Commentary

Politics Of America's Supply State: Health Reform And Technology

by Lawrence R. Jacobs

Explanations for the defeat of national health care reform in 1994 generally fall into two broad categories. First, insiders and journalists stress the personal characteristics of the persons involved—the difficult personalities of key officials and President Clinton's failings as a leader. Second, students of American politics emphasize the immediate context or situation surrounding the Clinton administration's and Congress's attempts to act on health care: A weak electoral mandate and a well-organized conservative opposition created unfavorable "conditions" for reform.[1] Although these factors obviously contributed, the political impact of America's distinctive structure of health care policy played an even more important role. The commitment in this country to expanding the supply of technologically sophisticated health care (what I characterize as America's supply state) creates structural pressures that discourage support among elites and the general public for comprehensive national health care reform. In particular, America's supply state has two enduring influences on the political process: It shapes how elites and the general public define their interests and goals, and it differentially affects the political capabilities and resources of politically active groups.[2] In short, America's established health policy produces political obstacles to reform that are more enduring and more deeply embedded than the personality traits or immediate conditions associated with any one particular point in time.

I begin this Commentary by discussing America's distinctive health care policy; this concept of policy refers to macro decisions that provide an organizing principle for what are otherwise discrete government decisions. One illustration of this kind of metapolicy is Canada's arrangement for financing health care and for limiting each province's discretion in designing its health plans. I then examine the impact of U.S. health policy on political struggles to reform the delivery and financing of health care.

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The Development Of America's Supply State

Health care policy in industrialized countries has developed along two interrelated dimensions: the sequencing of government decisions and the form of government policy. The first dimension refers to the time sequence by which governments widen access to health care and expand the supply of health services. The second dimension involves the degree to which the government expands the supply of health services and, specifically, the supply of hospital-based health services. Government involvement in the expansion of supply typically has entailed participation in the construction of medical facilities, the training of medical personnel, and, since the 1960s, the development of medical technology. Despite variations in the specific features of different nations' health care systems, it is clear that the general sequence and form of health policy in the United States diverge from those in all other industrialized nations.

The U.S. government's first and most generous involvement in health care focused on expanding the supply of hospital-centered, technologically sophisticated health care.[3] With the drive to expand access to health insurance deadlocked by the 1940s, Congress and interest groups found that a durable consensus could be built on expanding the supply of health care services. Under the Hospital Construction Act of 1946 (popularly named Hill-Burton after its sponsors, Senators Joseph Lister Hill and Harold Burton), the government dramatically increased the number and geographic dispersion of hospital beds. Instead of concentrating hospitals in regional centers or building general medical clinics, the American government constructed acute care facilities and encouraged the diffusion of hospitals to smaller cities and underserved rural areas. In addition, it expanded the number of medical personnel and actively promoted the training of physicians who would provide acute care rather than primary or preventive care. As a direct consequence of this policy, nearly 80 percent of American physicians are specialists.[4]

Finally, government policy—as implemented through the Departments of Defense and Energy and, especially, the National Institutes of Health (NIH)—has championed biomedical research and innovations in medical technology. NIH's budget has skyrocketed from $26 million in 1945 to $7 billion in 1990 (in 1988 inflation-adjusted dollars).[5] Although the government generally has supported the development and distribution of medical technology over the past half-century, detailed histories of NIH and such programs as Heart Disease, Cancer, and Stroke offer important illustrations of ambivalence about or failure in delivering high-technology medicine.[6]

The result has been the geographic dispersion of large numbers of acute care facilities, the stable employment of burgeoning numbers of acute care

personnel, and the growth of a large market for innovative medical technology. While other countries also have encouraged the development of medical technology, the U.S. government's unprecedented degree of involvement has contributed to the far greater availability of magnetic resonance imaging (MRI), radiation therapy units, organ transplantation, and other innovations than is the case in Canada, Germany, and other countries.[7] The expansion of supply has been financed by direct government subsidies as well as by insurance companies and Medicare, which reimburse hospitals for capital expenditures.

This emphasis on medical technology is not an unfortunate anomaly or oversight but rather a natural and indeed inevitable outcome of the government's promotion of sophisticated hospital-oriented health care. America's unparalleled level of health spending among Organization for Economic Cooperation and Development (OECD) nations is but the most visible sign of its priorities.

