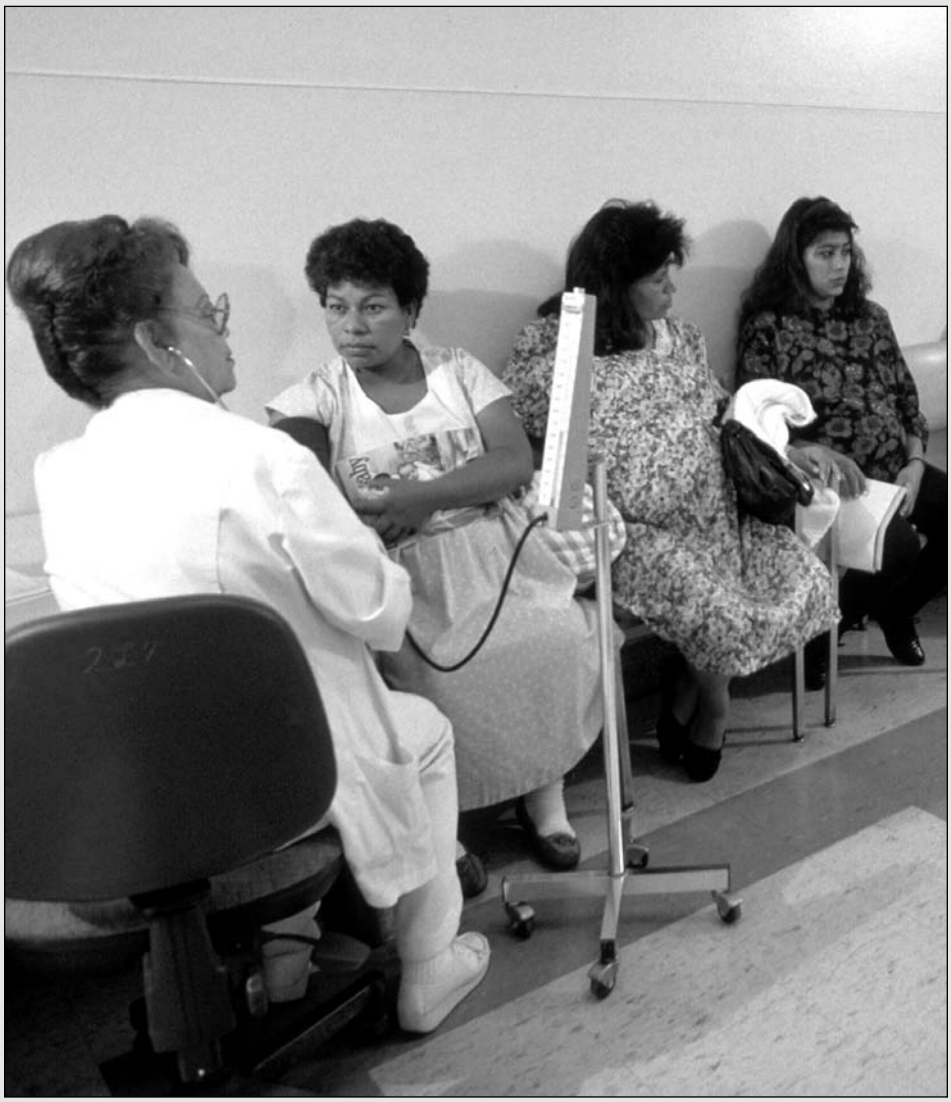
PART

# 3 Health Care Systems, Settings, and Technologies



In Part Two, we looked at illness primarily from the perspective of the ill individual. In this part, we move to a macrosociological level, looking at health care systems and settings. In Chapter 8, we consider the history and current nature of the U.S. health care system, examining why and how millions of Americans have found themselves uninsured, underinsured, or precariously insured—threatened with the loss of health insurance at any moment. Chapter 9 begins by presenting a series of measures useful for evaluating any health care system, and then uses these measures to explore four alternative health care systems—those of Canada, Great Britain, the People's Republic of China, and Mexico. With this as a basis, the chapter concludes with a look at the prospects for reforming the U.S. health care system. Finally, in Chapter 10, we investigate the major settings in which health care is offered in the United States (other than individual doctors' offices), and the increasingly important role technology plays in those settings, as it helps solve old problems and creates new problems.

# CHAPTER 8



# The U.S. Health Care System and the Need for Reform

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.*
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> *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. . . .*
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> *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 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 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. In this chapter we look at how health insurance is structured in the United States, how pharmaceutical companies increasingly affect the costs and nature of U.S. health care, and the growing crisis in U.S. health care.

