightly between 1989 and 1999, most Americans believe it *decreased* due to managed care, which further eroded their trust in the health care they receive (Mechanic, 2001a). These cultural factors made managed care an easy target for the mass media, politicians who wanted to spruce up their image with the public, medical groups that wanted to regain some of their former independence, and pharmaceutical companies that wanted to reduce the power of MCOs over drug prescribing or prices. As a result, the managed care revolution has been substantially curtailed.

THE CRISIS IN HEALTH CARE COSTS

The cost of health care has risen steadily for many years, to the point that the U.S. health care system is now in crisis. In 1980, each American spent on average about $1,000 (in 2007 dollars) for medical care, drugs, supplies, and insurance. Those costs had increased to $7,000 by 2007 and are expected to pass $13,000 by 2017 (U.S. Department of Health and Human Services, 2008: Table 3). Moreover, although costs have also risen in other developed nations, they remain far higher in the United States than elsewhere. These costs, coupled with the problems of health care access described later in this chapter, largely explain why Americans are considerably more likely than people in other developed nations to believe that their health care system needs to be completely overhauled (Table 8.1).

The Myths of Health Care Costs

What accounts for the rising and unusually high costs of health care in the United States? If you ask the typical American—or member of Congress—he or she is likely to respond with one of four popular "myths" about U.S. health care (Starr, 1994).

The first myth is that Americans receive more and better care than do citizens of other nations. Yet on average, the reverse is true. As Figure 8.1 shows, although we spend far more than other countries on health care, we actually receive fewer days of inpatient hospital care for our money. We also receive on average fewer and shorter doctor visits per capita, among other things. And as Figure 8.2 shows, despite our higher expenditures and gross national income, our life expectancies are lower than in many other industrialized nations.

The second myth attributes our high health care costs to our unique propensity for filing malpractice suits. Malpractice suits can raise prices both because doctors have to pay malpractice insurance premiums and because they may engage in **defensive medicine**—performing tests and procedures primarily to protect themselves against lawsuits. Federal researchers estimate, however, that the costs of our malpractice system account for no more than 2% of total U.S. health care costs (Beider and Hagen, 2004). Moreover, their data suggest that changing the malpractice system would not significantly reduce the number of unnecessary tests and procedures.

TABLE 8.1 | PERCENTAGE OF CITIZENS WHO BELIEVE THEIR HEALTH CARE SYSTEM NEEDS COMPLETE REBUILDING.*

Country	Percent
Australia	19
Canada	18
New Zealand	20
United Kingdom	18
United States	28

*Percent agreeing with the statement "Our health care system has so much wrong with it that we need to completely rebuild it."

Source: Organization for Economic Cooperation and Development (2008).

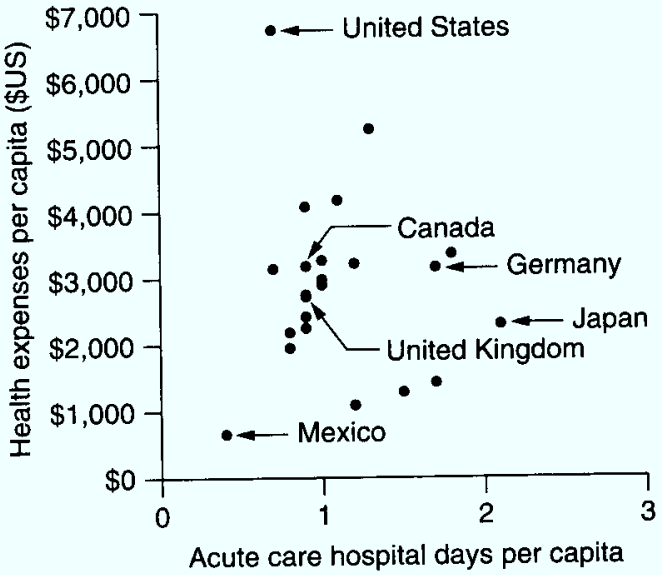


FIGURE 8.1 | HEALTH EXPENSES* AND INPATIENT DAYS IN ACUTE CARE HOSPITALS, IN 22 DEVELOPED NATIONS**

*Dollar amounts adjusted for purchasing power parity. This strategy controls for differences over time and across countries in the worth of a nation's currency by factoring in the number of units of a nation's currency required to buy the same amount of goods and services that $1 would buy in the United States.

**Member states of the Organization for Economic Cooperation and Development; data not available for Denmark, Iceland, Luxembourg, New Zealand, Poland, Sweden, and Turkey

Source: Organization for Economic Cooperation and Development (2008).

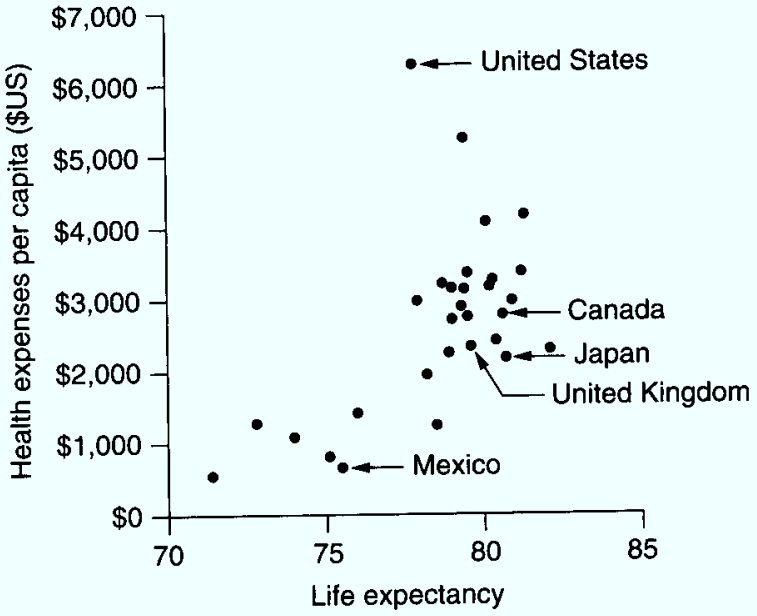


FIGURE 8.2 | HEALTH EXPENSES AND LIFE EXPECTANCY, IN 30 DEVELOPED NATIONS*

*Dollar amounts adjusted for purchasing power parity. This strategy controls for differences over time and across countries in the worth of a nation's currency by factoring in the number of units of a nation's currency required to buy the same amount of goods and services that $1 would buy in the United States.

Source: Organization for Economic Cooperation and Development (2008).

The third myth attributes our rising health care costs to our aging population. Yet the population of the United States is no older than that of any of the other top industrialized nations and, at any rate, economists have found no relationship between the age of a nation's population and its health care costs (Bodenheimer 2005a).

The fourth myth is that health care costs are so high in the United States because of our advanced technologies. Although these technologies certainly play a role in health care costs, they account for only a small fraction of all health care costs. Moreover, the same technologies exist in the other industrialized nations without producing equally high health care costs. Thus, the mere existence of technology cannot explain these costs.

Understanding Health Care Costs

If patient demand, malpractice costs, the aging population, and advanced technology do not explain the rising costs of health care, what does? Research points to two underlying factors: a fragmented system that multiplies administrative costs, and the fact that health care providers (doctors, hospitals, pharmaceutical companies, and so on) have greater power to set prices than do health care consumers, whether individuals, the government, or insurers (Reinhardt, Hussey, and Anderson, 2004; Bodenheimer, 2005a, 2005b, 2005c).