The government's efforts to increase access followed its supply-side commitments and evolved in a restrained manner: Access to care was granted as a condition of employment, age, and medical condition. The aged and disabled receive Medicare, the indigent are eligible for Medicaid, and persons with middle and upper incomes receive private health insurance as a nonwage benefit or purchase it themselves. The thirty-seven million Americans who are uninsured and the twenty to forty million who have inadequate health insurance coverage are but one indication that widening access has always taken a back seat to expanding the supply of health care.

The sequencing and form of American health policy are interrelated. When policymakers decided to expand supply and later to expand access under Medicare and Medicaid, they operated under comparatively simple assumptions about medical technology. The government's early commitment to a simple notion of supply locked it into a payment system that supported technology. Early decisions about supply fed into later decisions about access.

In contrast to the United States, however, other Western countries have made the expansion of access their first and primary priority; governments have accelerated the expansion of supply in response to widening access and growing demand for care. In European countries the national commitment to guaranteeing all citizens unimpeded access to health care evolved from private and voluntary arrangements, guided by the overriding principle that health care is a right of all citizens.[8] Most governments offering statutory health insurance also consider expanding supply an important function, but these governments historically have treated this function as secondary and possible to achieve without building the kind of hospital-oriented system that the U.S. government has encouraged. Other industri-

alized countries have geographically concentrated medical facilities; new medical programs have been placed in selected regional centers rather than being allowed to proliferate throughout the country. The comparatively constrained development of new medical facilities as well as government decisions about medical personnel have produced a relatively high proportion of physicians in general and family practice: 20–40 percent of physicians in other industrialized countries are specialists, while 60–80 percent are generalists.[9] Finally, the development and diffusion of medical technology has been limited by comparatively constrained facility development, greater emphasis on primary care physicians, and the exercise of governmental planning authority.

Canada, much like the United States in the immediate postwar period, expanded hospital capacity and failed to pass national health insurance. However, by 1950 four Canadian provinces had established government hospital insurance plans that formed the basis of a national program in 1957. In addition, both the general public and the leading political parties explicitly embraced the principle of universal health insurance.[10] Canada's government programs for all citizens were incrementally expanded according to service: first hospital care and then physician services. Although Canada relies on provincial (rather than national) government bargaining with providers, its health policy follows the same pattern found among European countries—an emphasis on access over supply.

Political Impact Of America's Supply State

Most discussions of America's promotion of technologically sophisticated, hospital-centered care focus on the financial consequences and, specifically, their contribution to America's exceptional level of medical spending.[11] The commitment in the United States to the supply of high-technology care, however, has both economic and political significance.

America's supply state has shaped its citizens' political resources as well as their conception of their interests and their definition of what seem like feasible and desirable objectives. Intense political conflict over the delivery and, especially, financing of health care is of course evident in all industrialized countries. The common theme is that individuals and groups demand a high level of services for minimal costs in a context of constrained resources and divergent values. American political conflict is distinctive because of the kind (and not simply the degree) of struggles over health care. What Americans fight over is starkly different from what citizens of other industrialized countries consider appropriate for and worthy of battle.

The factionalization of health politics. America's supply state encourages factionalization, in contrast to other advanced democracies in which

access preceded supply. In those countries institutional mechanisms aggregate individual interests, articulating a collective interest and forming something close to an "encompassing organization."[12] Statutory health insurance that provides universal coverage and relies on government involvement in funding encourages individuals to think of quality, access, and cost as affecting everyone.

The consequences of defining interests in inclusive and encompassing terms are twofold. First, hospitals, specialists, and other providers who are intensely committed to protecting their concentrated interests face countervailing pressures from general practitioners and interests outside the health care sector. Second, medical resources come to be understood in collective terms. The deterioration of care and cost control have clear penalties for the entire society in the form of substandard services, increased taxes, and more cost sharing. For instance, in Germany sickness funds are chiefly financed by collecting premiums through a payroll deduction, which averages approximately 13 percent of gross wages. Although this rate is split between employers and employees, the total premium rate is the focus of public discussion. A diffuse set of actors—unions, employers, and providers—all cue on that figure; when pressure builds to increase the rate, collective action to contain costs quickly follows. In Canada and many European countries, doctors, hospitals, and patients all accept the fact that providers may deny available medical technology after weighing the net benefits of health care against alternative uses of the funds.