## Health Insurance in the United States

Until at least the 1930s, most Americans paid for their health care out of pocket. The wealthy could buy whatever health care they desired, the middle class could afford most needed health care, and the poor mostly went without.

There still are some Americans who can afford to purchase whatever care they want, as well as many, like Kim, who cannot afford needed care, for the United States is the only **industrialized nation** that does not guarantee health care to its citizens. (The problems faced by the uninsured are discussed later in this chapter.) Most Americans, however, rely on health insurance to make health care affordable. In this section, we first look at the two main health insurance *models* that historically existed in the United States, fee-for-service insurance and health maintenance organizations (which are a form of managed care). Key Concepts 8.1 compares these models. Although both models have changed considerably over the years, understanding them makes it easier to understand the newer models that have emerged more recently. After looking at these two models, we look at how U.S. health insurance overall has moved toward managed care. Finally, we look briefly at the two main government-provided health insurance *programs* in the United States, Medicare and Medicaid, each of which offers insurance based on both the fee-for-service and health maintenance models.

*Key Concepts 8.1*

### *Comparing Insurance Models*

| MODEL | FEE-FOR-SERVICE INSURANCE | HEALTH MAINTENANCE ORGANIZATIONS |
|---|---|---|
| **Examples** | Blue Cross/Blue Shield | Kaiser Permanente HMO |
| **Underlying purpose** | Protect doctors and hospitals. | Provide health care to all. |
| **Historically restrained costs through . . .** | Community ratings: insure entire, largely healthy, communities to reduce risk and spread costs. | Community ratings, plus emphasis on maintaining health and preventing costly illness. |
| **Doctors paid** | Fee-for-service | Salary |
| **Typical coverage** | Open choice of and access to doctors. | Limited choice of doctors and limited access to specialists. |
| | Many bills not covered (deductibles, preexisting conditions, prescription drugs, limits on yearly and lifetime coverage). | Almost all bills covered. |
| | Preventive care not covered. | Preventive care emphasized. |
| **Changes in model over time** | Commercial fee-for-service insurers emphasize generating profits for stockholders. | Commercial HMOs emphasize generating profits for stockholders. |
| | Move to actuarial risk rating. | Increased use of copayments and restriction of HMO membership to healthier populations. |
| | Doctors pressed to accept negotiated fee schedules (in PPOs). | Doctors paid on capitation or fee-for-service. |
| | Choice of doctors limited in preferred provider options. | Choice of doctors expanded by preferred provider options. |
| | | Access to specialists expanded with elimination of "gatekeepers." |
| | Managed care strategies become common (utilization review, etc.). | Managed care strategies become more common. |

## Health Insurance Models

Both fee-for-service insurance and health maintenance organizations first appeared during the Great Depression of the 1930s, when millions of Americans were out of work and few could afford to pay for medical care. But the two forms differed dramatically in their origins and goals.

### *Fee-for-Service Insurance*

The first major fee-for-service insurance program, **Blue Cross,** was founded by the American Hospital Association. Through selling insurance to cover individuals' hospital bills, the association hoped to preserve hospitals' income and protect them from bankruptcy. The success of Blue Cross led the American Medical Association (AMA) to found **Blue Shield** shortly thereafter. Whereas the purpose of Blue Cross was to protect hospitals' incomes, the purpose of Blue Shield, which provides coverage for medical bills, was to protect doctors' incomes, by ensuring that middle-class Americans would be able to afford medical care. These two nonprofit plans (collectively known as "the Blues") continue to play an important role in the U.S. health care system; during 2004, 92.3 million Americans belonged to these plans (Blue Cross and Blue Shield Association, 2005).

Historically, individuals who had Blue Cross/Blue Shield insurance could seek care from whatever hospitals and doctors they chose. In turn, hospitals and doctors charged Blue Cross/Blue Shield patients on a **fee-for-service** basis; that is, patients were billed a fee for each office visit, test, or other service they received. For this reason, Blue Cross/Blue Shield is known as **fee-for-service insurance.** Under such insurance, individuals must first pay their medical bills and then request reimbursement from their insurance providers. However, individuals typically must pay on their own the first $100 to $500 in bills they receive each year (known as the **deductible**), 20 percent or more of their hospital bills, and all costs for preventive medical care. To keep Blue Cross/Blue Shield premiums low, many plans now offer **preferred provider organizations (PPOs)**, in which doctors agree to charge lower, preset fees in exchange for the additional business, and consumers agree to obtain care from these doctors in exchange for lower premiums and deductibles.

Both Blue Cross and Blue Shield usually establish lifetime and sometimes annual maximums. Individuals who exceed their maximums must pay their remaining bills themselves, a serious problem for those with **chronic illnesses** or serious injuries.

