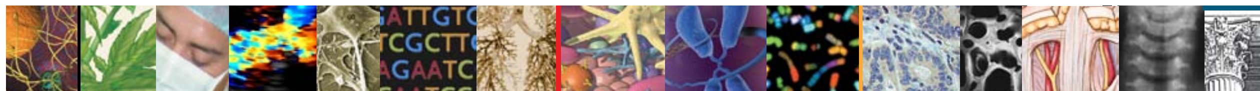

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Perspective

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Unfinished Journey — A Century of Health Care Reform in the United States

Jonathan Oberlander, Ph.D.

In 1915, reformers issued the first major proposal for national health insurance in the United States (see timeline). They believed that America should follow European countries such as Germany and England in securing access to medical care for workers and protecting them against the economic burdens of illness. The leadership of the American Medical Association (AMA) initially agreed, and the prospects for reform appeared promising.

Yet by 1920, the health care reform campaign had failed, the victim of intense opposition (from businesses and the insurance industry, among others), bad timing (the American entry into World War I), demagoguery, and xenophobia (charges that the health care proposals were "Made in Germany," "Bolshevik," and "un-American"). After an internal revolt, the AMA became a steadfast opponent of national health insurance. The issue briefly disappeared from the agenda.[1]

Nearly 100 years after that first proposal, Americans are still debating health care reform, the perils of "socialized medicine," and the tensions between individual liberty and government aid. What have been the major developments in U.S. health policy over the past century? And what challenges lie ahead? I focus here on two critical issues, health insurance coverage and cost containment.

COVERAGE

Political struggles over expanding access to insurance have long defined U.S. health policy. Although proposals focused at first on industrial workers, by the 1940s reformers were seeking a universal health insurance program for all Americans. But universal coverage remained elusive during the 20th century. The same forces that initially stalled national health insurance — resistance from powerful interest groups bent on preserving the status quo, demagoguery, and fear of socialized medicine — endured to undercut subsequent reform efforts. A parade of presidents — including Harry Truman,

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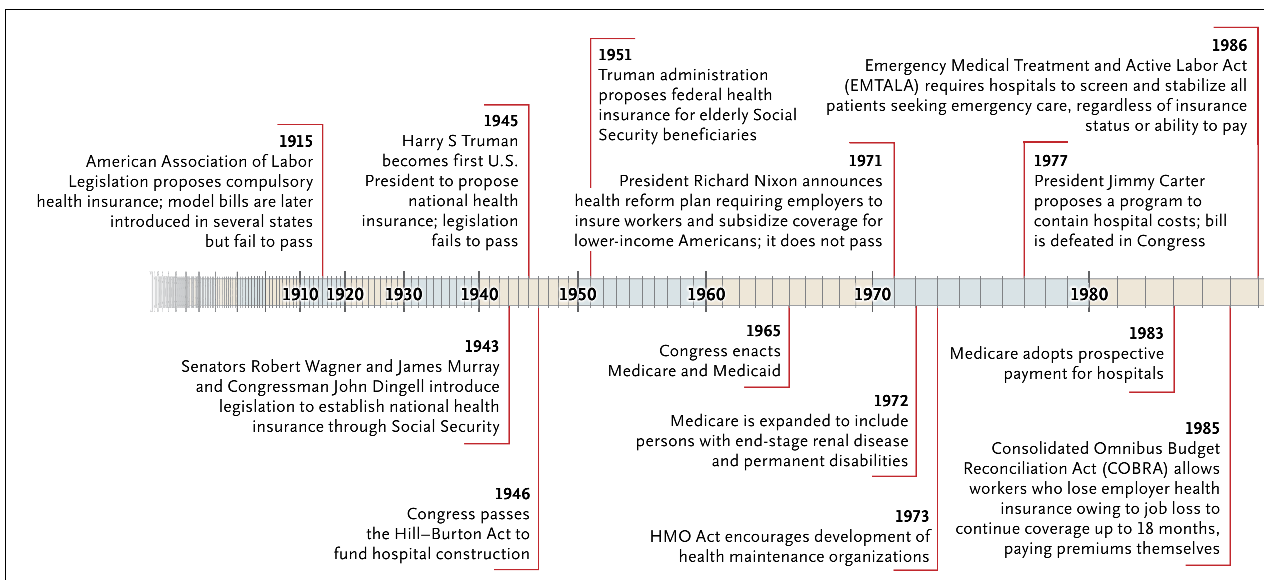
Richard Nixon, and Bill Clinton — pursued universal coverage.[2] They all failed.

