© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

CHAPTER 2

American Exceptionalism—Structural and Conceptual

Healthcare reform in the United States has been a roller coaster ride for 50 years or more. Presidents Truman and Nixon made proposals for reform that were not really acted on. Lyndon Johnson's 1965 Great Society legislation establishing Medicare and Medicaid set the stage for the current pulling and hauling. Since the Clinton "health security" proposal in 1993, we have seen many attempts by Congress and successive administrations to address the mounting problems of access, coverage, and cost.

Even the George W. Bush administration pushed a significant change in the delivery system based on subsidized interoperative digital health records. Then the Affordable Care Act (ACA) became the law of the land. After the 2016 election, Congress and the Trump administration were committed to unwinding it and moving back toward the prior system, but promising to hold down the proportion of the population without health insurance. Their efforts to repeal and replace it in 2017 failed because of splits within their party in the Senate.

The roots of the turmoil have been structural, conceptual, historical, and political.

The emergence of a generalized concern about the issues of healthcare policy has paralleled:

- The ability of the medical system to treat more and more diseases and syndromes
- Higher than average rates of inflation in professional service sectors, including higher education and health care
- Freeing up the health sector to marketing and advertising, triggering rising expectations and demand
- An aging population with fewer full-time workers to support Medicare and Medicaid
- The obvious successes of other national health systems in providing as much or more with less

This, coupled with a period of declining personal income growth, has put many families in a bind and contributed to a feeling of being left behind. Health

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

care with its growing share (18% in 2015) of our economy and employment cannot be ignored.

This chapter deals with a number of structural and conceptual issues. Subsequent chapters deal with historical and political ones.

Key Structural Issues

There are a number of structural issues virtually unique to the United States' situation:

- Constitutional guarantees of states' rights
- The bureaucratic dispersal of healthcare programs
- The separation of healthcare demand and health professions supply
- Uneasy balance between public and private financing
- Conflicts between consolidation and market competition

Constitutional Guarantee of States' Rights

If everyone is in charge, then no one is in charge. Health policy is problematic throughout the world, but it is particularly challenging in the United States where there is no consensus about which government agency or social institution, if any, has an accepted, legitimate role of developing or implementing national health policy. The U.S. Constitution is silent on the subject of health and health care. Although its preamble promises "to promote the general Welfare," the Tenth Amendment states, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." The omission of health, however, cannot be attributed solely to the framers' intent, despite the presence of three physicians at the Constitutional Convention. They lived in a world of "evil humours" where one visited "barbers and chirurgeons."

Constitutional issues almost derailed the ACA before the Supreme Court. In 2012, the Court, by a 5–4 vote, upheld the constitutionality of the "individual mandate" provisions that require most individuals to carry basic health insurance or pay a penalty on their income tax return. At the same time, it overturned a provision requiring states to expand Medicaid access, ruling that it was unconstitutional because it coerced the states to provide coverage.

The Trump administration and the Congress opposed the federal insurance exchanges under the ACA and sought to block-grant Medicaid to the states. The latter has always been a state program with close federal supervision and a lot of experimentation going on under Section 1115 and 1123 waivers. Repeal and replace legislation would have given even more flexibility to the states, including a possible work or service requirement for able-bodied individuals, but would have sharply reduced the federal portion of Medicaid funding over time.

Bureaucratic Dispersal of Healthcare Programs

Given the highly visible opposition of organized medicine to Lyndon Johnson's War on Poverty, the health components of these new programs were housed outside of the U.S. Public Health Service. For example, the Office of Economic Opportunity

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

started neighborhood health centers, and its Head Start program provided health assessment and healthcare components for children.

When the Johnson administration finally secured passage of the Social Security Amendments of 1965, it accommodated American Medical Association (AMA) concerns by offering three separate programs: (1) Medicare Part A, which provided hospital coverage for most older persons, mirroring the existing insurance relationships; (2) Medicare Part B, a voluntary supplementary medical insurance program that paid doctors directly on a fee-for-service basis; and (3) Medicaid, which expanded the Kerr-Mills welfare programs under the Welfare Administration with its traditional federal-state partnership. Meanwhile, the Department of Defense, the Veterans Administration and the Indian Health Service continued to operate separately. Furthermore, the Employee Retirement Income Security Act of 1974 included a provision called the deemer clause that exempted self-insured employer health plans from the usual state regulation of health plans.

