Foreword

National Health Reform and America's Uninsured

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For those uninitiated to the intricacies of the U.S. health system, perhaps its single most striking characteristic is its failure to function as a universal benefit in a manner similar to education, Social Security, and essential, population-based community services. This nation enjoys extraordinary and unprecedented wealth; yet it stands alone among industrialized countries in the area of health coverage. Why and how we as a people have chosen this pathway, the human, financial and economic, and social consequences of our choice, and the imperative for reform, are the subject of this special symposium of *JLME*.

There are some who maintain that the need for health reform is overblown. No one, they say, ever really goes without health care in this country. Hospital emergency departments are available for true emergencies as a matter of law, and a health care safety net of community clinics and charitable services exists for those who do not have insurance. There is little or no hard evidence, they add, that the presence or absence of health insurance makes much difference to the health of individuals or populations. Moreover, when critics of reform do concede the existence of a problem, they argue that the nation simply cannot afford to finance health care for 43 million additional persons or make other changes to improve the accessibility and quality of health care.

Readers of this volume should be able to appreciate the clarity and power of the argument for national health reform which emerges from the essays assembled. By any measure, the absence of a health system capable of responding reasonably and fairly to the population's health needs takes an enormous toll on this country. No amount of empirical research probably ever would produce sufficient evidence to satisfy critics of reform; but it also is abundantly clear that we do not lack for evidence.

At the same time, it is probably fair to say that national health systems offering equitable, affordable and accessible health services rest on considerations far more profound than the results of empirical research. Powerful evidence can support far-reaching innovation and social change; but by itself, even the best evidence rarely, if ever, can alter ethical, social, and political norms. In the modern world, health care has emerged as one of the fundamental building blocks on which any nation's future rests. In the end, national health systems reflect the philosophical, ideological, and political undercurrents which collectively yield decisions regarding how a population's resources should be shared and deployed.

The struggle for health reform has been a feature of the U.S. social and political landscape for nearly a century. This health reform reader has been designed to concisely but thoroughly frame the current state of play by examining the issues and challenges across a range of perspectives. This volume has been assembled with certain specific audiences in mind: instructors and students across many fields of study; policymakers, and those who seek to shape policy, who are actively engaged in the debate over national health reform; the health care professionals and enterprises which together comprise the health care system; members of the news media who cover the topic in its seemingly infinite twists and turns; and persons with a serious interest in the subject.

In order to produce this special edition, *JLME* commissioned essays from some of the country's best known and most respected analysts and researchers. These experts collectively represent an array of disciplines and a spectrum of views, but they share a common commitment to creating a more rational U.S. health policy. Together, their essays present a broad view of the current state of affairs, an exploration of what lies beneath the nation's repeated failure to legislate in its own best long-term interest, and their collective assessment regarding what it will take to achieve significant improvements in the health system.

Any topical treatment of a subject as vast as national health reform requires editors to make choices about how the materials are organized and how the story gets told. We have opted for a relatively straightforward presentation organized into three overarching Parts. Part One lays out the dimensions of the problem and its consequences for individuals, families, communities, the public's health, and the nation as a whole.

Part Two explores several of the key components of the nation's strikingly atomized system of health care financing, the underlying political, economic, and social dynamics which shape them, and the implications of recent reform efforts and pending reform proposals. The components of the system examined in this part are those that tend to dominate the debate: employer-sponsored coverage; Medicare; and Medicaid. This part also discusses the universe of publicly financed clinics, hospitals, and health systems (known collectively as the "health care safety net"), which have as a primary purpose the provision of health care for persons most at risk of exclusion from health care by reason of poverty, a lack of insurance coverage, serious health vulnerabilities, and cultural and social isolation.

The final section of the symposium opens by posing the inevitable question raised by any student of national health policy: why can't this country manage to devise a coherent national health reform strategy,

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as have other nations with comparable economies and reasonably similar social traditions? It then examines the range of approaches which have been pursued, as well as the underlying principles and beliefs that have propelled progress in nations that have chosen to act. This Part also considers two specific dimensions of reform in the U.S.: the extraordinary role played by cost estimation in both advancing and defeating reform efforts; and the political environment in which national health reform proposals are endlessly debated. Part Three concludes with perspectives offered by two of the nation's most seasoned policy analysts who, despite very different political outlooks, both argue that the country is ready for a marked departure from business as usual.