Because Canadian society is probably the most similar to U.S. society, comparing these two countries helps to illustrate why costs are so high in this country. In the next chapter we examine the Canadian health care system in detail. At this point, we need only note a few major points. Most important, Canadians receive their health insurance directly from the government. Similarly, hospitals receive an annual sum each year from the government to cover all costs. Those costs are restrained because, unlike in the United States, Canadian hospitals do not need an expensive administrative system to track patient expenses and to submit bills to multiple insurers. Economists estimate that simplifying the U.S. health insurance system would save tens of billions of dollars each year (Bodenheimer, 2005b).

In Canada, costs are also restrained by government oversight on major capital development: If a Canadian hospital wants to add new beds or purchase new advanced technologies, it must first convince the government that such services are needed (Bodenheimer, 2005b). As a result, hospital costs are considerably lower in Canada than in the United States, even though admission rates are about equal and average stays are longer.

Similar forces keep medical and drug costs down. Like hospitals, doctors need submit their bills only to the national insurance system, rather than filing myriad different forms with different insurers. Meanwhile, no one need spend money on advertising or selling insurance, trying to collect unpaid bills, or covering the costs of unpaid bills. Drug costs are limited because provincial health administrators develop formularies of the most cost-effective drugs and negotiate with pharmaceutical companies to buy those drugs at discount. Similarly, the national health care system has the economic "muscle" to control the prices it pays doctors, technology companies, and other health care providers.

The second major reason health care costs are higher in the United States than in Canada is that U.S. health care providers have proportionately more market power than do U.S. health care consumers. This results from the fact that profit-making—by doctors, hospitals, insurers, pharmaceutical companies, and others—lies at the heart of the U.S. health care system.

As the next section will discuss in more detail, in the United States, pharmaceutical companies are largely able to control which drugs come to market, how they are advertised, and at what prices, with few constraints imposed by any national consumer or government forces. Similarly, because no national health care system effectively controls the number or distribution of doctors in the United States, there are far too many specialists here. Because health care consumers typically purchase whatever medical services their doctors recommend, when an oversupply of doctors increases competition for patients, doctors protect their incomes by increasing either their fees for each service or the number of services they perform (Bodenheimer, 2005c). In particular, compared to doctors in other countries, American doctors are far more likely to adopt new, expensive, and often unproven technologies (such as full body scans or bone marrow transplants) and to use these technologies with a broad range of patients even if the technologies have only been shown to benefit small and specific populations (Bodenheimer, 2005b). As a result, persons living in areas with the greatest numbers of doctors per capita receive more medical tests, surgeries, and other procedures; pay more for those services; and have *worse* health outcomes (Center for the Evaluative Clinical Sciences, 1996; Bodenheimer, 2005b). The rise of managed care has constrained doctors' incomes only slightly, because the primary goal of most MCOs is to increase their profits, not to restrict costs to consumers.

Like U.S. doctors, U.S. hospitals are both free of the sort of governmental oversight that lies at the heart of the Canadian system *and* forced to compete for patients to pay their bills, let alone earn a profit. As a result, hospitals must create demand by adding beds, specialized units (such as heart transplant units), and expensive technologies (such as CT scan machines), and then encouraging doctors to use those services.

Unfortunately, whereas in any other field low demand leads to lowered prices, the reverse is true in medical technology. For example, as sociologist Paul Starr explains (1994: 25):

> With fully utilized mammography machines, a screening mammography examination [for early breast cancer detection] should cost no more than $55, according to studies by the GAO [U.S. General Accounting Office] and Physician Payment Review Commission. But because machines are typically used far beneath capacity, prices run double that amount [so that hospitals can recoup their investment]. With prices so high, many women cannot afford a mammogram.... In other words, *because* we have too many mammography machines, we have too little breast cancer screening. Only in America are poor women denied a mammogram because there is too much equipment. [Emphasis in original.]

Moreover, when equipment is underutilized, health care providers cannot maintain their skills, so rates of complications and death rise significantly. To maintain skills—and profits—hospitals and doctors tend to overuse any technologies

they have at their disposal, leading to wide regional variations in usage (Leape, 1992). In sum, whereas under the normal laws of the marketplace, greater supply leads to lower prices, in health care, greater supply leads to *higher* prices.

In addition, Canada has succeeded at cost control better than the United States because attempts at cost control occur in a unified system where everyone shares the same goal. In contrast, those who have attempted in the past to control the costs of medical and hospital care in the United States have failed because they could not avoid the broader, hostile, profit-driven system in which those costs were generated. For example, faced with rising costs under the Medicaid and Medicare programs, the government since 1983 has used a system of **diagnosis-related groups (DRGs)** that sets an average length of hospital stay and cost of inpatient treatment for each possible diagnosis. Under this prospective reimbursement system, the government determines in advance each year the amount it will pay hospitals per patient based on the average cost of treating someone with a given DRG. If the hospital spends less than this amount, it earns money; if it spends more, it loses money. Theoretically, then, the DRG system should have limited the costs of providing care under Medicaid and Medicare. Instead, hospitals now sometimes use sophisticated computer software to identify the most remunerative, but still plausible, diagnosis for a given patient—a process known as *DRG creep*. In addition, hospitals responded to the adoption of the DRG system by shifting services to outpatient units (where the DRG system does not apply) and by increasing the number of patients they admitted. As a result, the DRG system only marginally reduced government costs for hospital care. Similarly, when the government restricted the fees it would pay health care providers for treating Medicare and, especially, Medicaid patients, many providers either stopped accepting such patients or shifted the costs by increasing the fees they charged patients with other forms of insurance.

The Role of "Big Pharma"

Because the pharmaceutical industry, or "Big Pharma," as it is often known, has so quickly emerged as a major source of health care costs, it is worth exploring in more depth. This section looks at how the pharmaceutical industry affects doctors' and patients' ideas about illnesses and treatments and, as a result, affects health care costs.

Big Pharma Comes of Age

The pharmaceutical industry is an enormous—and enormously profitable—enterprise. Indeed, it has been the most profitable industry in the United States since the early 1980s. In 2001, for example, the combined profits of the top *ten* pharmaceutical companies on the Fortune 500 list surpassed the combined profits of the other *490* companies on that list (Angell, 2004). Although the pharmaceutical industry routinely argues that their high profits merely reflect the high cost of researching and developing new drugs, such work accounts for only 14% of their budgets. In contrast, marketing accounts for about 50% (Angell, 2004). Due largely to this marketing, American citizens now spend a total of about $200 billion per year on prescription drugs, not including drugs purchased by doctors, nursing homes, hospitals, and other institutions (Angell, 2004: 3). Americans are buying *more* drugs, buying more *expensive* drugs, and seeing the

prices of the most popular drugs rise more often than ever before. (The price of the popular antihistamine Claritin, for example, rose 13 times in 5 years.) Prescription drugs now account for more than one-quarter of all U.S. health care expenses (National Institute for Health Care Management Foundation, 2002).

The pharmaceutical industry has not always been this profitable. Profits only began soaring in the early 1980s, following a series of legal changes reflecting both the increasingly "business-friendly" atmosphere in the federal government and the increased influence of the pharmaceutical industry lobby—now the largest lobby in Washington (Angell, 2004). First, new laws allowed researchers funded by federal agencies (including university professors and researchers working for small biotech companies) to patent their discoveries and then license those patents to pharmaceutical companies. This change dramatically decreased pharmaceutical companies' research costs—while giving these researchers a vested interest in emphasizing the benefits of new drugs. Second, new laws almost doubled the life of drug patents. As long as a drug is under patent, the company owning that patent has the sole right to sell that drug and so can set its price as high as the market will bear, with no concern about competition. In addition, companies can now extend their patents by developing "me-too" drugs, which differ only slightly from existing drugs; these drugs now account for about 75% of all new drugs (Angell, 2004). Third, the pharmaceutical industry won the right to market drugs direct to consumers. Direct-to-consumer advertising—a $3.8 billion business in 2005—has proven highly effective. According to a nationally representative survey conducted in 2008 for the nonprofit Kaiser Family Foundation, almost one-third of American adults have asked their doctors about drugs they've seen advertised, and 82% of those who asked for a prescriptions received one (Appleby, 2008). Box 8.2 describes the work of No Free Lunch, a group dedicated to weaning doctors from their dependence on the pharmaceutical industry.