That failure is often attributed to a political culture suspicious of centralized power and enamored of individual responsibility. There is no question that the antigovernment strain in U.S. politics made the reformers' task extraordinarily difficult. However, U.S. political institutions represented an equally important — or perhaps even more important — barrier to reform. In the fragmented U.S. system, health care legislation died in Congress even when it enjoyed support from the president and the president's party had majorities in the House and Senate. If we had a parliamentary system, the United States probably would have adopted universal insurance decades ago.

The failure of early proposals for national health insurance crucially shaped U.S. health policy. Instead of a single insurance system organized by the government, the United States developed a patchwork of public and private coverage. Employer-sponsored private insurance emerged to cover working Americans and their families. It spread widely in the 1940s and 1950s, as unions pressed for health benefits. Linking insurance to employment provided insurers with a convenient risk pool and a reliable source of premium payments. It also gave opponents of government insurance a viable alternative that embodied "the American way." Yet private insurance benefited from government largesse: the federal government subsidized employer-sponsored coverage by excluding from taxable income premium payments made by employers on behalf of workers.

Even as it grew, employer-sponsored insurance remained beyond the reach of many Americans. Having failed to secure national health insurance, reformers switched strategies midcentury. They promoted less controversial policies, such as federal funding of hospital construction and medical research,[1] and they decided to build a federal health insurance system incrementally, group by group. Government programs would cover politically sympathetic, deserving populations — beginning with the elderly — who had trouble obtaining private insurance, as well as certain categories of low-income people who couldn't afford it. The 1965 enactment of Medicare and Medicaid established this pattern of demographic incrementalism, while transforming the government role in U.S. medical care. Thereafter, policymakers would focus on expanding public insurance coverage of pregnant women, children, and persons with disabilities and specific illnesses (such as end-stage renal disease).

Despite the rise of employer-sponsored insurance and the advent of Medicare and Medicaid, the U.S. health insurance system has long had serious gaps and inequities. Many working Americans, particularly those at small firms, do not have access to employer-based coverage and have found it difficult to purchase af-



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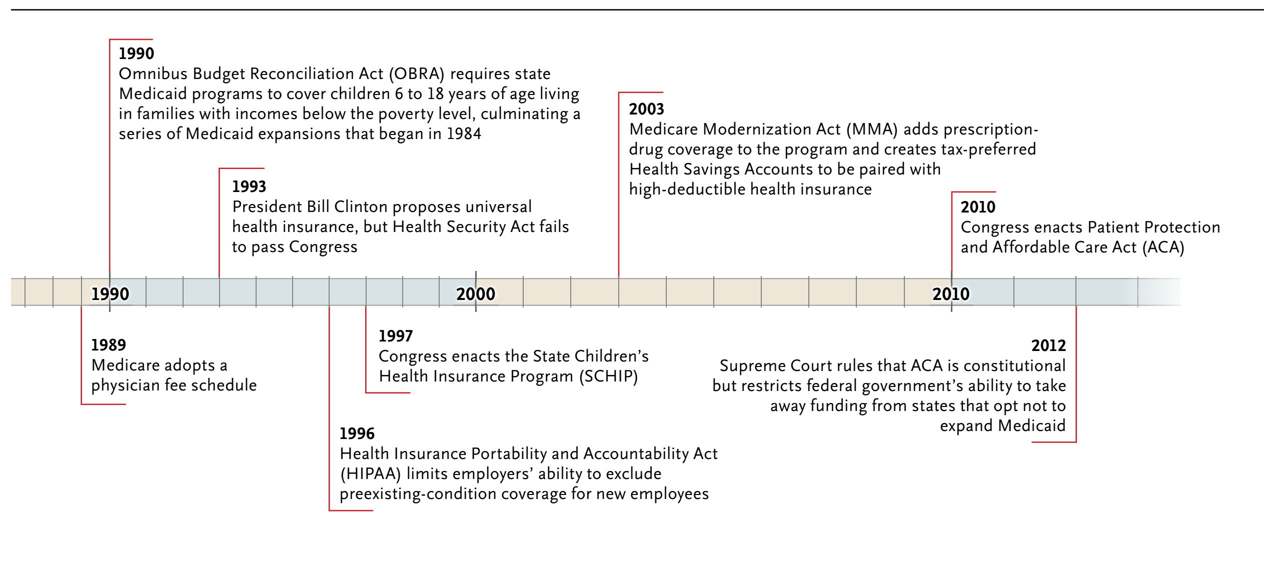
fordable, comprehensive policies in the nongroup insurance market. The revelation that private insurers have targeted pregnant women and patients with cancer for coverage rescissions[3] — contriving reasons to cancel insurance for persons whose medical circumstances made them "bad" actuarial risks — perfectly captures the economic imperatives and moral illogic of the individual market. In this market, the sickest persons who most need insurance have had the hardest time obtaining it.