Until the 1980s, both Blue Cross and Blue Shield established their fees based on **community rating.** Under community rating, each individual pays a "group rate" premium (or yearly fee) based on the average risk level of his or her community as a whole. Even if a particular individual is a bad insurance risk because of a preexisting illness, a dangerous job, or a family history of illness, the insurer need not charge that individual a high premium because most members of the community will have much lower risks, keeping the

average costs to the insurer low. This explains why those who purchase insurance as part of a large group, such as all employees of IBM, pay far lower premiums than do those who purchase insurance individually.

In contrast, fee-for-service insurance offered by **commercial insurance** companies (i.e., insurers that function on a for-profit basis) is based on **actuarial risk rating** rather than community rating. Under actuarial risk rating, insurers maximize their profits by insuring only individuals whose health risks are low or by charging very high premiums to those whose health risks are high. For example, commercial insurers typically charge higher premiums to those who have allergies, back strain, kidney stones, or ulcers; typically deny coverage to those who have ulcerative colitis, diabetes, or severe obesity; and often deny coverage to individuals who work in high-risk fields or in fields that attract risk takers, such as aviation, auto sales, construction, and law.

Conversely, to attract a low-risk clientele, commercial insurers charge lower rates to such individuals. As a result, they have successfully lured many low-risk individuals away from the Blues, leaving the Blues with a sicker clientele overall. To avoid having to raise their rates for all members to cover the bills of their sicker members, many Blue Cross/Blue Shield companies now use actuarial risk rating.

### *Health Maintenance Organizations*

The 1930s and 1940s also saw the rise of a very different type of health insurance program: **health maintenance organizations (HMOs).** Unlike the Blues and the commercial fee-for-service insurers, the first HMOs to attract national attention—Kaiser Permanente and the Group Health Cooperative of Puget Sound—were organized by individuals whose primary aim was providing affordable, high-quality health care to their communities. Like the Blues, these HMOs based their fees on community rating. But whereas the Blues and the commercial insurers used **retrospective reimbursement,** reimbursing individuals for health care costs after they fell ill, the HMOs used **prospective reimbursement** in an attempt to keep people from falling ill in the first place.

Under prospective reimbursement, HMOs paid doctors a salary, rather than paying them on a fee-for-service basis. Because doctors received the same salary regardless of how many times they saw their patients or how many procedures they performed, they could not increase their income by providing unnecessary medical care. Instead, doctors would earn the highest net income by keeping patients healthy so the patients would require less of their time and resources in the long run.

In line with their emphasis on restraining costs by keeping members healthy, HMOs, unlike the Blues and commercial insurers, paid the full cost of preventive care. Patients, meanwhile, paid nothing beyond the cost of their insurance premiums as long as they used only doctors affiliated with their HMO and saw specialists only if referred by their **primary care doctor** (known as a **gatekeeper** in systems of this sort).

As research increasingly suggested that HMOs could provide care at least as good as that offered by fee-for-service insurance but at lower cost (e.g., Leape, 1992), interest in developing HMOs to generate corporate profits began to grow. As a result, by 2002, 31 percent of privately insured Americans belonged to HMOs (National Center for Health Statistics, 2004: 355), with most of these belonging to for-profit HMOs.

The interest in HMOs as cost-saving and profit-generating mechanisms has altered the structure of HMOs substantially. Like commercial fee-for-service insurers, commercial HMOs work to enroll as healthy a population as they can. To discourage unnecessary medical visits by members, most HMOs now charge **copayments**—small fees consumers must pay each time they see a care provider. To discourage primary care doctors from unnecessarily referring patients to specialists, HMOs began setting aside annually a pool of money to pay for referrals to specialists and allowing primary care doctors to divide among themselves any money left over at the end of the year. A California survey of primary care HMO doctors found that 57 percent felt pressured to limit referrals (Bodenheimer, 1999); those who do not limit referrals are less likely than others to have their contracts renewed. To further increase doctors' incentives to control the costs of health care, most HMOs no longer pay doctors on salary. Instead, HMOs typically pay primary care doctors by **capitation,** paying them a set annual fee to cover all care (both primary and specialty) per patient in their practice, and pay specialists (and occasionally primary care doctors) on a fee-for-service basis. Like doctors in PPOs, however, HMO doctors paid fee-for-service must abide by a schedule of fees negotiated in advance with the HMO.

## The Managed Care Revolution

The most striking change in the U.S. health care system over the last quarter-century has been the dramatic rise of **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. 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 to prescribe any drugs not on that MCO's formulary.

Although the terms *HMO* and *managed care* increasingly are 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 now belong to some form of managed care plan.