Summary of the Articles

Part One opens with an overview of the uninsured prepared by Diane Rowland, one of the best known analysts of trends in health policy, and her colleagues Cathy Hoffman and Alicia Carbaugh. This article synthesizes the remarkable body of research on the issue which has been carried out over the past dozen years by the Kaiser Commission on Medicaid and the Uninsured, a special program of the Henry J. Kaiser Family Foundation. In their essay, the authors report that between 2000 and 2002 alone, the number of persons uninsured throughout the year grew by nearly 4 million, from 39.6 million to 43.3 million persons. The number of uninsured Americans rises to nearly 60 million persons – a 50% jump – when the number of Americans who are uninsured at some point during a year are taken into account. Over a three-year time period, the authors report, as many as 85 million nonelderly Americans can experience some period of time without coverage. The authors chronicle not only the racial, ethnic and income disparities which underlie these figures but also underscore that employment is no protection: fewer than one in five persons without health insurance in 2002 lived in a household in which no one worked.

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This opening article reveals the two critical factors which underlie the problem of being uninsured. The first is a voluntary employment-based system which was never sufficiently strong enough to begin with and which is growing weaker, especially in the lower-tier wage sectors for all workers, and in all wage sectors for retirees not yet eligible for Medicare. The second underlying factor is a public insurance system which while partially compensating for critical gaps in coverage, falls disastrously short of complementing and supporting the faltering, voluntary employment-based scheme.

The second essay in Part One, by Dianne Wolman and Wilhelmine Miller of the Institute of Medicine, synthesizes the findings from an extraordinary series of studies conducted by the IOM between 2001 and 2004 with special funding from the Robert Wood Johnson Foundation. Collectively, these studies set aside any notion that the health insurance crisis in this country lacks the types of externalities that justify a national response. The IOM studies demonstrate that the consequences of the nation's insurance problem extend to entire communities, as well as the nation's overall economy. The widespread absence of health insurance takes a broad toll on community health systems which in turn lack the revenues they need to operate properly. High uninsured rates in urban areas affect not only those without the coverage; these communities also have fewer hospital beds, offer fewer specialized services for vulnerable populations, and are less likely to have advanced emergency services and burn and shock/trauma systems. Rural hospitals serving disproportionately uninsured communities have fewer intensive care and inpatient psychiatric services and lower operating margins; depressed operating margins in turn make systems more vulnerable to economic downturns. Public health systems in communities with high proportions of uninsured persons can face serious budgetary shortfalls, with essential functions such as surveillance and emergency preparedness implicated.

The Wolman and Miller essay also documents other national consequences which flow from the health insurance problem. These consequences include diminished health and premature mortality, financial stress for families, reduced workforce productivity, and greater financial stresses on government programs. Most important perhaps is the IOM's estimate of the lost "health capital" that results from poor health status over a lifetime. As Miller and Wolman report, the annual, aggregated cost of not adequately financing health care for the population as a whole ranges between $65 and $130 billion.

The insurance problem inflicts serious financial consequences as well, which in turn put the unaffordability arguments made by critics of reform into a far different perspective. The IOM estimates that in 2001, the nation spent some $99 billion on health care for uninsured persons. Of this amount, the uninsured bore about 25% on their own, insurers another 40% as a result of part-year coverage, and the government more than one third – spending an estimated $35 billion on public subsidies to health care providers.

The three major health coverage arrangements explored in Part Two form the financial backbone of the health care system. They, too, are strained by the cumulative stress which emanates from an array of economic, political, and social factors that have produced runaway costs and a skewed distribution of resources away from preventive and primary health services and toward the highest technological interventions. The issue of employment-based coverage is explored by Sherry Glied and Phyllis Borzi of Columbia University School of Public Health and the George Washington University School of Public Health and Health Services, respectively, two of the nation's best-known experts in employer-sponsored health plans. The authors review the employer coverage arrangements which bear the bulk of the financing burden for workers and their families, (as well as the spillover effects of having 43 million persons without coverage). Their essay illuminates the intense debate which surrounds the future of a system on which millions depend (to the point of foregoing other important forms of compensation to join an employer's plan), and which employers struggle to keep afloat. The conflicting realities which arise from the employment-based health system are striking: on the one hand, its economic burden, cost, inefficiencies, inequities and structural coverage gaps; on the other, its enduring popularity despite its obvious limitations, particularly for lower-wage employees and the vast army of contingent and part-time workers. These conflicting realities illuminate what lies beneath the ceaseless policy search to preserve what is best about employment-based coverage while compensating for its severe shortcomings.