Public health services are split between the federal, state, and local government levels. Research and oversight are at the federal level, including the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and Food and Drug Administration (FDA), while state laws govern public health practice and professional licensure, and local health departments deliver public health services and sometime care.

Separation of Healthcare Demand and Health Professions Supply

In most countries, a Ministry of Education or the like determines how many doctors and other health professionals to train annually and allocates resources to educational institutions for that task. There is the opportunity to coordinate that process with the perceived demand for health services. Admittedly, the linkage is often not what it could be due to bureaucratic and interpersonal issues and budget constraints. U.S. educational institutions make their capacity decisions quite independently. Congress and the states step in occasionally to support expansion of programs to cover acute shortages or to promote new approaches, but the supply is left pretty much to the free market.

There is little or no impetus for reducing the output of specific types of providers, and this upward bias contributes to the sector's cost inflation. In fact, some efforts aimed at limiting numbers of specialists trained and credentialed have given rise to suits charging a conspiracy in restraint of trade.

Uneasy Balance Between Public and Private Financing

The U.S. system is usually described as a private healthcare system. That is true in the sense that most providers are employed in the private sector. But financing of health care is split pretty evenly between the governmental and private sectors. This has produced the unique situation that the U.S. "private" system spends more public money per capita on health care than most other developed countries spend in private and public funds combined (OECD, 2017).

Conflicts Between Consolidation and Market Competition

Consolidation of healthcare organizations continues at a rapid place. This has been driven by numerous factors:

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

- Needs for better coordinated care
- Economies of scale
- Enhanced bargaining power
- Weak antitrust legislation and enforcement

Poor coordination of care is known to be a major factor driving up costs and reducing quality. It has motivated case management, medical homes, bundled payments, and investments in information technology. But one effective way to achieve coordination and align incentives is to have a single manager over the entire process. The decades of success of financially integrated systems, such as Kaiser Permanente and Intermountain Health, are a case in point.

Economies of scale are a frequent justification for consolidation—touted benefits include the elimination of duplicated managerial and staff positions, improved access to capital, and reductions in redundant services. So far, it is hard to notice the cost impact of these effects in the face of higher executive salaries and increased prices.

The most visible impact of consolidation is increased pricing power (Dafny & Lee, 2015; Scheffler & Arnold, 2017). Consolidation has left midsized cities and even some large ones with only two or three hospitals, which insurers need to make their networks competitive. This applies elsewhere in health care (Fowler, Grabowski, Gambrel, Huskamp, & Stevenson, 2017). The most egregious example of pricing power has been the large and rapid price increases for low-volume drugs when a single supplier is left in the marketplace. Patents and regulations can enable legal monopolies and oligopolies. Havighurst (2017) observes that monopolies and oligopolies are especially pernicious when they are paid through insurance. Gaynor and Town (2012) estimate price increases with hospital mergers in markets with few hospitals at up to 20% and found little evidence of quality improvement.

Weak healthcare antitrust laws make remedies hard to find. They are further weakened by state and local resistance to enforcement and by political support for local institutions. Underfunding for enforcement and the large number of potential cases is also a problem (Greaney, 2017). Effective judicial remedies are hard to develop given existing regional flows of people and information, as well as regulatory and capital investment barriers to entry.

Key Conceptual Issues

There are many differences in how individuals and groups see the possibilities for improving the system. Among the key conceptual issues are:

- The extent to which health care is an entitlement
- Contending visions for controlling quality and cost
- Ownership and enhancement of intellectual capital

Extent to Which Health Care Is an Entitlement

The position that everyone should have coverage regardless of income has steadily gained traction in American society. Paradoxically, no assumption gets more attention than whether health care is a right. A yes or no answer gets us nowhere

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

(Gawande, 2017). Is one talking about antibiotics for a serious illness, cosmetic surgery, or *in vitro* fertilization? Again, there is a need to try to define what one is arguing about, rather than repeating assertions based on undefined assumptions.

But coverage to what extent? That debate has been evident in policy decision about access and coverages before, during, and after the ACA. The ACA included a provision requiring plans subsidized on the exchanges to meet "minimum essential benefit" requirements. Qualifying plans under the ACA had to offer a basic package that included preventive services, maternity benefits, and behavioral health care. This concept of a "minimum essential benefit" was a lightning rod in the bill. It led to the cancellation of some less expensive existing policies and upset individuals who believed these cancellations broke election promises that they could keep their current insurance. Proponents of ACA repeal have talked in terms of assuring that all people can get the benefits they can afford. That has been linked to tax credits that seem quite small compared with the amount necessary to purchase a package like those meeting ACA requirements. Should we allow and subsidize plans that fail to provide extensive support in case of a major adverse event—the purpose of insurance in most other settings?