### *The Rise of Managed Care*

The use of managed care spread rapidly around the country during the 1980s and 1990s in an effort to restrain spiraling health care costs. This explosive growth led to many questions regarding whether MCOs cut quality of care along with costs. Research suggests that in at least some circumstances, managed care can reduce costs while maintaining or even improving quality of care. For example, one study tracked, for seven years, almost 2,000 patients who had high blood pressure or adult diabetes; no differences were found in outcomes between managed care patients and other patients, even though the managed care patients received fewer tests, had fewer hospitalizations, and thus had lower bills overall (Greenfield et al., 1995). Similarly, another study found that older women with breast cancer who received managed care through nonprofit HMOs were more likely than those who had fee-for-service insurance without managed care to have their cancers diagnosed at earlier stages and to receive all treatments currently recommended by medical experts (Riley et al., 1999).

Overall, however, most studies have found few significant differences between managed care and other plans in access to care, quality of care, or patient satisfaction (Mechanic, 2004; R. Miller and Luft, 1997). At any rate, current research provides a poor basis for predicting the economic or health impact of MCOs in the future. As the use of MCOs has spread, they have attracted a more typical and less-healthy population than in the past. For these less-healthy patients, MCOs' emphasis on preventive, primary care rather than on interventionist and specialty care may not be the best choice, and so the health benefits of MCOs are diminishing (Draper et al., 2002).

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 HMOs use managed care to control costs, the former due so to generate profits, while the latter do so to free the funds needed to improve services for their members. Data collected in 1997 from most HMOs in the country found that for-profit HMOs scored lower than nonprofit HMOs 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, similarly discusses the impact of profit incentives on 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

### *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 percent 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

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. 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, and to virtually abandon the use of primary care gatekeepers (Bodenheimer, 1999).

Why has this backlash been so large and 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 both consumers

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; 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 this policy? Whose views are these?
2. Which social groups are in conflict over this issue? Whose interests are served by the different sides of this issue?
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 this policy? What are the unintended social, economic, political, and health consequences of this policy?

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 doctors or clinics to managed care as a whole.

Similarly, the belief that more health care is better health care is longstanding 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 prior to 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 has further eroded their trust in the health care they receive (Mechanic, 2001a). More broadly, some patients now think of their doctors as "double agents," whose loyalties are split between serving their patients and serving the MCOs that pay their bills (Shortell et al., 1998). Such patients are less likely to trust their doctors and, as a result, more likely to decline treatment, participate in treatment only halfheartedly, or withhold needed information about their health from health care providers (Mechanic, 1999).

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.

## Government-Funded Health Insurance Programs

Although the United States does not offer a national health insurance program to cover all citizens, it does offer smaller programs for specified subgroups. For example, the Veterans Administration offers health coverage to veterans, TRICARE (formerly CHAMPUS) offers coverage to active and retired members of the armed forces and their families, and the Federal Employees' Health Benefits Program offers coverage to federal employees and their families. In this section we focus on the two best-known, government-funded health insurance programs, Medicare and Medicaid. Both programs started as traditional fee-for-service without managed care but increasingly are based on managed care principles.

### *Medicare*

**Medicare** covers more persons than any other single insurance program in the nation. Virtually all Americans over age 65 receive Medicare, as do some permanently disabled persons. All persons eligible for Medicare receive, at no

cost, coverage for as many as 150 days of hospital care, although these persons must pay substantial deductibles and copayments. In addition, they receive limited coverage for posthospital nursing services, home health care, and hospice care. Medicare also offers fee-for-service insurance for outpatient medical costs, at a monthly premium of $66 as of 2004. This insurance, too, has substantial deductibles and does not cover many medical costs, such as prescription drugs, long-term nursing home care, and routine eye care. Adding together the costs of copayments, deductibles, premiums, and items not covered by insurance, 60 percent of Medicare recipients over age 65 spend more than 20 percent of their income on health care (Health Care Financing Administration, 2000: 27). To keep their costs to a minimum, almost all Medicare recipients purchase (or receive from their former employers) additional insurance known as **medigap policies.** (The poorest Medicare recipients may receive additional coverage through Medicaid, the government's program for indigent health care.)

Medicare faces increasing economic pressures from all sides. Medicare is primarily funded through federal Social Security taxes. Essentially, working adults pay taxes into a trust fund that pays the health care bills of the elderly. Because of our aging population, this financial structure cannot work in the long run (Health Care Financing Administration, 2000). In 2004, 14 percent of Americans received Medicare (DeNavas-Walt, Proctor, and Mills, 2004). If current trends continue, by 2030, when 22 percent of Americans will be eligible, federal researchers expect the system to go bankrupt, because there will be too few workers paying into the system to support it. Responding to this problem, Congress has instituted a long-term program for increasing Medicare premiums paid by consumers and reducing fees paid to health care providers.