Bruce Vladeck, who directed the administration of Medicare and Medicaid during the Clinton Administration, was intimately involved in the 1993-1994 national health reform effort, and today serves on the faculty of Mount Sinai Hospital in New York City, is considered one of the nation's foremost health policy analysts. Vladeck's essay explores Medicare, which stands alone as the nation's only universal health insurance scheme. The title of the article, borrowed in part from Deborah Stone's seminal 1993 article on health insurance,[1] is particularly apt given the thrust of his essay. Vladeck explores the evolution of Medicare both programmatically and within the social and political context in which it exists. Using the 2003 Medicare prescription drug reform legislation as a platform, he critically examines the political, ideological, and social undercurrents which lie beneath

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Medicare and which can be expected to reemerge in the broader Medicare reform debate sure to come.

In the face of mounting pressures flowing from a "troublesome interaction of demography and health economics," Vladeck notes that Medicare must change. But as he notes, Medicare today is caught at the epicenter of a historical conflict between two fundamentally different world views. The first is one based in the concept of social contract. It would use the power of government to intervene in the conduct of markets in order to manage and redirect national resources to the millions elderly persons and persons with severe disabilities whom the health coverage market otherwise might either wholly or partially eschew. The second world view – and one that acts as a mirror image of the first – would achieve long-term reform through a combination of privatization in both program design and administration, the further loosening of existing market constraints, and substantially constrained subsidization by the federal government as a means of exposing consumers to market forces to constrain use and increasing market pressures. Whether these two world views can find a basis for compromise is, in Vladeck's view, a question whose answer will be determined by national political and cultural forces that extend far beyond Medicare policy.

Of less visibility but equal importance is the future of Medicaid, the nation's single largest insurer. This is explored by Tim Westmoreland and Cindy Mann of Georgetown University's Law School and Institute for Health Policy, who together led the federal Medicaid program during the final years of the Clinton Administration. Medicaid's size, complexity, and protean nature (never has a single program been asked to do so much and in so many different structural forms), makes it easy to overlook as a central part of the nation's health financing pantheon. Yet no national health reform debate is complete without its exploration. Medicaid shoulders an almost unbelievable range of health system burdens, from insuring the poor and uninsurable, to supporting institutional and community-based health care systems for children and adults with serious disabilities, to shouldering the health care safety net. As the authors point out, one of the program's greatest strengths is its ability to serve as a "stopgap for other public programs" such as Medicare, programs for persons with HIV/AIDS and serious physical and mental disabilities, public health agency initiatives for pregnant women, infants and children, and even programs whose primary purpose is other than health care, such as child welfare systems and special education programs for children with disabilities.

Mann and Westmoreland observe that Medicaid has succeeded at these tasks for a number of reasons – its open-ended financing, its entitlement structure for both states and individuals, and the flexibility of program design which allows it to cover services that lie outside the outer realms of other insurance programs. This essay poses the central question of how to reform Medicaid while retaining its unequaled capacity to finance services essential health services that cannot be insured. The principal challenges, the authors note, are a serious underfunding of the shared federal/state financing partnership (which has spawned numerous state "schemes" to artificially inflate their actual expenditures in order to qualify for additional funds), the lack of a national coverage floor for all poor persons, and enrollment barriers. Mann and Westmoreland also probe the growing tendency on the part of lawmakers to avoid the Medicaid reform challenge by quietly permitting the Executive Branch to make what arguably is excessive use of unique federal statutory powers to conduct "demonstrations," which in turn are now so widespread that they are effectuating vast and controversial changes in Medicaid's most basic characteristics without open and public debate. The essay closes with a discussion of the continued need for Medicaid even in a universal coverage system.