The 2017 Republican American Health Care Act submitted to the House and the subsequent Senate version included major changes to Medicaid, essentially limiting the federal government's liability and increasing both the liability and flexibility of state programs. One change insisted on by the conservative caucus was to allow a work or service requirement for able-bodied recipients. This, however, lost votes from more centrist Republicans.

McClure, Einthoven, and McDonald (2017) argue that the right vs. left arguments over universal health coverage miss the point. They argue for universal coverage not as a right, but as an important public investment. "If you want to outcompete a billion Chinese, you better have a workforce not only better-educated, but healthier than anyone else." They back up their arguments by making reference to the "general welfare" clause of the Constitution. They go on to suggest that if the system is treated as a public investment, incentives should be realigned to reduce costs by 15%–20%.

Gawande (2017) observes that compared with Medicaid, support for Medicare is not as conflicted. A long-term set of contractual rules have bound the public to Medicare. He cites the first attempt at universal coverage in the United States, the Vaccine Act of 1813, which provided cowpox-based smallpox vaccine from a private supplier to everyone free of charge. However, that law was repealed in 1822 after a batch infected with smallpox caused an outbreak in Tarboro, NC. But gradually we have achieved near-universal coverage through cooperative activities between the federal government and state and local governments.

> What we agree on, broadly, is that the rules should apply to everyone. But we've yet to put this moral principle into practice. The challenge for any plan is to avoid the political perils of a big, overnight switch that could leave many people with higher costs and lower benefits.
>
> (Gawande, 2017, p. 54)

Contending Visions for Controlling Quality and Cost

There are a number of ways of looking at our healthcare system and how it might be organized and controlled. **BOX 2-1** suggests how someone happening onto our health policy landscape might end up quite confused.

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

BOX 2-1 Arriving at Healthville for the First Time

In late 2017, a passenger airliner was on the landing approach to the new Healthville airport. This was the pilots' first visit here and they seemed confused.

Pilot to Healthville Control Tower: What approach are we on? We are getting three sets of signals at once!

Control Tower to Pilot: That is the way we see things around here. You will just have to get used to it.

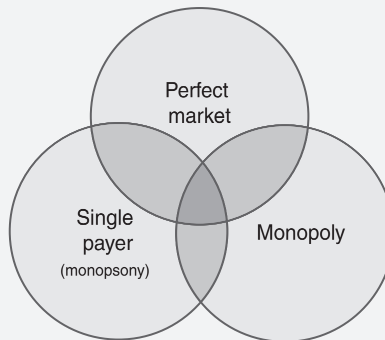
Pilot: What do I do next?

Tower: Circle and consult the Manual.

Pilot: Under which topic?

Tower: Lenses

They circle while the copilot frantically searches and finds the following page under Lenses.



MANUAL SECTION 2.1.23.B.I

They look down and select Runway CL3 which looks most familiar. They land smoothly and begin to taxi.

Pilot to Ground Control: Taxiing on CL3, awaiting Ramp Instructions.
No response.

Pilot to Tower: I cannot rouse Ground Control!

Tower: There isn't any Ground Control here!

Pilot: Need ramp to gate instructions.

Tower: There are three clusters. Look around. They crisscross each other everywhere and most any route will get you there. Just feel your way in.Finally. At the gate.

Copilot to Pilot: That was a great job navigating through the short-term parking lot.

Pilot: Thanks. It was OK given that we're paid by time and mileage. But next time we need a roadmap to avoid the parking lots.

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

Conflicts between different visions of how the health system should operate have dominated U.S. healthcare policy making for almost a century.

> The PPACA is in some respects a conglomeration of some of the pieces of past proposals for major healthcare reform. The provision of health insurance coverage through private insurers instead of directly through the government, employer mandated health insurance, the creation of state, regional or national clearinghouses for insurance, federal subsidies for low income individuals, and "guaranteed eligibility" have all been proposed in previous attempts at reform.
>
> (Taylor, 2014)

The three distracting lenses represent ideological abstractions.

Three related but significantly different lenses have emerged and been more or less dominant at different times. Yet there has not been a single dominant viewpoint since the 1960s, and all three contending approaches have remained on the table. We have labelled them: Corporate Lite, Managed Competition, and Consumer-Driven Care.