### *Medicaid*

Whereas Medicare provides coverage to individuals based primarily on age, **Medicaid** (and S-CHIP, the associated the State Children's Health Insurance Program) provide coverage based on income and physical vulnerability. To receive Medicaid, adults must be both poor and either aged, blind, disabled, pregnant, or the parent (almost always the mother) of a dependent child. About 13 percent of Americans have Medicaid insurance, most of which comes through some form of managed care organization.

Medicaid is funded through a combination of federal and state taxes. States have considerable leeway to determine eligibility and benefits, however. In the last few years, as the current economic recession combined with political pressure to reduce taxes have reduced states' income, states have found it increasingly difficult to pay the expenses of running Medicaid programs (Pear and Toner, 2002). As a result, about one-quarter of poor children and half of poor adults are not covered (Kaiser Commission on Medicaid and the Uninsured, 2004). States also have reduced the amounts they pay to health care providers (physicians, hospitals, and nursing homes)

who work with Medicaid patients, leading many doctors to refuse to treat Medicaid patients except in life-threatening emergencies.

## "Big Pharma": Pharmaceutical Companies and U.S. Health Care

In addition to the health insurance system, the other "big player" in the U.S. health care world is the pharmaceutical industry, or "Big Pharma," as it is often known. Because it is a for-profit enterprise, Big Pharma's goal is not only to develop drugs but to sell those drugs. As a result, the pharmaceutical industry plays a major role in determining how doctors and the public think about illnesses and treatments and in the rising costs of health care.

### 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 ten pharmaceutical companies in the Fortune 500 surpassed the profits of the other 490 companies on the list combined (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 percent of their budgets. In contrast, marketing accounts for about 50 percent (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 whose work was funded by federal agencies (including medical school faculty, university professors, researchers working for small biotech companies, and some federal employees) to patent their discoveries and license those patents to pharmaceutical companies. This change gave these researchers a vested interest in supporting the pharmaceutical industry, and made it possible for the industry to dramatically decrease its own costs for research. 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. As a result, the company can set the price for that drug

***Box 8.2*** ***Making a Difference: 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.

as high as the market will bear, with no concern about competition. In addition, current regulations make it easy for companies to extend their patents by developing "me-too" drugs, which differ only slightly from existing drugs in their dosage, formula, or advertised target market. Me-too drugs now account for about 75 percent of all new drugs on the market (Angell, 2004). Third, the pharmaceutical industry won the right to market drugs direct to consumers, on television as well as in print media. Direct-to-consumer advertising—a $3.8 billion business in 2005—has proven highly effective. According to a nationally representative survey conducted in 2001 for the nonprofit Kaiser Family Foundation, 30 percent of American adults have asked their doctors about drugs they've seen advertised, and 40 percent of these received prescriptions for the drugs as a result (Brodie, 2001). Similarly, in one experimental study, pseudo-patients were sent to doctors' offices to request specific prescriptions, and more than half received them (Kravitz et al., 2005). 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 goes into effect in 2006, is expected to raise pharmaceutical profits even higher. 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 will pay more in premiums and deductibles for the drug program than they will save by enrolling in it. 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, for under the new law, Medicare (unlike private insurance programs) cannot restrict which drugs will be purchased and cannot negotiate with pharmaceutical companies to purchase drugs at bulk rates.

## 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? adults as well as children? persons with early as well as late-stage disease?), what are 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 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 articles published in medical journals and 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). 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 interest 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.

## 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 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. Once doctors graduate, the pharmaceutical industry continues to serve as their 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 now typically pay for-profit firms to organize these courses, and these firms in turn pay universities to accredit their courses (Angell, 2004).

In recent years, and as noted earlier, marketing directly to consumers has become as important as marketing to doctors. Since 1997, when pharmaceutical companies won the right to advertise brand-name prescription drugs on television, such advertising has skyrocketed. 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 treatments for diseases, but the diseases themselves. 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 as diseases. For example, a variety of neurological conditions (such as head trauma, stroke, Lou Gehrig's disease) can cause uncontrollable laughing or crying unrelated to individuals' emotional state. Avanir Pharmaceuticals markets the drug Neurodex to reduce these symptoms (Pollack, 2005). Although Neurodex seems to help some patients, its side effects are serious enough to cause at least one-quarter of users to stop taking the drug. Critics have questioned whether it is worth promoting a new, under-studied drug to individuals who have far more serious problems and must take numerous other medications.