The final essay in this Part, by Bruce Siegel, Marsha Regenstein, and Peter Shin of the George Washington University, School of Public Health and Health Services, focuses on the battered but enduring and remarkably resilient health care ecosystem of safety net providers, which collectively provide an array of services that are critical to any national health system but poorly financed in this one. The authors bring tremendous knowledge of the health care safety net, Siegel through his career administering and overseeing safety net systems, and Regenstein and Shin through extensive health service research. Their essay illustrates the financial underpinnings of the safety net, which can be found in direct federal, state and local government grants and allotments, supplemented by Medicaid (both through its coverage of poor and medically indigent persons and its favorable payment arrangements to the health care safety net).

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Their essay also describes the remarkable array of functions carried out by members of the safety net. They are best known as a collective source of primary, acute and advanced medical care for the poorest members of any community who work at low-wage jobs that carry no benefits. But these providers also perform critical health care management services for low-income persons with chronic physical and mental illness whose own health vulnerabilities and lack of (or inadequate) health insurance coverage isolate them from "mainstream" sources of care. Safety net providers are often rich in cultural diversity and thus are a bulwark for millions of immigrant families who settle in inner cities and increasingly rural areas. Many of these providers, particularly large metropolitan hospitals and health systems, are the premier source of advanced care for the sickest newborns as well as victims of catastrophic events who require shock, trauma, and burn management. The essay explores current challenges which face this essential part of the health system and how health reform proposals could and should address their needs.

Part Three begins with an essay by Timothy Stoltzfus Jost, one of the nation's leading health law scholars. This essay, which is based on his landmark book *Disentitlement*, asks the question which inevitably arises in even a cursory exploration of U.S. health policy: why can't this nation do what others have done? In his essay, Jost lays out the broad range of approaches that other countries have taken and the methods by which nations with economies and governmental structures similar to our own have taken to ensure a fair and reasonably economical investment of social resources. He also explores the major factors that appear to frustrate progress in this country, including our health care pricing structure, extensive inefficiencies emanating from payer fragmentation, the lack of a national health budget, political institutions that frustrate far-reaching innovation, and a culture and social world view that does not demand from policymakers a serious and coherent national discussion about balancing social and individual interests. What is apparent from this essay is that we are distinguished from other nations not by the specifics of what they do – indeed, the range of approaches to reform is enormous – but by their will to do something that is coherent, national in scope, and reasonably uniform.

The Jost essay is followed by a commentary developed by Richard Southby, Executive Dean of the George Washington University Medical Center and a leading authority on health systems both here and abroad. Southby sets out what have come to be recognized as essential principles of health systems adopted by international organizations and professional societies throughout the world. He also writes

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of the decision by his native Australia some 20 years ago to adopt a national health reform system that guarantees a range of health services for all residents through a carefully designed mix of public and private investments. What is perhaps most fascinating about Southby's description is that unlike this country, Australia was able to both recognize nearly 40 years ago the extent to which a voluntary and privately financed system could not be sustained, and to act on that recognition. As a result, Australia has achieved an evolution toward a national health scheme that offers universality, stability, and the ability to execute broad policymaking powers over questions of health quality, practice improvement, dissemination of innovation and accountability for financial resources, while continuing to rely on and foster private health care arrangements.

The essay by Jeanne Lambrew, a co-editor of this volume and a member of the faculty of the George Washington University School of Public Health and Health Services, examines the role of cost estimation in health policy formulation and thereby illuminates one of the most pivotal and yet little known dimensions of the entire process of policymaking. An eminent researcher, Lambrew has devoted her career to health reform and has served on the health policy staff of both the United States Department of Health and Human Services and the White House. In her essay, she explores cost estimation not merely as a discipline but as a world view, describing both its essential role in health reform and the process by which cost estimation is conducted. As importantly, she explores the ease with which it can be – and has been on many occasions – misused to defeat reform and advance political agendas. She illustrates her essay throughout with evidence of how cost estimation techniques have both advanced and retarded critical efforts in reform over the past decade.