Another possibility, a provider monopoly, has been ruled out by our legal system, even though there are current problems with antitrust enforcement in the healthcare sector. The extreme monopsony position, the *single payer*, can be represented by the original version of the United Kingdom's National Health Service. This model is not currently a realistic contender for adoption in the United States.

Corporate Lite

Corporate Lite dominates the status quo as health care industrializes and consolidates. Many of the compromises in the ACA were made in deference to the lobbying power of established payers and providers to get them on board. The 2017 attempts to repeal and replace Obamacare failed to recruit industry backing and was heavily opposed.

This oligopolistic competition model involves a market dominated by a few large sellers and is a characteristic of many U.S. industrial sectors including health care. Usually, three or four major sources for goods or services exist, and those sources together control at least 40% of the market. In health care, two, three, or four providers often control state or local markets in the absence of a national market. In health insurance, there is a near monopoly in many markets. National oligopolies appear to exist in many other health-related markets, such as Medicare managed care, replacement joints, imaging equipment, and pharmaceuticals distribution. Concentration in hospital markets has been increasing sufficiently to become a concern of the Federal Trade Commission (FTC). Although available studies of hospital concentration can yield conflicting findings (Gaynor & Town, 2012), there can be little doubt that concentration increases pricing power. In many state markets, the same is true of health insurance providers. It is widely believed that market power has shifted in recent years from insurers to providers, especially larger hospitals and their associated group practices.

Examples of the approaches often associated with each lens are include in **TABLE 2-1**.

Many of the policy approaches associated with Corporate Lite maintain the status quo (employment-based insurance, current pricing methods, self-regulation).

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

TABLE 2-1 Approaches Associated with the Lenses

What Is Managed Competition	What Is Consumer-Driven Care	What Is Corporate Lite
■ "Sponsor" to manage system ■ Evidence-based medicine ■ Competitive bidding among health plans ■ Penalties for readmissions, HACs, etc. ■ Administered prices ■ Reference pricing ■ Value purchasing (bundling) ■ Certificate of Need	■ High deductible insurance with tax-sheltered gain-sharing ■ Consumer ratings ■ Quality transparency ■ Price transparency ■ Multistate insurance ■ Competition ■ Insurance exchanges ■ Premium tax credits replacing employer payments ■ Individual mandate	■ Employed physicians ■ Self-regulation or "get the incentives right" ■ Employer-based insurance ■ Organizational learning and peer enforced change ■ Competition on reputation and amenities ■ Reasonable & customary + Relative value scale (the physician's Red Book) ■ Consolidation/market dominance ■ Lip-service about disruptive innovation

Consolidation has led to many more employed physicians and to attention to institutional learning and control of practice methods.

Managed Competition

Managed competition implies that there are multiple suppliers but that the market is strongly influenced by a powerful buyer or "sponsor," usually a government creation (Einthoven, 1993). When the sponsor is a government, this is sometimes referred to as administered competition. It may involve universal coverage, a single disbursement agent, and/or a single underwriter. Somewhere in the mix is a "sponsor" with sufficient clout to keep the system in line. Currently, price competition is avoided, but increased share of market is prized. Access is gladly increased and competition is based on reputation, amenities, and availability, but seldom on price.

The size of governments' stake in financing health care has been one driver of this approach. Health policy makers have also observed that many other developed countries have resolved their access issues by having tightly managed universal health coverage. Yet another factor is the belief that there are attributes of health care that make it an imperfect market and that a managed approach is necessary to overcome the results of market failure (Arrow, 1963).

Those in charge of payment want rational decision-making. So, measures are put in place to restrain the arms race among hospitals and to penalize poor care such as unnecessary readmissions and hospital-acquired conditions. Proponents of managed competition act to align incentives to encourage price competition among all

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

providers and insurers. Given sufficient market power, these managers might want to have clinical decisions made on the basis of evidence, support value purchasing, promote reference pricing, and ultimately set prices.

Consumer-Driven Care

Consumer-driven health care is more of a free-market approach that assumes consumers' choices will help shape the market if consumers have accurate and adequate information and are not subject to perverse incentives. This approach is driven by a free-market ideology reinforced by American individualism. We want our choices among doctors, hospitals and insurers.

Perfect (free-market) competition assumes the following conditions:

- There are large numbers of buyers and sellers so that no one controls prices.
- All buyers and sellers have complete and accurate information about the quality, availability, and prices of goods.
- All products have available perfect substitutes.
- All buyers and sellers are free to enter or leave the market at will.