Passage of the Medicare drug benefit program, which went into effect in 2008, has increased pharmaceutical profits even more. The pharmaceutical industry was heavily involved in the drafting and passage of this program, under which Medicare recipients can choose to buy supplemental insurance to cover some of their prescription drug costs (Abramson, 2004; Angell, 2004). However, most Medicare recipients who participate in the drug program will pay more in premiums and in **deductibles** (required minimum amounts individuals must pay out of pocket before their insurance coverage kicks in) than they will save by enrolling in the program. In addition, the program is so complex that few consumers will be able to make informed decisions about whether to purchase the insurance. The pharmaceutical industry, meanwhile, is guaranteed to earn high profits from the program, because the new law forbids Medicare from either covering only drugs on a formulary or negotiating with pharmaceutical companies over drug prices.

DEVELOPING NEW DRUGS Whenever a new drug is developed, the crucial question for health care providers and patients is whether its benefits outweigh its dangers. For this reason, it is crucial that any new drug be extensively tested to determine whether it works better than already available drugs (which almost certainly are cheaper), whether it works differently in different populations (does it help men as well as women? persons with both early- and late-stage disease?), what are

BOX 8.2 | CHANGING THE WORLD: NO FREE LUNCH

No Free Lunch was founded by Dr. Bob Goodman (Koerner, 2003). From the start of his medical training, Dr. Goodman had questioned the influence of pharmaceutical companies on doctors' prescribing practices. When in 1993 he opened a clinic for low-income patients in a poor New York City neighborhood, Dr. Goodman decided he would no longer accept samples or other "goodies" from pharmaceutical salespeople. But like most doctors, he had come to depend on samples for treating patients who could not afford to buy drugs. To help pay for the drugs his patients needed, Dr. Goodman started a website, www.nofreelunch.org, to provide up-to-date information on the nature, extent, and consequences of pharmaceutical advertising to doctors while selling mugs and pens with the "No Free Lunch" logo he had devised. The website also features a list of doctors who have signed a pledge "to accept no money, gifts, or hospitality from the pharmaceutical industry; to seek unbiased sources of information and not rely on information disseminated by drug companies; and to avoid conflicts of interest in my practice, teaching, and/or research."

No Free Lunch remains mostly a one-man (money-losing) operation, although it now has many members and other supporters around the country. Physician members have organized talks at their hospitals and medical schools on the impact of pharmaceutical advertising on medical behavior. Medical student members have held "pen amnesty days," in which students and doctors are encouraged to turn in their drug company pens and other paraphernalia for No Free Lunch pens. Pen Amnesty Days often are accompanied by lectures, other events, and media coverage to help spread the word about the dangers of relying on pharmaceutical companies for medical information.

appropriate dosages, and what are the potential side effects. But because pharmaceutical companies earn their profits by selling drugs, they have a vested interest in overstating benefits and understating dangers. And increasingly, these companies are both willing and able to manipulate the data available to outside researchers, doctors, federal regulators, and consumers (Abramson, 2004; Angell, 2004).

In the past, university-based drug researchers provided at least a partial check on the drug research process, because these researchers could bring a more objective eye to their research. Between 1980 and 2000, however, pharmaceutical industry funding for research by university-based scientists increased almost nine times (Lemmens, 2004). That funding comes in many forms, from research grants, to stock options, to all-expenses-paid conferences in Hawaii. Moreover, as other federal funding for universities declined over the past quarter-century, university administrators came to expect their faculty to seek pharmaceutical funding. Importantly, when the pharmaceutical industry funds university-based research, it often retains the rights to the findings of that research, and can keep university researchers from publishing any studies suggesting that a particular drug is ineffective or dangerous (Angell, 2004; Lemmens, 2004).

At the same time that the pharmaceutical industry has increased its funding to university-based researchers, it has even more dramatically increased funding to *commercial* research organizations (Lemmens, 2004). These organizations are paid not only to conduct research but also to promote it. To keep on the good side of

the companies that fund them, these research organizations must make drugs look as effective and safe as possible by, for example, selecting research subjects who are least likely to suffer side effects, studying drugs' effects only briefly before side effects can appear, underestimating the severity of any side effects that do appear, and choosing not to publish any studies suggesting that a drug is ineffective or dangerous.

Doctors, medical researchers, sociologists, and others have raised concerns about the impact of bias on research publications (Bodenheimer, 2000). Researchers have found that medical journal articles written by individuals who received pharmaceutical industry funding are four to five times more likely to recommend the tested drug than are articles written by those without such funding (Abramson, 2004: 97). Similarly, researchers have found that research studies suggesting a drug is effective are several times more likely to be submitted and accepted for publication than are those that suggest it is ineffective (Turner et al., 2008). Concern about such biases led the *New England Journal of Medicine* (one of the top two medical journals in the United States) to briefly adopt a policy forbidding authors who have financial interests in a drug from writing editorials or review articles on that drug. This policy was dropped quickly because it was virtually impossible to find authors who did not have such financial interests (Lemmens, 2004).

Even more astonishing than pharmaceutical industry funding of university-based researchers is the growing practice of paying such researchers to sign their names to articles actually written by industry employees (Elliott, 2004). For example, between 1988 and 2000, ninety-six articles were published in medical journals on the popular antidepressant Zoloft. Just over half of these were written by pharmaceutical industry employees but published under the names of university-based researchers. Moreover, these ghost-written articles were *more* likely than other articles to be published in prestigious medical journals (Elliott, 2004).

REGULATING DRUGS In the United States, ensuring the safety of pharmaceutical drugs falls to the Food and Drug Administration (FDA). But during the same time period that the profits and power of the pharmaceutical industry grew, the FDA's power and funding declined, as part of a broader public and political movement away from "big government." These two changes are not unrelated: The pharmaceutical industry now routinely provides funding of various sorts to staff members at government advisory agencies, doctors who serve on FDA advisory panels, and legislators who support reducing the FDA's powers (Lemmens, 2004).

Under current regulations, the FDA must make its decisions based primarily on data reported to it by the pharmaceutical industry. Yet the industry is required to report only a small fraction of the research it conducts. For example, the company that produced the antidepressant Paxil had considerable data indicating that, among teenagers, Paxil did *not* reduce depression but *could* lead to suicide. To avoid making this information public, the company submitted to the FDA only its data from studies on adults (Lemmens, 2004). Similarly, drug companies must demonstrate only that new drugs work better than **placebos**. In contrast, in Europe drug companies must demonstrate that new drugs work better than older, less expensive drugs—a standard few new drugs attain. For example, the painkiller Vioxx, at $4 per pill, was eventually found to be no more effective than ibuprofen, at

50 cents per pill. Yet Vioxx quickly became one of the most popular drugs worldwide before it was withdrawn from the market because of its sometimes-fatal side effects. Much of the recent rise in health care costs in the United States comes from the shift to new drugs; as of 2004, spending on drugs stands at $162.4 billion—more than double the amount spent in 1997 (Harris, 2004).