By contrast, America's pattern of promoting supply and making access conditional on age, medical condition, economic status, and employment produces social divisiveness and discourages the mobilization of broad-based constituencies. America's health policies have created incentives for citizens to fight as individuals or small groups to champion what they see as their narrow interests.

Each component of the health care system—from access and cost to actual care—is perceived in factional terms. Making health insurance conditional invites Americans to equate their interests with winning classification in one of the covered categories and then protecting their benefits. Premiums for private insurance similarly encourage Americans to define their interests in individual terms—fighting on the basis of their personal health profile for the best deal that they can get. New York State's recent insurance reforms demonstrate the difficulty of introducing community rating into the current context: The inevitable rise in premiums for the young prompted 12 percent of individual policyholders to drop their coverage; the result was a net increase in the number of uninsured persons.[13]

Payers also adopt a factional approach: They equate their interests with minimizing their own expenses by shifting costs to others—patients, em-

ployers, or providers. The nation's overall health care spending is dispersed throughout the economy, and Americans gradually absorb these costs through such indirect means as consumer prices and nonwage compensation. The effect is to impose the financial costs of sophisticated care on the large but diffuse groups that receive and underwrite care.

Finally, patients, providers, and suppliers perceive clear stakes in providing maximal care for each insured person. Patients feel freed by third-party reimbursement to demand all available care; hospitals are reimbursed for purchasing, maintaining, and using medical technology; suppliers are eager to furnish new products for a well-paying and stable market; and physicians are financially rewarded and professionally trained to use every possible diagnostic and therapeutic service.

This factionalization and a dense pressure-group environment defeated two of the most recent efforts at systemic reform.[14] Jimmy Carter's proposal to establish centralized budgetary controls on annual hospital revenues and on the system's volume of capital spending was defeated by the political tag team of intense stakeholder opposition and subdued support for addressing the national problem of runaway health spending.

Bill Clinton's recent attempt to achieve cost containment and universal coverage faced a similar political tag team. One of the central issues in the Clinton plan was taxation. In an attempt to dampen opposition, the Clinton administration decided to avoid an explicit tax in favor of a more indirect payroll tax (an employer mandate). But both the explicit and the indirect payroll taxes faced the same political problem: They represented a collective action; that is, the government would be collecting, controlling, and dispersing money. President Clinton's dilemma was that health care reform required a collective mechanism for raising revenue, but the country lacked the means for mobilizing the diffuse actors behind programs that were perceived as advancing their "interests." Instead, Republicans gleefully exploited President Clinton's vulnerability; they drew on the Congressional Budget Office's (CBO's) evaluation of the Clinton plan to hammer it for proposing new federal taxes that would threaten individual Americans.

Not only did national health care reform lack aggregating mechanisms, but it also provoked a multitude of oppositional minority coalitions intent on protecting their stakes in the current system. One set of groups, such as representatives of unions and Medicare beneficiaries, offered conditional support: They backed reform as a whole but lobbied intensely to make sure that it did not jeopardize their existing benefits. Other groups also hedged support: The American Medical Association (AMA) and other physician organizations voiced concern about shrinking clinical autonomy and income; academic health centers complained that the Clinton plan would

undermine their financial positions and compel quotas on the numbers of primary care practitioners; and different geographic regions lobbied to ensure that the inevitable reshuffling of funds between and within different states did not come at their expense.[15]

A second set of groups stood to benefit from reform but opposed Clinton's plan nonetheless. Large businesses stood to gain from controlling cost escalation and the incidence of uncompensated care, but their umbrella organization—the Business Roundtable—opposed the Clinton plan because of innate ideological hostility to governmental social regulation and intense pressure from a few members (namely, health insurers) that had large stakes in the existing system.[16] Similarly, health maintenance organizations (HMOs) also stood to profit from the Clinton plan's efforts to increase their number but voiced strong reservations because of fears about governmental regulations and requirements to accept poor people.[17] A third set of interests, including small businesses, pharmaceutical companies, and small and mid-size health insurers, were implacable foes of what they saw as a dire threat to their survival.