Free-market ideology has been playing out in health care even in the absence of a true free market. It goes by several names—*consumer-driven health care* is one example, as is *market-driven health care*. Supporters of this approach call for much greater transparency and more consumer choice and responsibility. It has been implemented, in part, through innovations such as health savings accounts (HSAs) and private options for Medicare. Insurance exchanges are another manifestation of this approach and were initially suggested by conservative think tanks that support a free-market approach.

Early attempts at managed care ran into strong resistance. A more recent approach has been the movement to empower consumers to be much more involved in making choices about their care. Proponents of consumer-driven care typically support high-deductible health insurance with HSAs. They were also early supporters of the individual mandate and insurance exchanges, especially ones that allowed multistate insurance competition. Consumer choice is supported by efforts to overcome information asymmetry and make available data for comparisons of consumer experience, outcomes, and cost.

More recently, strong proponents of market solutions have revived the concept of nonrefundable premium tax credits. For the poor, they would allow individualized purchase decisions. They would require high-risk pools behind them to assure affordability. As a strategy for universal coverage, the credits would replace the employer contribution, partly financing the credit by eliminating the tax deductibility of employer contributions. This strategy would do away with a standardized coverage and allow the individual to pick and choose from a wide variety of plans. The primary objective would be to unleash competition to reduce costs. This, however, would require enhanced anti-trust enforcement and having the credit rising at a slower pace than healthcare costs.

Living with All Three at Once

So how do these three lenses relate to the confusing picture of healthcare reform? **FIGURE 2-1** provides a very rudimentary roadmap. In it, all three relevant visions have

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

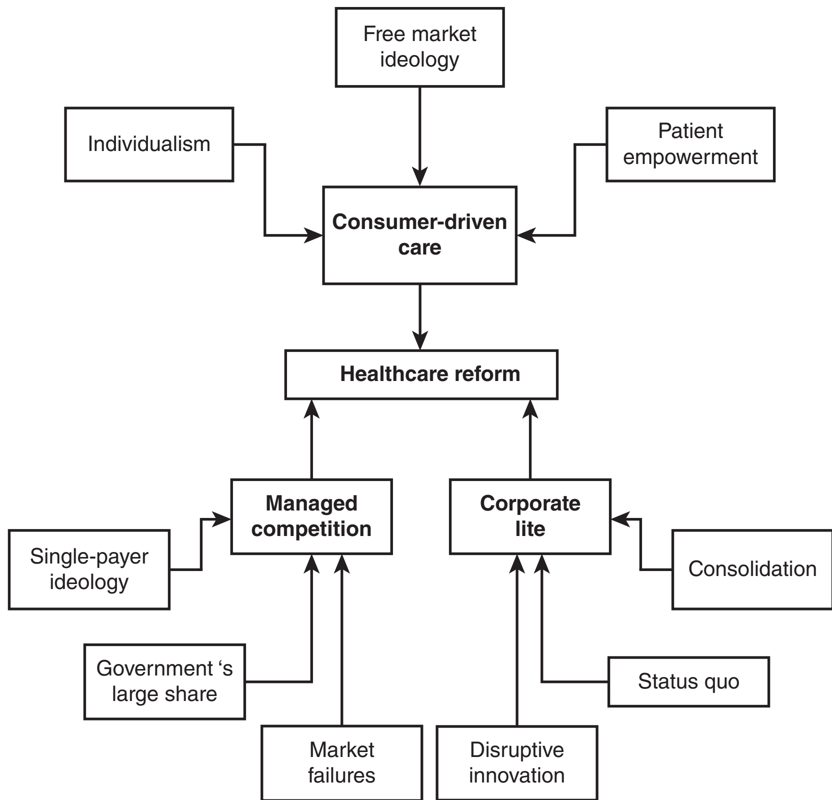


FIGURE 2-1 A roadmap of major influences on healthcare reform

had a place in recent healthcare reform attempts. They are influenced by many factors, a few of which appear in the drawing in Figure 2-1.

FIGURE 2-2 represents our current view of the influence distribution between the three relevant lenses.