There are gaps in public insurance, too. Medicare beneficiaries face substantial cost sharing, and the program does not cover long-term nursing home stays. Medicaid enrollees often have trouble finding doctors who will see them, largely a consequence of low reimbursement rates for a population that lacks the political clout to ensure adequate payment. Cash-strapped states have at times cut Medicaid benefits and eliminated coverage for optional populations during economic downturns.

U.S. insurance arrangements are also bedeviled by complexity: Medicaid has about 50 different eligibility pathways, low-income Medicare beneficiaries are also covered by Medicaid, Medicare's benefits are sufficiently limited that most enrollees carry secondary insurance, and most uninsured children are eligible for Medicaid or the Children's Health Insurance Program (CHIP) but are not enrolled. Americans "churn" across different insurance programs depending on their age, parental status, employment, income, and disease. It's no wonder that U.S. medical care is often characterized as a "nonsystem."

As the costs of medical care increased, Americans' access to health insurance eroded. Between 1987 and 2010, the uninsured population grew from 31 million (12.9% of the population) to 50 million (16.3%). The incremental policies adopted to expand access to insurance could not keep pace with the large number of Americans who were losing employer-based coverage. Neither could the safety net of community health centers, hospitals, and other providers who care for the uninsured. Uninsured patients are financial losers for health care institutions, and they consequently face serious barriers to care — a reality underscored by a 1986 law that sought to stop hospitals from dumping patients who lacked coverage. Providers who do see many uninsured patients are, in effect, punished financially for their compassion.

Despite their growing numbers, the uninsured often faded from public view in recent decades. Changing political alignments, the sobering legacy of previous failed reform efforts, and the limited electoral power of the uninsured pushed health care reform down the congressional agenda. However, federal inaction spurred state efforts. No state achieved universal coverage, but some made significant coverage gains during the 1980s and 1990s. And the landmark 2006 Massachusetts law provided a



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political and policy blueprint for national health care reform.

In 2010, President Barack Obama and Democratic majorities in Congress drew on that blueprint, and lessons from previous reform failures, to win passage of the Patient Protection and Affordable Care Act (ACA) — a historic achievement. The ACA's sweeping scope — encompassing subsidies for the uninsured, a Medicaid expansion, new insurance exchanges, individual and employer mandates, insurance-market regulations, and much more — broke with the incrementalism of recent decades.[4] When the ACA is fully implemented, an estimated 30 million people will gain insurance coverage, and insured Americans will receive important new protections, such as the prohibition of lifetime dollar caps on insurance benefits. The ACA moves the United States closer to the ideal that all persons, regardless of health status and income, should have access to health insurance.