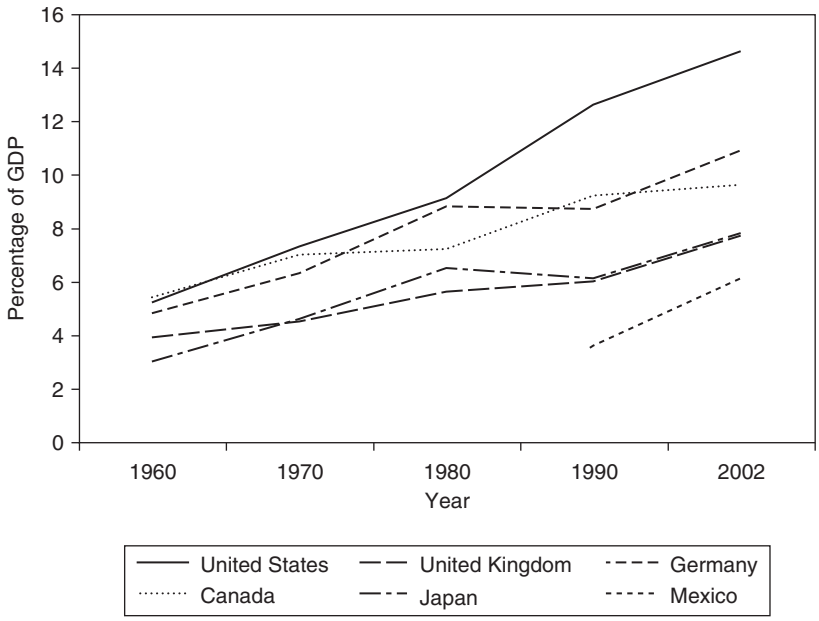
In addition to marketing Neurodex, Avanir is marketing the symptom of uncontrollable laughing or crying as a condition it has named pseudobulbar affect, or PBA. To convince doctors that uncontrollable laughing and crying is a disease, Avanir has advertised in medical journals and sponsored continuing education courses, conferences, and a PBA newsletter. Because the drug does not yet have FDA approval, none of this marketing can mention Neurodex by name, but it can talk about the need to treat PBA and mention that Avanir has a new treatment for this new "disease."

Avanir is also marketing the concept of PBA directly to consumers. It has targeted consumers through its PBA website and by giving educational grants to stroke and multiple sclerosis patient advocacy groups. For drugs that have FDA approval, direct-to-consumer advertising can go much farther, describing drugs by name and suggesting that consumers mention the drugs to their doctors.

## The Crisis in Health Care

Whereas the rise of managed care and the increasing power of the pharmaceutical industry have raised concern about the quality of care available in the United States, the increased costs of health care and the resulting decrease in access to it have challenged the very basis of the U.S. health care system.

*Figure 8.1* ***Expenditures on Health Care as Percentage of Gross Domestic Product, 1960–2002***




Source: Organization for Economic Cooperation and Development (2004).

## Rising Health Care Costs

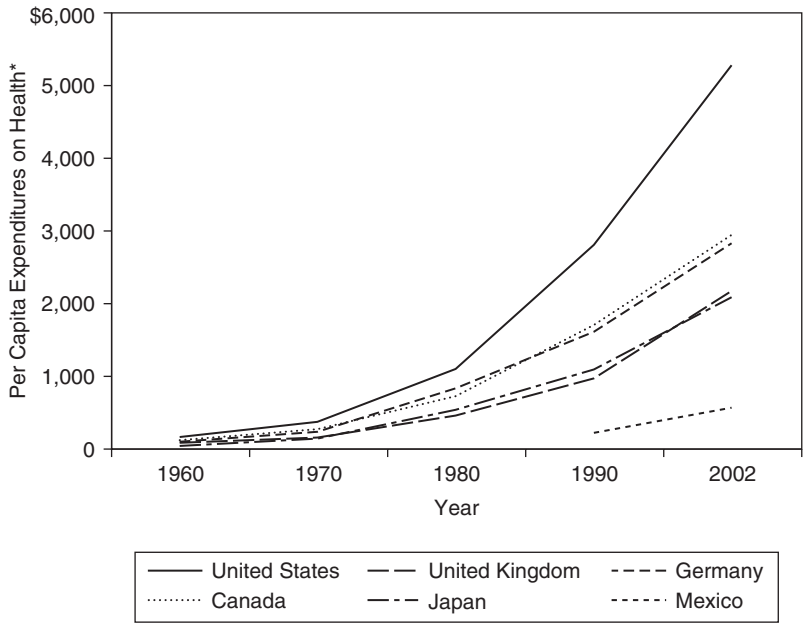
According to federal researchers, in the United States average costs per capita in 2003 for medical care, drugs, supplies, and insurance was $5,241, with expenditures expected to double by 2013 (U.S. Bureau of the Census, 2004: Tables 114 and 117). These costs continue to be higher and to rise more quickly than in other industrialized nations—far outpacing inflation, as Figures 8.1 and 8.2 show (Organization for Economic Cooperation and Development, 2004).