MARKETING DRUGS Once the pharmaceutical industry develops a drug and gets FDA approval, the next step is to market the drug. One of the most important limitations to the FDA's power is that, once it approves a drug for a single use in a single population, doctors legally can prescribe it for *any* purpose to *any* population. For example, some doctors prescribe human growth hormone to middle-aged men to stimulate muscle growth, even though the FDA has approved its use only for children with genetic pituitary defects that produce short stature.

Drug marketing has two major audiences, doctors and the public. Marketing to doctors begins during medical school, as students quickly learn that pharmaceutical companies provide a ready source not only of drug samples and information but also of pens, notepads, lunches, and all-expense-paid "educational" conferences at major resorts. After graduation, the pharmaceutical industry continues to serve as doctors' main source of information about drugs. The *Physicians' Desk Reference* (or *PDR*), the main reference doctors turn to for drug information, is solely comprised of drug descriptions written by drug manufacturers. In addition, the pharmaceutical industry spends $6,000 to $11,000 (depending on medical specialty) per doctor per year to send salespeople to doctors' offices, this on top of the money it spends advertising drugs to doctors in other ways. Most doctors meet with pharmaceutical salespeople at least four times per month and believe their behavior is unaffected by these salespeople. Yet doctors who meet with drug salespeople prescribe promoted drugs more often than other doctors do, even when the promoted drugs are more costly and less effective than the alternatives (Angell, 2004; D. Shapiro, 2004). In addition to these personal meetings with doctors, the pharmaceutical companies now pay for much of the "continuing education courses" doctors must take each year. To hide their role, however, pharmaceutical companies typically pay for-profit firms to organize these courses, and these firms in turn pay universities to accredit their courses (Angell, 2004).

In July 2008, the pharmaceutical industry announced a new voluntary program to reduce marketing to doctors; it remains to be seen what if any impact it will have.

In recent years, and as noted earlier, marketing directly to consumers has become as important as marketing to doctors. To the companies, such advertising is simply an extension of normal business practices, no different from any other form of advertising. Moreover, they argue, advertising to consumers is a public service, because it can encourage consumers to seek medical care for problems they otherwise might have ignored. Finally, companies have argued that these advertisements pose no health risks because consumers still must get prescriptions before they can purchase drugs, thus leaving the final decisions in doctors' hands. Those who oppose such advertisements, on the other hand, argue that consumers lack the expertise to evaluate the (frequently misleading) advertisements (*Consumer Reports*, 1996). And because the purpose of these advertisements is to encourage consumers to press their doctors for prescriptions, it is disingenuous of advertisers to argue

that doctors will protect consumers from making poor drug choices. At any rate, companies increasingly encourage consumers to obtain prescriptions and drugs on the Internet, guaranteeing that they will do so without a doctor's advice.

MARKETING DISEASES As part of its marketing, the pharmaceutical industry sells not only drugs but also diseases. In some cases, drug companies have encouraged doctors and the public to define disease *risks* (such as high blood pressure) as *diseases* (such as hypertensive disease). In other cases, drug companies have defined symptoms into new diseases.

One example of this is the newly defined illness *pseudobulbar affect*, or PBA. PBA refers to uncontrollable laughing or crying unrelated to individuals' emotional state, and can be caused by various disabling neurological conditions (such as head trauma, stroke, and Lou Gehrig's disease). The concept of PBA was developed by Avanir Pharmaceuticals, which markets the drug Neurodex as a treatment for it (Pollack, 2005). Although Neurodex seems to help some patients, its side effects are serious enough to cause at least one-quarter of users—all of whom already have serious health problems and must take numerous other medications—to stop taking it.

To convince doctors that uncontrollable laughing and crying is a disease in itself, Avanir has advertised in medical journals and sponsored continuing education courses, conferences, and a PBA newsletter. Avanir also has marketed the concept of PBA directly to consumers through its PBA website and through educational grants it has given to stroke and multiple sclerosis patient advocacy groups, among others (Pollack, 2005).

THE CRISIS IN HEALTH CARE COVERAGE

UNINSURED AMERICANS

The rising costs of care have led directly to declining coverage. Between 2001 and 2007, health insurance premiums increased 78% even though wages increased only 19%. As a result, whereas in 2001 about 40 million Americans were uninsured, by 2006, 46.5 million Americans—18% of the population under age 65—were uninsured (Kaiser Commission on Medicaid and the Uninsured, 2007a.) Moreover, almost two-thirds of these individuals have lacked insurance for two years or more.

Because Medicare covers almost all Americans over age 65, health care coverage is essentially a problem of the young and middle aged. As Figure 8.3 shows, lack of health insurance affects substantial portions of all age groups below age 65, but is especially acute among younger adults (the population least likely to be covered by government health care programs). Many of these individuals simply cannot afford to purchase health insurance; others are in good health and so do not feel it is worth the cost.

As described earlier, insurance in the United States is typically linked to employment, with about two-thirds of Americans receiving insurance through their employer or a family member's employer. This system is far from perfect, however. Over the last decade or so, employers have kept profits high by reducing the benefits they offer to full-time employees and by hiring more part-time and temporary workers without benefits. Consequently, in 2006, 71% of the uninsured lived in families with one or

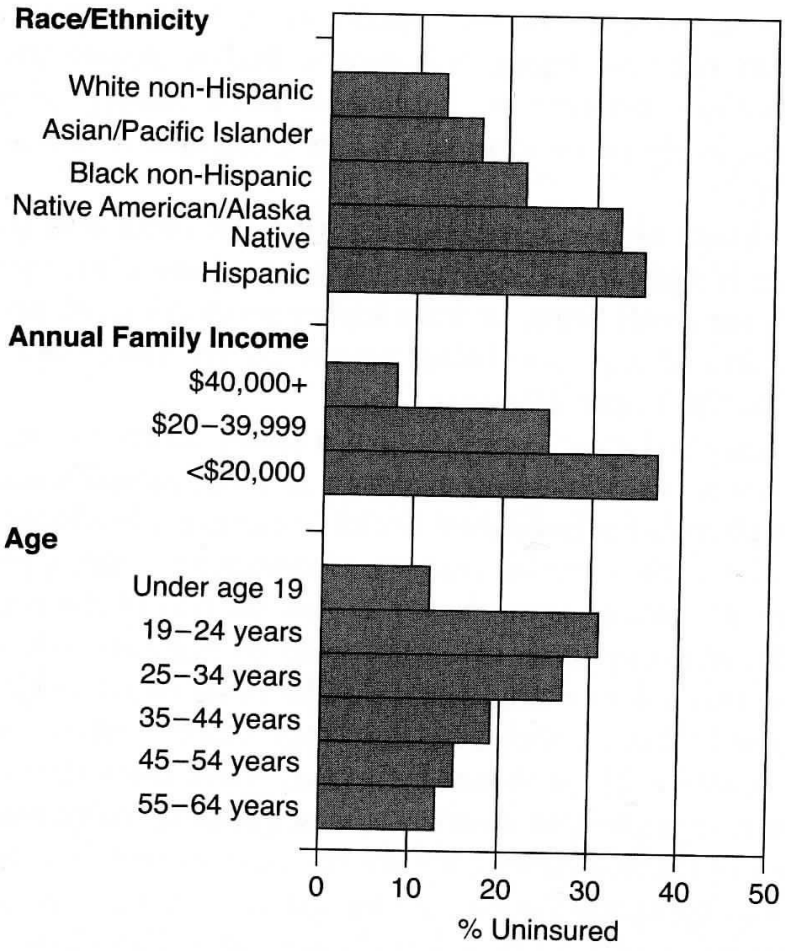


FIGURE 8.3 | PERCENTAGE OF AMERICANS UNDER AGE 65 WHO LACK HEALTH INSURANCE, 2006

Source: Kaiser Commission on Medicaid and the Uninsured (2007b).

more full-time workers (Kaiser Commission on Medicaid and the Uninsured, 2007a). Not surprisingly, insurance coverage also varies by income level, with poor and near-poor persons far more likely to be uninsured (Figure 8.3).