Still, the ACA underscores the limits of U.S. health policy. Even if the ACA's projected enrollment targets are met, 30 million persons will remain uninsured a decade from now. That this landmark law will leave half of the uninsured without coverage reveals just how difficult the politics of U.S. health care reform are and how far we still have to go to reach universalism.

COSTS

During most of the 20th century, health care costs were not a public policy issue. Spending more on medical care was seen as an investment in the country's health. Private insurance plans — which largely catered to physicians' and hospitals' interests — had few restraints on costs. Medicare, too, initially implemented generous payment policies, partly to curry favor with the health care industry and thereby ensure the program's successful start.

Investing in medical technologies has produced substantial benefits, such as reduced mortality from heart disease. But since 1970, excessive rates of health care spending have been viewed as a serious problem that threatens government budgets and employers' bottom lines. In response, U.S. policymakers have formulated a wide array of responses.[5] President Richard Nixon imposed price controls on the health care industry and promoted health maintenance organizations (HMOs). During Gerald Ford's presidency, Congress advanced health planning, including health systems agencies and certificate-of-need requirements, which aimed to rationalize resource use and restrain expansion of medical facilities. President Jimmy Carter tried and failed to win passage of a plan to contain hospital costs; the hospital industry instead launched a short-lived "voluntary effort" at restraint. The Reagan administration supported prospective payment of hospitals by Medicare, and during President George H.W. Bush's administration, Congress enacted a Medicare fee schedule for physicians. The Clinton administration proposed managed competition within a budget. The Obama administration has emphasized delivery- and payment-system reform.

Some of these proposals were designed to curtail spending across the health care system. However, cost control has been defined largely as a budgetary problem, meaning that presidential administrations and Congress often focus only on reducing federal spending. Medicare savings have been a regular feature of deficit-reduction legislation since the 1980s.

Absent systemwide controls, it has fallen to private payers to contain spending for Americans not covered by government programs. Indeed, much of U.S. health policy is effectively ceded to private actors, who help drive the direction of change. Employers have pursued a variety of cost-containment strategies over the years, ranging from moving workers into HMOs and relying on selective contracting with providers to secure lower payment rates to adopting high-deductible plans and requiring greater cost sharing.

Increasing cost sharing and moving from comprehensive to catastrophic coverage rest on the dubious idea that patients can and should act as consumers do in other markets. In a country with a vast uninsured population, the belief that Americans are overinsured has oddly taken root. Various cost-containment measures — including managed-care limits — have also eroded physicians' clinical autonomy.

U.S. health policy, in both the public and private sectors, has been highly innovative in producing new organizations and payment methods. Currently, employers, insurers, and state and federal governments are embracing value-based payment- and delivery-system reforms, such as accountable care organizations, that seek to

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reverse the traditional financial incentives to provide more services. These reforms are central to the ACA's vision of cost containment.

Americans used to reassure themselves that although the United States failed to provide universal coverage and affordable care, at least the quality of our health care system was superb. Since the 1970s, research has increasingly challenged that assumption, showing that the quality of care in the United States is inconsistent, often inadequate, and varies by geographic location — problems that other countries struggle with as well. By highlighting the potential for saving money by cutting down on wasteful services, these discoveries have strengthened policymakers' interest in containing health care costs. Enthusiasm for delivery- and payment-system reform embodies the politically appealing aspiration that the United States can moderate spending by improving quality.

Yet for all the innovation, Americans have been singularly unsuccessful in restraining health care spending. The United States has moved through fads at a dizzying pace in recent decades — from managed to consumer-driven to accountable care — but they have thus far failed to produce reliable cost control.[6] Rising health care costs are an issue throughout the industrialized world, though other countries manage to spend much less while insuring their entire populations. Still, lessons from international experience are largely ignored by U.S. policymakers and analysts intent on fashioning a "uniquely American solution." The United States has not adopted the cost-containment policies that work in other countries: global budgeting, systemwide fee schedules and payment rules, monopsony purchasing, and supply-side controls on expensive technologies. Instead, America continues to abide high prices and the staggering administrative costs imposed by our byzantine insurance system.