In nations where access has preceded supply, the health system encourages the development of shared or collective interests; all patients and providers feel the impact of health policy decisions. The interests of successful employees and the aged are tied to the general interest rather than to discrete programs and identifiable services. By contrast, the American health care system promotes individualism and social divisiveness, pitting Medicare recipients and employees of large firms with generous health benefits against those who lack access to similar levels of care. During 1993 and 1994 Americans became increasingly concerned about the personal costs rather than the national benefits of health reform. Reiterating a concern voiced by many policymakers, Drew Altman, president of The Henry J. Kaiser Family Foundation, observed that "the American people want change as long as it doesn't cost them too much or affect them too much personally."[18] Although the media and political elites have contributed to the public's increasing focus on self-interest, America's supply state makes the public especially predisposed to individualistic appeals and resistant to collective considerations.[19]

The fiscalization of access. Health policy decisions also feed back into political deliberations by influencing the perception and definition of new problems as they emerge. The central problem in all Western countries since the 1970s has been rising health expenditures. Although all of these countries have wrestled with health costs, cost escalation has been understood and framed in the United States in dramatically different terms than it has been elsewhere.

In other industrialized countries the escalation of health expenditures

has been defined as a problem involving the supply of care. This has meant that in Canada, for instance, cost escalation during the 1970s was addressed by a series of strict limits on health care supply: the strict imposition of prospective budgets and physician fee schedules, and the confinement of new medical technology to teaching hospital centers. Germany, France, Great Britain, and other Western governments also used prospective hospital budgets, physician fee schedules, and physician practice style (for example, the gatekeeping function of British general practitioners) to constrain the supply of expensive, sophisticated services. These constraints on supply have produced the significantly lower levels of health spending and use of specialized services than exist in the United States.

Medical professionals in these countries have fiercely resisted restrictions on the supply of services. Doctors warn that quality and patient "need" are being sacrificed. However, governments have overcome professional opposition and successfully offered an alternative definition of "need." A diverse group of politicians, employers, and employees equates quality with the average care available for the entire population, accepting that cost and the demonstrated effectiveness of medical interventions are legitimate considerations.[20] Because equal access to available health services is a guiding principle, care is rationed in Britain, Canada, and other countries on the basis of relative medical need as determined by physicians' judgment.

In the context of America's dense pressure-group environment and absence of aggregating mechanisms, cost escalation has not been defined as a problem of excess supply, and attempts to restrict the supply of health services have been blocked. Cost control efforts in the 1970s began by narrowly focusing on modifying the clinical behavior of providers.[21] By the 1980s cost containment shifted from behavioral to budgetary regulation. In contrast to the centralized budgetary controls established in European countries, American efforts were disjointed and indirect. Hospitals and physicians continued to be reimbursed by numerous and uncoordinated channels of payment, and new government prospective payment systems avoided direct controls over spending on non-Medicare patients. Moreover, the U.S. private sector continues to reimburse doctors on the basis of innumerable, distinct payment scales; other Western countries base physician fees on clearly specified and uniformly binding schedules. The guiding theme in this country has been to minimize disruption of the existing system of health care delivery.

The recent defeat of health care reform illustrates the difference in the handling of cost escalation between the United States and other industrialized countries. President Clinton's efforts to control costs were snared by two contradictory pressures. On the one hand, Republicans, some Democrats, and many commentators warned that universal health insurance

would increase taxes or costs for employers and employees who were already insured.[22] The recurrent question was: Could the country afford to provide universal access to high-technology care? The focus on the cost of expanding access rather than on the expense of operating sophisticated health care delivery systems was a natural and inevitable consequence of America's supply-side orientation. On the other hand, when President Clinton responded that the country could afford universal access if it restructured its supply of health services, he ignited a political firestorm of opposition. To build the foundation for universalism, the White House proposed a global budget to be enforced through a cap on tax-favored premiums; an increase in the proportion of primary care physicians; a significant change in long-standing practice patterns; and a reduction in the number of hospital beds and redundant medical programs.