Size of employer also affects the likelihood of insurance coverage. Large firms are far more likely than smaller ones to offer health insurance, and to offer it at affordable rates (Kaiser Commission on Medicaid and the Uninsured, 2007a). Three factors explain why persons who work in small firms or are self-employed are most likely to be uninsured. First, whereas large firms can spread the administrative costs of insurance over many employees, small firms and self-employed persons cannot. Consequently, although those costs pose a minor nuisance for large firms, they can make insurance prohibitive for small firms and self-employed persons. Second, large firms, unlike small firms, have enough ready capital to **self-insure**—putting aside a pool of money from which to pay all health care expenses for their workers rather than purchasing insurance from a commercial provider. Because self-insuring costs less than buying insurance, large firms that self-insure can better afford to insure their workers. Third, insurers are more willing to offer lower rates to large firms because they assume that any money they might lose paying for the health care of ill employees will be more than counterbalanced by the money they earn in premiums from the many healthy employees in the same firm.

Women and men are more or less equally likely to be uninsured, but ethnicity plays an important role. As Figure 8.3 shows, Native Americans and Hispanics (some of whom are non-citizens) are least likely to be insured whereas white non-Hispanics are most likely to be insured (Kaiser Commission on Medicaid and the Uninsured, 2007b).

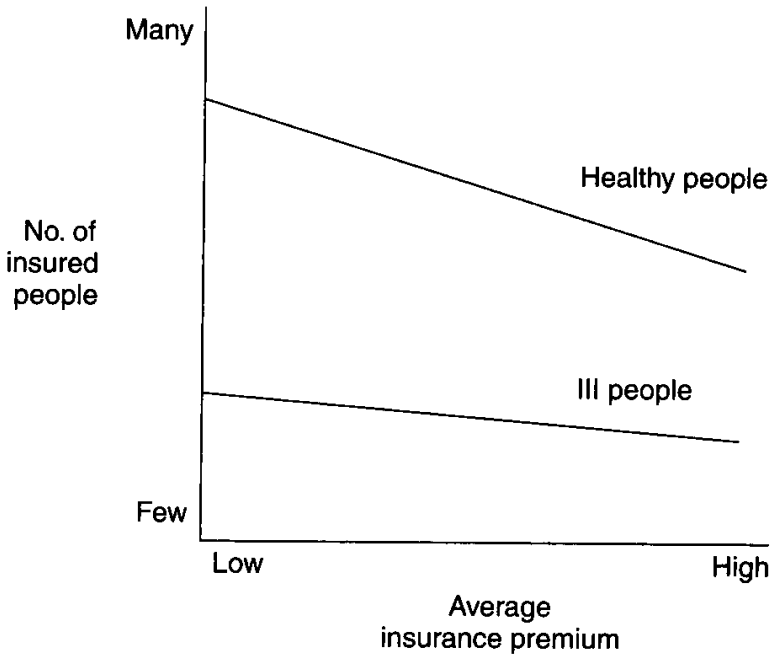
Insurance coverage also varies by state, with insurance less common in those states that provide less-generous Medicaid coverage, have higher proportions of residents who work for small firms, or have higher proportions of poor residents. For example, the chances of a person being uninsured are about twice as high in the South compared to the Upper Midwest.

Finally, insurance coverage varies by health status. Ironically, health insurance is hardest to get when a person actually needs it. In most jurisdictions, insurers legally may reject any applicants for individual health insurance who do not pass a series of medical tests and have clean health records. Consequently, although most uninsured adults are healthy, a minority is much sicker than the rest of the population.

Paradoxically, not only have rising costs led to declining coverage, but declining coverage has also led to rising costs. As the costs of coverage have increased, many healthy people have concluded that they cannot afford insurance. Those who know they have health problems, however, more often decide that they must purchase insurance regardless of its costs. Consequently, compared with the past, a higher proportion of insured Americans are ill. To maintain their financial stability, therefore, insurance companies must increase prices, driving away still more healthy persons. This process creates a **rate spiral** (illustrated in Key Concepts 8.1) in which

KEY CONCEPTS 8.1 | RATE SPIRALS

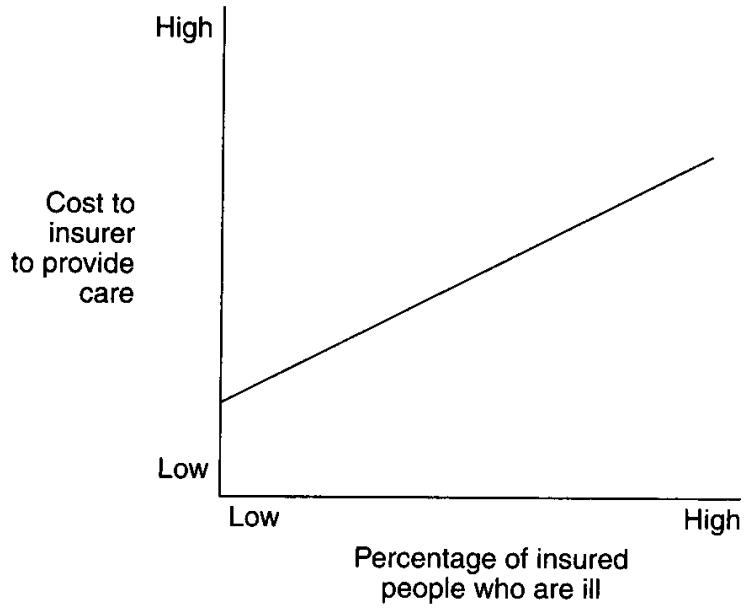
Step 1: When the cost of insurance premiums rises, some ill people drop their coverage, but many more healthy people do so. As a result, insurers are left with a higher proportion of ill members.



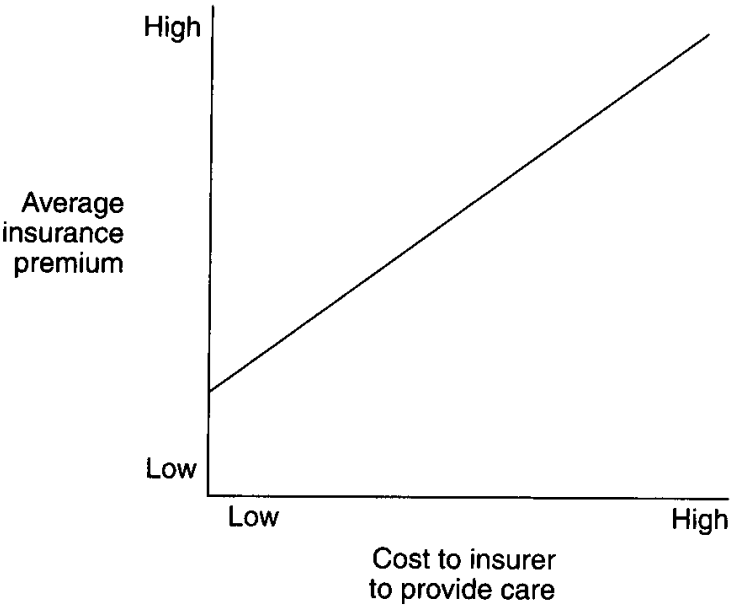
(*continued*)

KEY CONCEPTS 8.1 | RATE SPIRALS (*continued*)

Step 2: As the proportion of insurance plan members who are ill rises, insurers must spend more money to cover their member's medical bills.