What accounts for the rising costs of health care? 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 care than do citizens of other nations. Yet on average, the reverse is true.

The second myth attributes our high health care costs to our unique propensity for filing malpractice suits. Yet malpractice insurance accounts for less than 1 percent of total U.S. health care costs (De Lew, Greenberg, and Kinchen, 1992). Even if we add the estimated costs of **defensive medicine**—tests and procedures doctors perform primarily to protect themselves against

*Figure 8.2* ***Per Capita Expenditures on Health, 1960–2002***




*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 (2004).

lawsuits—these expenses increase to only 4 percent of total health care costs. Moreover, those tests and procedures would offer doctors no legal protection if they were obviously unnecessary (Starr, 1994). Consequently, doctors might do the tests and procedures even if not pressured by fear of lawsuits. Nor would health care costs necessarily decline if doctors stopped doing defensive medicine, because they could still maintain their incomes by increasing the number of other services they provided.

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 (Population Reference Bureau, 2004).

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.

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).

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 submit bills to multiple insurers. 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. 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 can develop formularies of 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 we have seen, 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

can protect their incomes by increasing their charges for services or the number of services they perform. As a result, persons living in areas with the greatest numbers of doctors per capita receive more medical tests, surgeries, and other procedures and pay more for those services, with *worse* health outcomes as a result (Center for the Evaluative Clinical Sciences, 1996). 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 national 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 can and must create demand for their services. To do so, hospitals have added more beds, units (such as heart transplant units), and expensive technologies (such as CT scan machines), whether or not they are needed in their communities.

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 did not take into account 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, and taking advantage of the fact that patients often have multiple illnesses and that the same symptoms often suggest more than one diagnosis, doctors and 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 Medicaid patients, providers increased the fees they charged other patients.

## Declining Coverage

### *Uninsured Americans*

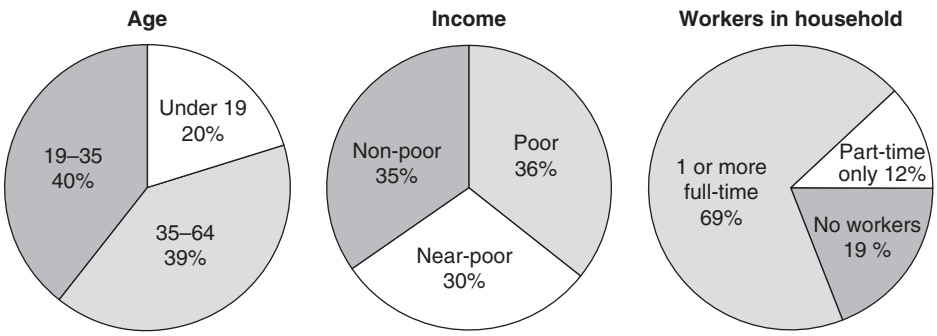
The rising costs of care have led directly to declining coverage. Whereas in 2000 about 40 million Americans were uninsured, by 2004, about 45 million Americans—18 percent of the population under age 65—were uninsured (Kaiser Commission on Medicaid and the Uninsured, 2004.) Moreover, almost two-thirds 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 working-age 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 purchasing insurance if it is expensive.

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 hiring more part-time and temporary workers without benefits. Consequently, in 2004, 69 percent of the uninsured live in families with one or more full-time workers (Kaiser Commission on Medicaid and the Uninsured, 2004). Not surprisingly, insurance coverage also varies by income level, with poor and near-poor individuals making up two-thirds of the uninsured (Figure 8.3).

Size of employer also affects the likelihood of insurance coverage. Almost all firms with 200 or more employees, compared to only 37 percent of smaller

*Figure 8.3* ***Uninsured Americans, 2004***




Source: Kaiser Commission on Medicaid and the Uninsured (2004).

firms, offer health insurance (Kaiser Commission on Medicaid and the Uninsured, 2004). 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 on the many healthy employees in the same firm.

Women and men are equally likely to be uninsured, but ethnicity plays an important role: About 33 percent of Hispanics, 25 percent of Native Americans, 21 percent of African Americans, and 20 percent of Asian Americans are uninsured, compared to 13 percent of white Americans (Kaiser Commission on Medicaid and the Uninsured, 2004).

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. The chances of a person being uninsured are about twice as high in parts of the South and Southwest when compared to the Upper Midwest, for example.

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** in which increasing costs and declining coverage each foster the other.