Lawrence Jacobs, a political scientist at the University of Minnesota who is recognized nationally for his work on the politics of health care, writes with his colleague Michael Illuzzi on the impact of post-September 11, 2001 priorities on health reform. The authors explore the prospects for health reform in an age of terrorism and national safety priorities that simply were unimaginable a generation ago, immense deficits that are the result of trillions of dollars in tax cuts, a recession, and the long and costly war in Iraq. The weak political environment for reform, the authors note, is compounded by the lack of consensus on any approach to reform and the fading belief among the public that health reform is a national problem which should be central to national policymaking. This peculiarly lethal combination of factors leads the authors to give low odds to the passage of even modest reform.

The final essays offer the viewpoints of two of the most seasoned veterans of health policy. Judith Feder, Professor and Dean of the Georgetown Public Policy Institute, is one of the nation's most recognized figures in health policy, having served in numerous public capacities, most recently as a senior member of the Clinton Administration's health policy team. Dean Feder offers a population-level perspective on health reform. Hers is a voice for broad reform and a renewed commitment to far-reaching approaches, even if these approaches threaten the status quo and demand something from those who already have coverage, whether in the form of somewhat increased tax burdens or the acknowledgment of the limits of governmental generosity toward any specific, highly favored population subgroup. Of particular concern to Feder is the extent to which policy makers, in their attempt to avoid asking anything of powerful constituents, have seized upon the issue of health insurance "crowd out" (i.e., the substitution of public for private health care financing resources). This crowd-out doctrine in Feder's opinion carries with it the danger of effectively "crowding out" any meaningful efforts at reform as well as the millions of Americans without access to private resources. Reform is possible in her view when policymakers cease to view as "undeserving" the millions who reside at the outer edges of the current system, cease to ignore the ties which (as the IOM reminds us) so intricately bind all health system users together, and cease to use concepts such as crowd out to deflect efforts at comprehensive reform.

The final essay by Mark Pauly shares this realm of broad thinking. A professor of health economics at the University of Pennsylvania whose career places him among the most eminent of health policy analysts, Pauly examines the conundrum that appears throughout this volume in one respect or the other, namely the tendency on the part of stakeholders to eschew any reform if the preferred ideological approach to reform is not dominant. This polarization over the proper approach to reform is an enduring theme in U.S. health policy and is hardly surprising, given the sheer magnitude of national resources (some one-seventh of the U.S. economy) which are at stake. Pauly views the problem of who is uninsured in America as relatively simple and straightforward, and his specific approach to health reform emphasizes individual coverage models, compared to the broad population approach urged by Feder. However, he shares her willingness to see the nation engage in a broad reconsideration of how it allocates health resources in order to move toward a more rational approach that does not leave millions lingering at the system's edge.

What is most important about the Pauly and Feder essays is that both see the challenge as a national problem rather than one that falls into a specific sector – federal, state, public or private. The two might hold very different views about how health resources should be aggregated or distributed, or perhaps where the resources should come from. At the same time, both see the problem as nationwide in scope, whose resolution will be found in a coherent approach rather than an atomized and chaotic set of (not infrequently) counterproductive policies.

Concluding Thoughts

For nearly a century, the nation has been engaged in a public debate over how to reform the health system to make it fair. Other nations have had the same debate; indeed, such a debate became inevitable as the value of health care – and its high cost – became increasingly evident, and as government leaders came to appreciate the importance of an accessible, properly functioning, and fair health system to the protection of the public's health and the advancement of a nation's economy and governmental strength. Achieving a coherent national approach to ensuring adequate health care financing for all Americans becomes even more essential in this utterly remarkable age of technology and information; reform offers a more rational pathway for translating innovation and quality improvement into practice, as well as for achieving a basic level of discipline over the excessive health costs which are the inevitable result of atomized and undisciplined markets.

These essays underscore the critical juncture at which the nation stands. How we address the question of national health reform will be resolved only through real and difficult choices about the health system, to be sure. It also will tell us a great deal about who are as a society and as a people. Can we live with a certain level of collective decision-making about how we find and distribute resources at a society level? Can we agree to accept certain limits on our own individual access to resources in the name of broader national approaches that ask for at least some modicum of constraint so as to make coverage more affordable? Can we have an honest debate over approaches to reform which recognizes the parameters of the existing health, economic and social system while striving toward goals developed by consensus rather than by pure ideology? If the insights offered in these articles are an indication, then we may indeed be ready to restart the debate.

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