Step 3: As the costs that insurers must spend to cover their members' medical bills rises, insurers respond by raising their premiums.



Step 4: Repeat Steps 1, 2, and 3.

increasing costs and declining coverage each foster the other. The only way to avoid a rate spiral is to require *all* members of a community to participate in the same health insurance plan or plans.

Underinsured Americans

In addition to those who have no coverage, many more Americans have insurance that leaves them with more medical bills than they can afford to pay. These problems stem from required and increasingly expensive premiums, deductibles, and **co-payments** (unreimbursable fees paid out of pocket each time one sees a doctor); long waiting periods before insurance covers preexisting conditions; caps on insurance reimbursement per treatment, per drug, per year, or per lifetime; and costs not covered by insurance, such as nursing-home care and prescriptions. About 25 million Americans are underinsured—20% of all insured adults under age 65 (Schoen et al., 2008). These numbers have increased by 60% since 2003, primarily because so many middle-class Americans now lack good insurance.

Just over half of underinsured Americans could not afford to seek needed medical care at some point during 2007 and just under half already are suffering financial stress because of medical bills (Schoen et al., 2008). Medical bills are responsible for between one-third and one-half of all personal bankruptcies in the United States, even though most people who file for bankruptcy have health insurance (Sered and Fernandopulle, 2005). Because of these problems, many Americans purchase health care or prescription drugs in Mexico or fraudulently use the Canadian health care system.

Other Americans face financial difficulties not because they lack sufficient insurance but because they cannot get their insurers to pay for their care (Light, 1992). For example, in the past, once an individual had belonged to a plan for about six months, his or her insurance generally would cover any medical bills for preexisting conditions. Now, however, insurers sometimes demand new contracts each year, with new lists of preexisting and excluded conditions. In addition, insurers can adopt near-impossible rules and procedures to avoid paying individuals' bills, such as requiring individuals to obtain insurer approval within twenty-four hours after receiving emergency care or assigning insufficient personnel to staff claims department telephones.

Precariously Insured Americans

Finally, in addition to the millions of Americans who are uninsured or underinsured, many more are precariously insured—liable to lose their insurance coverage at any time. Those who receive Medicaid lose their coverage once their income rises above a specified ceiling. Those who receive their insurance as part of a family plan can lose their insurance following divorce. Those who are covered through their own employment can lose coverage if they change to a job that does not offer insurance or where the insurance does not cover health problems they developed earlier. Finally, those whose employers either self-insure (thus avoiding state insurance regulations) or negotiate new insurance contracts yearly may have their insurance dropped if they or a family member becomes ill.

The Consequences of Declining Coverage

The decline in health care coverage in the United States has directly affected the use of health care services and indirectly affected health outcomes among the uninsured and underinsured.

Individuals who do not have health insurance still sometimes can obtain health care. Federal, state, and some local governments provide clinics and public hospitals that offer low-cost or free care. In addition, governments sometimes provide low-cost or free vaccination, cancer screening, and "well child" programs. These facilities and programs, however, are not always geographically accessible to those who need them. In addition, these facilities are continually underfunded, so individuals may have to wait hours for emergency care and weeks or months for nonemergency care.

Uninsured persons also sometimes can obtain health care through the private sector. First, some individuals can find private doctors who will reduce or waive their fees, and some live in communities where nonprofit hospitals offer inexpensive outpatient clinics. Second, uninsured persons can obtain care for both acute and chronic, emergency and nonemergency health problems from hospital emergency rooms; although emergency rooms legally can refuse care to anyone who is medically stable, many provide at least basic treatment to all who present themselves. As a result, emergency rooms around the country have become primary care providers for those who cannot afford care, even though the services they offer only poorly match the needs of these individuals and could be provided at far lower costs elsewhere. Finally, uninsured persons increasingly have volunteered for experimental trials of new drugs to obtain at least sporadic treatment (Kolata and Eichenwald, 1999). Yet in such experiments some patients will receive placebos, some will receive drugs that prove ineffective, and some will receive drugs that prove harmful. Moreover, even if the drugs work well, patients receive only temporary benefit, because the drugs become unavailable once the experiments end.

Depending on where they live, therefore, uninsured persons may have some access to health care. However, this access is substantially less than that available to other Americans. In 2006, 49% of the uninsured (compared to 9% of those with private insurance) either had not sought or had delayed seeking needed care due to costs (Kaiser Commission on Medicaid and the Uninsured (2007)). Similarly, 23% of the uninsured (compared to 4% of those with private insurance) had not filled needed prescriptions. Uninsured persons are also significantly less likely than others to receive basic preventive health care, such as physical examinations, blood pressure checks, pap smears, and mammograms. Because of these differences in access to care, the health problems of uninsured persons are usually worse and more difficult to treat than those of insured persons.

When uninsured persons do seek health care, they typically receive less care, of lower quality, than do insured persons, even in life-threatening emergencies. For example, a thorough review of published research conducted by the prestigious federal Institute of Medicine (2002) found that compared with other Americans, uninsured Americans injured in car accidents were less often admitted to hospitals, received fewer services when admitted, and were substantially more likely to die from their injuries. Because of both undertreatment and lower quality of care, uninsured Americans are 25% more likely than are other Americans to die in any given year (Institute of Medicine, 2002).

The story of Deamonte Driver, told in Box 8.3, illustrates what can happen when people do not have reliable, quality health insurance coverage.

BOX 8.3 | IN THE NEWS: THE DEATH OF DEAMONTE DRIVER

Deamonte Driver grew up poor and, at the age of 12, died poor, when a tooth abscess led to a fatal brain infection (Otto, 2007).

Deamonte intermittently had Medicaid coverage, but neither he nor his brother ever received regular dental care. Most dentists across the country refuse to accept Medicaid patients; in Maryland, where Deamonte lived, less than 20% accept Medicaid and only about one-third of children on Medicaid receive dental care in any given year. In fact, for months before Deamonte fell ill, his mother, Alyce, had been trying to get dental care for his 10-year-old brother, DaShawn, whose teeth caused him constant pain. DaShawn finally got to see a dentist on October 5, 2006. That dentist informed his mother that six of DaShawn's teeth had abscesses and needed to be extracted. But no dental surgeon who accepted Medicaid would be available until January 16, 2007—three months later.

Even worse, on January 8, Alyce Driver learned that the boys' Medicaid insurance had lapsed, probably because some of the paperwork needed for annual renewal had mistakenly been sent to a homeless shelter where they used to live. Three days later, Deamonte (who had not complained about tooth problems, perhaps because his brother's problems seemed so much worse) came home from school with a headache. His health deteriorated rapidly, and the next day he received emergency brain surgery for an infection caused by an abscessed tooth—an infection that would probably never have developed if Deamonte had received regular dental care. Two weeks later, Deamonte died. The cost of his hospital care was more than $200,000—enough to buy a year's worth of preventive dental care for 2000 children.

In response to Deamonte's death, the state of Maryland has raised reimbursement rates to encourage dentists to accept Medicaid patients, made it easier for Medicaid patients to find dentists, and earmarked funds for dental treatment and screening in schools (Otto, 2008). But around the nation, one-third of all Americans continue to lack access to affordable dental care (Berenson, 2008). Some of these will die as a result, not only due to brain infections but also due to heart disease and stroke exacerbated by gum disease and to oral cancers that could have been identified and treated successfully if the individuals had received routine dental care (Wu et al., 2000).

WHY THE UNITED STATES LACKS NATIONAL HEALTH CARE

Why is the United States the only industrialized nation that does not guarantee access to health care for its citizens? The answer to this question reflects the particular history, politics, and culture of this country.