U.S. health policy is a story of progress — but also abject failure, having produced an inequitable, inefficient system that is the most expensive in the world and that leaves 20% of the nonelderly population uninsured.

THE FAILURES OF U.S. HEALTH POLICY

U.S. health policy is a story of progress, with substantial gains in health insurance coverage over the past century, culminating in the ACA's enactment. But U.S. health policy has also been an abject failure, having produced an inequitable, inefficient system that is the most expensive in the world and that leaves 20% of the nonelderly population uninsured. Health insurance should be a source of security and reassurance. The U.S. insurance system is too often a source of suffering, anxiety, economic insecurity, and frustration.

Too many Americans who fall ill are forced to worry about how to pay their medical bills and the threat of medical bankruptcy, rather than focusing on getting well or coping with maladies that won't improve. Too many Americans cannot obtain decent, affordable insurance because they have preexisting conditions, lack the financial resources, or work for a small business. Too many Americans with permanent disabilities must wait too long before Medicare covers them. Too many Americans who are eligible for Medicaid and CHIP fall between the cracks. Too many insured Americans are only one illness away from discovering they have inadequate coverage that leaves them with overwhelming bills. Too many Americans have to fight their insurance companies to obtain covered benefits.

That these and other indignities have persisted so long is an indictment of U.S. health policy and its moral quality. If there is one thing we should learn from the experiences of other countries that have universal coverage, it is that it doesn't have to be this way. None of these problems are natural or inevitable — they are all the result of policy choices that the United States has made.

FUTURE CHALLENGES

In coming years, U.S. health policy will be shaped and perhaps transformed by fiscal pressures and deficit politics. The size of Medicare and Medicaid and their

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projected spending growth make them likely targets for plans to reduce the federal deficit. The question is whether health care providers or Medicare and Medicaid beneficiaries will bear the brunt of spending cuts. Tax policy will also have a vital impact, since both programs will require additional revenues to absorb growing populations and finance rising medical costs. Meanwhile, the search for stronger cost control and improved quality will continue.

The most crucial issue, though, is what happens to the ACA after the 2012 elections. Barack Obama's reelection would ensure that the ACA moves forward, albeit with continued conflicts over its implementation at both the state and federal levels. If Mitt Romney wins the presidency, however, and Republicans secure majorities in the House and Senate, major provisions of the law could be overturned.

The ACA will not remedy all that ails U.S. medical care. Much can be done to strengthen its coverage and cost-containment foundations. But the ACA will dramatically improve the health care circumstances of tens of millions of Americans, making coverage more accessible and affordable for uninsured Americans and more secure for those who are insured. After a century of struggle, the ACA's enactment provides strong grounds for optimism about the future of the American health care system. Yet with implementation of the ACA uncertain, U.S. health policy stands at a crossroads: will we continue down the path of reform or move backward?

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the University of North Carolina at Chapel Hill.

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When the Cost Curve Bent — Pre-Recession Moderation in Health Care Spending

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Commentators have noted recent moderation in the rate of growth of U.S. health care spending — a bend in the cost curve.[1] A critical question is whether the low growth rate is likely to continue — an issue with enormous implications for the country's fiscal future. If the slowdown resulted from the recession, the rate is likely to increase as we return to full employment; if not, it may provide a respite from the problems created by spending inflation.

Our analysis of monthly data on health care spending shows that the moderation in growth began well before the recession and has continued through May 2012. Spending estimates are based on monthly data from the Bureau of Economic Analysis (BEA), transformed for consistency with the official annual figures from the National Health Expenditure Accounts (NHEA). Since the NHEA runs through 2010, our monthly estimates for 2011 and 2012 are based on BEA data, adjusted according to the historical relationship between BEA and NHEA figures.[2]

Economists and policymakers often compare the growth of health care spending to that of the overall economy, as measured by the gross domestic product (GDP). However, this comparison can give a false sense of "excess" health care spending growth during economic recessions and recoveries. Although this growth-rate differential surges during recessions, the surge signals ab-

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