The president's attempt to restructure health services frontally challenged America's supply state and was met by fierce attacks from physicians and politicians and by deep public uneasiness. The rallying cry was that quality was being sacrificed; patients would be "shortchanged" and denied useful tests and treatments.[23] In contrast to their Western counterparts, Americans define quality in terms of maximum technology to alleviate medical problems and prolong life. Although research indicates that many health services in the United States lack scientific basis and upwards of 30 percent of some treatments fail to produce beneficial outcomes, governmental efforts to redirect the supply of care could not have avoided being equated with inferior quality.[24]

In an era of constrained resources, the United States faces a choice between limiting access and restraining supply. Successive governments since the Nixon administration have failed to define excess supply as the cause of cost escalation and to establish centralized budgetary controls over supply. Instead, governments have opted to accept limits on access and to defer to the dynamics of the private sector. Free to play by their own rules, private insurers have been driven by cost considerations to drop claimants, deny benefits, and shift the cost of care to consumers via cost sharing.

In short, all other industrialized countries have equated cost escalation with excess supply and pursued the question: Can the country afford to continue to supply the same mix of services? In the United States, though, cost control efforts have fiscalized access and demonized attempts to redirect health resources from the country's system of sophisticated health care.

America's supply state shapes the meaning or rationality of political struggles over health care. The perception that some policy alternatives are "possible" while others are unlikely to be selected has been structured by previous policy choices. It is the height of political practicality in the United States (and nowhere else) to accept uneven access to available

medicine as unavoidable while continuing to encourage the supply of newer and more advanced medicine.

Mobilization Of Political Resources

In Canada and Europe national forums of negotiations have developed among providers, government ministries, and others that hammer out approaches to controlling cost while keeping health services universally available. As a result of these patterned interrelationships of bargaining, organized interests are challenged by regional and national policy organs. Pressure from the medical profession in France is offset by the resources of a centralized government.[25] In addition, national forums of bargaining coalesce or organize wage earners and employers, both of whom also counteract the pressure of health care providers. In short, health policy in other industrialized countries favors strategies of national mobilization and arguments based on the national benefits of cost control and continued universalism.

Health policy in the United States, however, has encouraged the formation of well-funded, decentralized interest groups. Washington disperses authority and funds for health care to a number of national government offices as well as to state and local governments. Groups that can closely mesh with America's system of federated, tripartite policy making are advantaged by this approach to public policy.[26] Relatively cohesive stakeholders can regularly interact with and influence policymakers at the national and state levels. The general public, however, lacks comparable opportunities for exerting countervailing pressure at these sites of decentralized decision making; broad-based constituencies are disadvantaged by the absence of aggregating mechanisms and inherent difficulties in forming cohesive federated organizations.

For instance, providers have enjoyed unusual success in lobbying the Department of Health and Human Services (HHS) as well as state governments throughout the country. The medical profession and hospitals influenced the Health Care Financing Administration's (HCFA's) implementation of the "reasonable and necessary" clause and its formulation of the physician fee schedule. One recent study of HCFA's handling of the fee schedule suggests that providers effectively supplemented their formal involvement with early and ongoing informal contacts.[27] Providers also lobbied HCFA indirectly through Congress; after the initial publication of the physician fee schedule, groups mobilized members of Congress to charge that HCFA had violated statutory intent and to demand further revisions of the schedule.

State agencies have found themselves outgunned by providers. For in-

stance, in the 1970s 205 agencies were established around the country to implement certificate-of-need legislation and to control the spread of medical technology. These small agencies were simply overwhelmed by organizationally coherent state bodies of doctors and hospitals.[28] Government encouragement of a decentralized approach to health policy gives the advantage to stakeholders who have the concentrated incentives to press their interests in dispersed settings.

Major stakeholders also took advantage of their federated organization to fight against national reform. Small businesses—specifically, the National Federation of Independent Business (NFIB)—were especially successful at directly lobbying individual members of Congress by mobilizing geographically appropriate members. The NFIB's well-funded national organization used advertising to play on the public's fear that health care reform would cost jobs.[29] Health insurers similarly drew on both grass-roots organizing and national pressure. Academic medical centers fought the Clinton proposal's requirement that they train more primary care doctors; they rallied members of Congress to help them preserve the current dependence on specialized care. What was notably missing from the recent debate was organized pressure for outcomes beneficial to the large but diffuse number of Americans who lack a concentrated stake in the current system.