As Chapter 10 will describe, since the nineteenth century the government has provided free care to indigent persons at hospitals scattered around the country. Many Americans, however, live in areas not served by such hospitals. Moreover, hospitals focus on providing intensive high-technology care, not the primary care individuals more often need.

Concern about the lack of basic health care coverage for the poor (as well as the middle class) first surfaced during the first half of the twentieth century. In 1912, Theodore Roosevelt proposed a national health insurance system as part of

a broader package of "Progressive Era" programs during his unsuccessful presidential campaign. Twenty years later, when poverty rates soared during the Great Depression and fears of a socialist uprising were rampant, President Franklin D. Roosevelt supported including national health insurance in the new Social Security program. His successor, Harry Truman, supported a similar plan. In each case, however, **stakeholder mobilization**—organized political opposition by groups with vested interest in the outcome—stymied the proposals (Quadagno, 2005).

Opposition to national health care came from numerous sources, each of which benefited from having organizational strength at the local, state, and national levels (Quadagno, 2005). During the first half of the twentieth century, probably the most important opponent of national health care proposals was the AMA, which feared that such proposals might reduce doctors' incomes or autonomy. More surprisingly, labor unions opposed national health insurance because it would eliminate one of the major benefits they could offer members: the ability to press employers to offer health insurance. In addition, national health care was opposed by conservative politicians who considered it socialistic and by Southern politicians who feared it would force racial integration of health care facilities. Meanwhile, the development of Blue Cross and Blue Shield in the mid-1930s freed most middle-class Americans from worrying about paying their health care bills. As a result, popular support for national health care among this important segment of the voting public declined, leaving insufficient stakeholder mobilization in favor of national health care to defeat its opponents (Quadagno, 2005; D. Rothman, 1997).

By the 1960s, however, lack of access to health care for the poor and the elderly became a growing popular concern, resulting in the initiation of the Medicare and Medicaid programs. These programs, however, only partially and temporarily solved the problem. But by alleviating middle-class Americans' guilt over the suffering of the poor and fears of being impoverished by medical bills in old age, passage of these programs reduced public pressure for national health care.

Such pressures began simmering again during the late 1980s and early 1990s, as more and more Americans found themselves uninsured or otherwise unable to pay their health care bills. These problems led President William J. Clinton to propose his Health Care Security Act (HCSA) in 1993.

The HCSA represented a liberal approach to health care reform. If adopted, the act would have broadened access to care without seriously threatening the basically entrepreneurial nature of the U.S. health care system or the power of the "big players" in health care. Under the HCSA, Americans still would have received health insurance from many different insurers, retaining the complexity and costs of the current system. Wealthier Americans would have retained the right to purchase health care options unavailable to others, and so health care would have remained a two-class system. And the proposal included no oversight mechanisms to restrain the costs (and profits) of hospital, drug, or medical care.

Nevertheless, opposition to the plan was fierce, especially from the insurance and pharmaceutical industries. Even though the HCSA was designed to appease these industries, the industries still feared government oversight and price controls. In addition, small businesses feared that the plan would shift too many costs to their shoulders. These groups poured millions into fighting the bill, outspending

those who favored it by a ratio of 4 to 1 (Quadagno, 2005: 189). In the end, Congress rejected it without even a floor vote.

The defeat of the HCSA showed once again the importance of stakeholder mobilization, even though the stakeholders were different from those in previous battles. In addition, this defeat illustrated the difficulties of developing a coherent and politically acceptable plan for completely overhauling a complex health care system. Finally, it illustrated how antitax sentiment and distrust of "big government" has become a powerful force in U.S. politics, making it difficult to generate support for any governmental programs (D. Rothman, 1997; Skocpol, 1996). Nevertheless, surveys consistently find that most Americans support health care reform, are willing to pay more taxes to fund health care, and believe that the government should play an important role in providing care to citizens.

REFORMING HEALTH CARE IN THE UNITED STATES

According to the World Health Organization (2000b), the United States spends a higher percentage of its gross domestic product on health care than do any of the other 191 member countries, but as of 2000 (the latest data currently available) it ranks only thirty-seventh in performance. Clearly, this system needs reform.

Since the defeat of the HCSA, numerous proposals have been presented at the state and federal level to incrementally expand health insurance coverage. These proposals have generally taken two forms: expanding eligibility for current government-run health insurance programs or making commercial insurance more affordable.

Those who favor expanding government programs have proposed such options as offering Medicaid coverage to middle-income disabled persons. Such proposals have the benefit of taking advantage of existing structures rather than requiring new bureaucracies, but run the risk of straining already overburdened programs.

Those who favor making commercial insurance more affordable have proposed such tactics as providing tax credits or tax deductions to individuals to subsidize the cost of insurance or requiring all employers to provide health insurance, coupled with developing statewide insurance purchasing pools that would provide affordable insurance for small firms. These proposals present a different set of problems. With tax credits, individuals can reduce their federal taxes by the amount they have spent on health insurance, up to a set limit. All the proposals so far, however, have set limits so low that they would cover only a small portion of the cost of health insurance. As a result, these proposals seem more likely to benefit those who already have health insurance than those who currently find insurance unaffordable. Proposals offering tax deductions, which allow individuals to deduct part of the cost of health insurance from their income before calculating their federal taxes, offer even less benefit, especially to poorer persons who are in low tax brackets anyway. Moreover, the existence of tax credits or tax deductions might lead employers to stop offering health insurance to workers, thus increasing the number of uninsured Americans. Proposals to require employers to provide insurance, on the other hand, will do nothing to reduce the administrative inefficiencies built into our current system with its hundreds of insurance providers. And in either event, if more people start purchasing private health insurance, insurance companies would likely respond to this increased demand by raising prices.

Incremental change in the health care system could also come about through state-level reforms. During the last decade, the federal government has supported innovation at the state level, allowing states to develop their own programs to serve persons eligible for Medicaid and Medicare. Some of these programs could eventually serve as models for the nation as a whole.

Hawaii's program has generated especially great interest. In 1974, Hawaii's legislators passed the Prepaid Health Care Act, which required employers to pay at least 50% of the cost of health insurance for all full-time employees (Neubauer, 1997). Small businesses that cannot afford to pay their share of premiums can draw subsidies from a special fund established under the act, although very few have done so. Because of Hawaii's booming economy and the resulting competition for workers, most employers voluntarily insure employees' families as well as their employees and pay more than their required 50% of the costs.

As in other states, elderly persons and very poor persons receive their health insurance from Medicaid or Medicare. To provide insurance coverage for the "gap group" of unemployed persons and part-time workers who earn too much to receive Medicaid but too little to purchase insurance on their own, Hawaii in 1989 established a state health insurance program (SHIP), which purchases insurance from HMOs for these individuals. By narrowing the insurance gap, Hawaii secured health insurance for about 90% of its residents (R. Mills, 2002; Hawaii Uninsured Project, 2006). Because such a high proportion of the state's population is insured, insurers can use community ratings rather than risk ratings—keeping rates affordable for all purchasers—and still remain financially viable.

In addition to ensuring a high level of coverage, the new system enabled Hawaii to achieve unusual success in restraining health care costs. In part, this success resulted from the unintended development of monopolistic, nonprofit insurance plans. About 70% of Hawaiians receive their insurance from one of two nonprofit insurers, the Hawaii Medical Service Association or Kaiser Permanente. Because these two insurers control such a large share of the market, they can exert considerable control over medical costs. Doctors who refuse to accept their reimbursement schedules or salaries can attempt to seek patients elsewhere, but will find few patients who do not belong to these plans.