### *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 premiums, deductibles, and copayments; long waiting periods before insurance covers preexisting conditions; caps on insurance reimbursement per treatment, per year, or per lifetime; and lack of insurance for certain costs, such as nursing-home care and prescriptions. Data collected during 2003 indicate that 16 million Americans—most either chronically ill or with low to moderate income—are underinsured (Schoen et al., 2005). Just over half of underinsured Americans went without needed medical care during 2003 because they could not afford it, and just under half already have medical bills they cannot pay. 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). Another large national survey conducted in 2001 found that 8 percent of Medicare recipients, 8 percent of adults with insurance through their employers, and 26 percent of Medicaid recipients could not afford to purchase a drug their doctors had prescribed (Pear, 2002b). Because of these problems, many who live near Mexico purchase health care or prescription drugs there, and many who live near Canada fraudulently use the Canadian health care system (Rosenau, 1997; Vuckovic and Nichter, 1997).

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 self-insure (thus avoiding state insurance regulations) or negotiate a new yearly contract with an insurance company 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 as a way of receiving 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. According to a large national random survey by the nonprofit, nonpartisan Kaiser Commission on Medicaid and the Uninsured (2004), 47 percent of the uninsured (compared to 15 percent of the insured) had delayed seeking needed care due to costs. Similarly, 37 of the uninsured (compared to 13 percent of the insured) 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 percent more likely than other Americans are to die in any given year (Institute of Medicine, 2002).

## 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, it had become apparent that access to health care was a major problem among the poor and the elderly, including those who had enjoyed middle-class status earlier in life. Reflecting the rise of the civil rights movement, the growing belief in the power and obligation of government to improve Americans' lives, and the shift of labor unions toward supporting national health care, Congress in 1965 authorized 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 limit the threat to these industries, they 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 acceptable plan for completely overhauling a complex health care system. It also 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 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.

## Conclusion

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 health maintenance organizations (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.

For those who believe reform is necessary, the question of *how* to reform the system becomes paramount. In the next chapter we grapple with this question.

## Suggested Readings

Angell, Marcia. 2004. *The Truth About the Drug Companies: How They Deceive Us and What to Do About It*. New York: Random House. Former *New England Journal of Medicine* editor Angell explains how the pharmaceutical industry has grown so powerful and wealthy, and what consumers can do to protect their health and the health care system.

Himmelstein, David U., and Steffie Woolhandler. 2001. *Bleeding the Patient: The Consequences of Corporate Health Care.* Monroe, ME: Common Courage. A series of charts and tables that succinctly explains and describes many of the problems with health care in the United States.

Sered, Susan Starr, and Rushika Fernandopulle. 2005. *Uninsured in America: Life and Death in the Land of Opportunity.* Berkeley: University of California Press. Explains in gripping detail who the uninsured are and what happens to individuals' health, income, and lives once they lose their health insurance.

## 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.

## Review Questions

What is the nature of Blue Cross/Blue Shield insurance, and how does it differ from commercial health insurance?

Why did the originators of health maintenance organizations believe HMOs would provide better health care at lower cost than would traditional insurers?

What is managed care? How can it restrain health care costs, and how can it harm individuals' health?

What are Medicaid and Medicare?

Why have health care costs in the United States risen?

Who are the uninsured?

Why do individuals who have health insurance still sometimes face financial difficulties in paying their health care bills?

How can individuals lose their health insurance?

How does lack of insurance affect health care and health status?

## 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?

3. Go to the website for the University of California's Survey Documentation and Analysis (SDA) Archive. This archive contains data from several national random surveys. Enter the archive, and then click on the GSS Cumulative Datafile, 1972–2002, full analysis. *Bookmark this page.* Select "browse codebook," and then click on "start." Next, click on "Standard codebook." On the left side of your screen, under Indexes, click on "Alphabetical Index." Once you get to the alphabetical index screen, you will see that the left-hand side of that window shows the mnemonic names for all the variables in the General Social Survey, with a brief description of the variable to its right. Click on each of the questions on opinions of HMOs (HMO1, HMO2, and so on). At this point, you'll be able to see what percentage of respondents answered each of the different questions.

To find out how different groups felt about these questions, go back to the page you bookmarked. This time, select "Frequencies or Crosstabulations." Then click on "Start." A form with several blank spaces will appear on your screen. For row variable, type *HMO1.* For column variable, type *class.* Click on the boxes to the left of "Column Percentaging," "Statistics," and "Question Text." Then click the button to "Run the Table." Repeat, using first *sex* and then *health* as the column variables. Do the same thing, using as your row variable *HMO2* and then *HMO3.* Which groups have the most positive opinions of HMOs? Which groups have the least positive opinions?