Industrialization and Corporate Lite

The current status quo, dominated by Corporate Lite, cannot be traced to a specific policy or period. Medicine before World War II has been described as a craft/guild system, which implies that medicine was primarily an art lacking decision rules that could be communicated effectively (tacit knowledge) (Ferdows, 2006). With more and more scientific and/or codified knowledge, it was possible to differentiate between cases and processes. Simple industrial activities can be turned into mass production systems that repeat the same process over and over. If the knowledge is still pretty much an art but the task simple, the work can be delegated to less experienced or less trained personnel as in the *apprentice system*, in which much of the simpler work was delegated to others but the master craftsman maintained control and handled the trickiest parts (or conducted rounds in the teaching hospital).

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

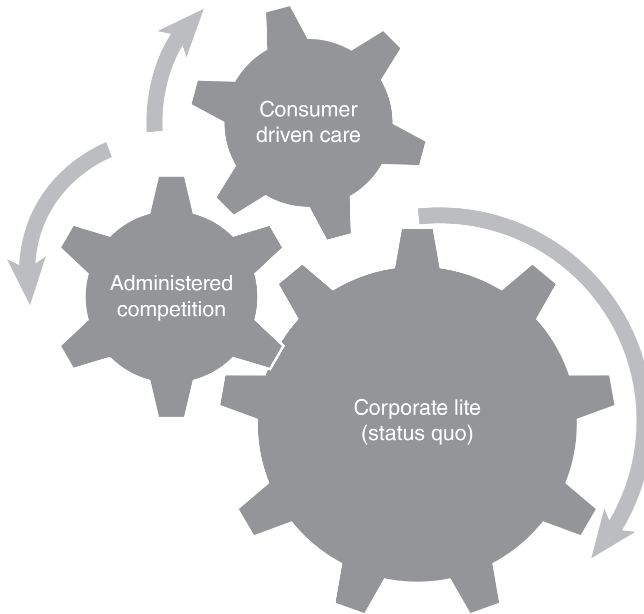


FIGURE 2-2 Current distribution of influence

Many healthcare tasks can be done by more than one level of healthcare worker. For example, both midwives and obstetricians can deliver babies. The practice of midwifery nearly disappeared in the United States but is now undergoing a resurgence. Nurse practitioners and physician assistants now are the first level of care for many patient encounters. In many psychiatric practices, the psychiatrist handles the patient's medications but delegates most other care activities to psychologists, social workers, or other counselors. Pharmacies now use pharmacy technicians as well as pharmacists. Dental practices have their own dental hygienists and technicians working in parallel with dentists. Primary care physicians perform procedures once limited to specialists. The key to further substitution is whether the alternative workers are qualified for the problem at hand and whether their unit cost is less. Most substitutions were initially proposed to overcome a shortage of personnel in one area, but after the experiment worked, more and more organizations have implemented it to increase access and reduce cost.

Mass production exists in cataract surgery centers and other "centers of excellence," but in general there is widespread desire to avoid mass production of medical services. That desire is legitimate given the inherent variability in patient anatomy, physiology, and psychological needs and preferences. Health care differs from industrial production in the sense that patients present with both simple and complex problems (multisystem problems or comorbidities). Problems that have a clearly optimal treatment regimen and those for which medical knowledge is limited can appear simultaneously in the same individual.

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

Ownership and Enhancement of Intellectual Capital

As work is industrialized, work methods are specified by the organization rather than the individual artisan. In health care, we have historically assumed that intellectual capital resides with the professional. But as competition increasingly depends on the implementation of evidence-based practices by an institution and on rapid dissemination and adoption by practitioners, organizational rather than professional learning comes into focus. That raises new questions about management–provider conflicts (often called *suits versus coats*), the nature of continuing graduate medical education, and access to clinical records and research outputs.

The drivers of industrialization in health care have been the expansion of the science base of medicine and the codification of product definitions and process specifications. An example of the trend toward codification by medical institutions and professions is the effort by the Institute of Medicine to support the "learning health care system." Professionals must be prepared to take leadership in issues around developing, disseminating, and compensating for intellectual capital or they will lose even more autonomy.

Conclusion

Health policy analysts must be aware of the structural history of health care in the United States and the conflicting visions of how the system should work. The analyst cannot expect consistency from individuals or groups, but he or she can benefit from recognizing where people are coming from in order to deal with both facts and fantasies.

Three visions played out in portions of the ACA, producing Taylor's "conglomeration." Starr (2011) describes the process leading up to the passage of the ACA as one of reaching a compromise between managed competition and consumer-driven health care, but the legislation was crafted to be "minimally invasive" to avoid public counterattacks from established corporate interests such as hospitals, pharmaceutical companies, and the insurance industry. It is likely that they will ultimately worm their way into any Republican replacement as well.