Concluding Comments

Passage of national health care reform that controlled medical costs and universalized health insurance seemed quite probable following Bill Clinton's election. The political context for national reform appeared promising as the Democratic party assumed control over both law-making branches and as some members of the medical profession and the business community became active, visible supporters of change. Moreover, the rationale for reform seemed unassailable. Reform was necessary and functional for America's economic and political systems because rising health care costs were undermining the middle class's security and the country's global economic position. Comprehensive national health care reform, it was argued, would preserve the country's well-being by correcting irrational features of U.S. health care: It would squeeze out excessive administrative complexity, cut exorbitant malpractice judgments, and end inadequate insurance coverage that wastefully encouraged excessive hospitalization among the poor because less costly primary care was unaffordable.

Despite the optimism following the 1992 election, comprehensive national reform faced three obstacles that were underappreciated at the time of Bill Clinton's inauguration.[30] First, pursuing what was functional for the country's political and economic systems—controlling rising health expen-

ditures and satisfying unmet human need—was not sufficient to force comprehensive reform through Congress. Politics and the inevitable struggle over competing values and interests unavoidably permeate policy making, and the outcome can be detrimental to the country's economic and political systems. Second, recent analyses suggest that the optimistic appraisal of health care reform's prospects following the 1992 election gave insufficient weight to the unfavorable conditions at the time.[31]

Finally, America's long-standing commitment to expanding the supply of sophisticated care produced a political dynamic that inhibited support for universal access and cost control. America's supply state reinforces current stakeholders' authority and promotes prevailing perceptions of status and class differences—perceptions that highlight self-interest and the personal costs of universalizing access to health care. These political obstacles are augmented by professional and financial pressures to expand the use of medical technology. Comprehensive reform is obstructed, then, not just by the liabilities of a particular president's leadership style or immediate circumstances but also by the established pattern of health policy that empowers stakeholders and fuels an individualistic political rationality.

Prospects for future reform. The confluence of political circumstances and structural conditions offers important insights in explaining the probability of enacting national health care reform. Reform efforts have the highest probability of success when they converge with a favorable political situation (that is, the president has won a landslide election and his political party enjoys a large, ideologically compatible majority in both legislative chambers) and when the proposed reform is consistent with America's supply state. Thus, Lyndon Johnson's success with Medicare came after the 1964 Democratic landslide victories and reformers' decision to pursue an incremental approach to health care reform instead of Harry Truman's plan to restructure the existing health care system.

Health care reform faces the stiffest odds when political circumstances and structural conditions are both unfavorable. This was the case in 1994. In addition to facing adverse political circumstances, the Clinton administration frontally challenged America's system of supplying high-technology care by proposing both centralized budgetary regulation and a comprehensive restructuring of health care delivery.

The prospect of successful reform enters a zone of uncertainty, though, when either (but not both) political circumstances or structural conditions are favorable. Lyndon Johnson decided after the 1964 election to minimize uncertainty by sticking with Medicare's incremental approach rather than proposing a more ambitious restructuring of the health care system.[32] In a context of unfavorable political circumstances, policymakers can boost the probability of their proposals' success by not directly targeting the supply of

sophisticated care. Although Bill Clinton's campaign promises precluded the chance of incremental reforms, proposing reforms that were less threatening to current structures would have improved the odds of political success.

The structural features of American health policy and the associated political dynamics do not eliminate the possibility of U.S. health care reform. The focus on the obstacles to comprehensive government reform should not obscure the fact that the private sector is profoundly restructuring the health care financing and delivery systems. Moreover, the political dynamics created by America's supply state complicate (but do not prohibit) governmental reform. Significant political and social upheavals comparable to those of the 1930s and 1960s would probably be necessary for the government to restructure the current health care system.

Redirecting the focus of reform efforts away from restructuring the supply of health services and toward incremental change would improve the political prospects for government action. Among the commonly discussed incremental changes that might be successful are proposals to reform health insurance markets and Medicare (to encompass children).[33] In addition, the political prospects for successful reform may be more promising at the state level where there is greater opportunity for experimentation and stakeholders' opposition is more uneven. Modifying the Employee Retirement Income Security Act (ERISA) to allow state government regulation of all employers would encourage state innovation.[34]

The lesson of the past two years is that previous government policy has created a trap: It is financially ruinous to open access to an unrestrained supply of ever-developing medical technology, and yet it is politically treacherous to attempt to restructure the supply of high-technology care. Pursuing incremental strategies provides an opportunity to maneuver out of this trap and the enduring political inhibitions that perpetuate it.

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NOTES

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