More important, Hawaii restrained costs through reducing hospital use and costs. Neither of the major insurers charges deductibles, so individuals have less incentive to put off needed care. As a result, health problems more often are caught at early stages, when treatment is relatively inexpensive. In addition, and unlike most U.S. insurers, both of these insurers pay only for stays in hospital wards, not in semiprivate rooms. Finally, Hawaii has implemented a strict system for prospectively reviewing any hospital capital expenses. Hospitals cannot purchase major equipment or construct new facilities unless they can demonstrate need for those services. Therefore, consumers need not pay the costs of maintaining unused hospital beds or duplicative technologies.

Conversely, the continued existence of Medicare and Medicaid has hampered Hawaii's ability to restrain health care costs. Because these plans do not reimburse hospitals at rates high enough to cover the actual costs of providing care, hospitals have shifted costs to patients with private health insurance. At the same time, Medicaid's and Medicare's low reimbursement schedules have produced problems

in access to health care because many doctors will not accept patients who belong to these plans. These problems have been exacerbated by nationwide shifts in hiring patterns from full-time to part-time work, which has resulting in a larger pool of part-time workers who fall into the gap group. These cost increases have forced Hawaii to reduce the benefits available through its insurance program.

In sum, the Hawaii experiment demonstrates both the advantages of moving toward a single-payer, nonprofit system with strong centralized control and the problems when multiple payers—in this case, public and private insurers—continue to function in the same economic sphere. It also demonstrates the benefits available from a reasonably unified managed care system, and the difficulties of sustaining a strong system in the face of external economic pressures.

Whether a Hawaii-type program or any other program for reforming health care is adopted will likely depend on stakeholder mobilization, and especially on whether powerful stakeholders line up in favor of change. At this point, the most important indicator that change might come is the growing support for health care reform among major corporations, which have come to view reform as essential to controlling their costs; in a recent survey, 96% of corporate executives identified health care costs as a significant or critical concern (National Coalition on Health Care, 2005: 6). As the National Coalition on Health Care (2005: 6), a nonprofit alliance that includes corporations as well as labor, consumer, and medical groups, explains:

> The escalation of health care costs is not only a health care issue; it is also a major national economic problem. As these costs rise, they eat into corporate margins, reducing the capacity of firms across the economy to grow their businesses by investing in research, new plants and equipment, and product development. Health care cost increases slow the rate of job growth by making it more expensive for firms to add new workers.... And double-digit premium increases—on top of what are already the highest per-worker health care costs in the world—put American firms at a steep and growing disadvantage in global markets, where they must compete against companies with much lower health care costs.

IMPLICATIONS

As we have seen, Americans obtain their health care through a wide range of funding mechanisms, from publicly subsidized health care programs to private fee-for-service insurance to nonprofit HMOs. Although some Americans have nearly unlimited access to health care—including unneeded and potentially dangerous care—others lack access to even the most basic health care. As a result, the United States must cope simultaneously with economic and health problems caused by both overuse and underuse of health care services.

Whether we choose to tackle these dilemmas depends on how we—both individually and as a nation—define the situation. If we view obtaining health care as an individual responsibility, we are likely to oppose any attempts to extend government sponsorship of health care. However, if we view health care as a basic human right, we are likely to support extending health care to all. At the same time, regardless of whether we view health care as a right, we may support health care reform as a

means of protecting the nation's economy; many corporations, for example, have begun lobbying for health care reform because they believe the money they spend on insuring their employees places them at a disadvantage compared with manufacturers in other nations that have national health care systems.

SUMMARY

1. The United States does not have a health care system. Rather it has an agglomeration of public and private providers functioning autonomously in often-competing ways.
2. The Blue Cross and Blue Shield insurance plans were established to protect the incomes of hospitals and doctors. Both plans were nonprofit, offered fee-for-service insurance (in which consumers are reimbursed for their medical and hospital bills), and were initially based on community rating (in which all members pay the same insurance premium based on the average risk level of their community as a whole).
3. Health Maintenance Organizations (HMOs) also used community rating but were established to provide health care to all. HMOs reduced costs by encouraging preventive care, monitoring doctors' behavior to make sure it was cost-effective, paying doctors on salary, and requiring HMO members to use only HMO doctors.
4. Medicare and Medicaid are government insurance programs that provide health care coverage to poor, disabled, and elderly persons. Because they initially were a form of fee-for-service insurance, with the government paying all health care bills for members, these programs dramatically increased the profits available in health care.
5. Commercial insurers rely on actuarial risk rating, in which insurance premiums are based on individual's health risks. Competition from commercial insurers has led Blue Cross, Blue Shield, HMOs, and other nonprofit insurers to begin operating more like each other and more like commercial insurers.
6. Managed care refers to any system that controls costs by monitoring and controlling health care providers' actions. Most U.S. insurers now use managed care.
7. The cost of health insurance has risen dramatically in the United States because our fragmented system multiplies administrative costs and because health care providers have greater power to set prices than do health care consumers.
8. Pharmaceutical companies are an important factor in rising health care costs because they largely control which drugs come to market, how they are advertised, and at what prices. Pharmaceutical companies market new diseases, as well as new drugs.
9. Currently, about 46.5 million Americans—18% of the population under age 65—are uninsured. Many more are underinsured or precariously insured. Those who lack good insurance are significantly more likely than other to suffer illness, disability, or death.
10. To date, proposals to institute universal health care in the United States have been stymied by *stakeholder mobilization*: organized political opposition by groups with vested interests in the outcome.

11. Most proposals to reform health care in the United States focus on incrementally expanding eligibility for current government-run health insurance programs or making commercial insurance more affordable.

Getting Involved

People's Medical Society. 462 Walnut St., Allentown, PA 18102. (610) 770-1670. www.peoplesmed.org. A consumer organization that investigates the cost, quality, and management of health care; promotes self-care and alternative health care procedures; and represents consumer interests in health care.

Physicians for a National Health Program. 332 South Michigan Avenue, Suite 500, Chicago, IL 60604. (312) 782-6006. www.pnhp.org. Organization of U.S. physicians for a Canadian-style health care system.

Review Questions

1. How and why does commercial insurance differ from insurance offered on a nonprofit basis?
2. Why did the originators of health maintenance organizations believe HMOs would provide better health care at lower cost than would traditional insurers?
3. What is managed care? How can it restrain health care costs, and how can it harm individuals' health?
4. What are Medicaid and Medicare?
5. Why have health care costs in the United States risen?
6. Who are the uninsured?
7. Why do individuals who have health insurance still sometimes face financial difficulties in paying their health care bills?
8. How can individuals lose their health insurance?
9. How does lack of insurance affect health care and health status?

Critical Thinking Questions

1. Researchers believe they have identified a gene that increases women's risk of breast cancer. You are the chief administrator of a health insurance plan. One of your board members, whose mother died from breast cancer, argues that your plan should offer this test for free as a routine preventive procedure.
   a. Explain to the board member what information you would want before you could make this decision and why you would want that information. Be sure to think about the consequences for the plan as a whole as well as for individual patients. (You might want to re-read the discussion in Chapter 3 about prostate cancer.)
   b. Would you want different information and reach a different decision if you were a doctor in private practice? if you were a patient?
2. How do we ration health care in our present system? What are the financial costs of this rationing? What are the social costs?

3. How are the costs of care distributed among U.S. residents now? Be sure to think about not only costs paid out of pocket, but also costs paid through taxes for government-provided care. How would those costs be distributed under a national health plan?

Internet Exercises

1. Find the website for the nonprofit Kaiser Family Foundation. Search the website for information on the characteristics of uninsured children.
2. Find the website for the nonprofit Consumers Union, and then find its section on health care. What does Consumers Union believe are the most serious problems in the U.S. health care system? What sorts of strategies does Consumers Union propose for relieving those problems?