

Chapter 2

Benchmark Developments in U.S. Health Care

This chapter describes the major developments in health care in the United States and the important legislative, political, economic, organizational, and professional influences that transformed health care from a relatively simple process to one professional service, and finally, to a huge, complex, corporation-dominated industry. The effects of medical education, scientific advances, rising costs, changing population demographics, and American values and assumptions regarding health care are noted.

From its earliest history, health care, or more accurately, medical care, was dominated by physicians and their hospitals. In the nineteenth and early twentieth centuries, participation in U.S. medicine was generally limited to two parties—patients and physicians. Diagnosis, treatment, and fees for services were considered confidential between patients and physicians. Medical practice was relatively simple and usually involved long-standing relationships with patients and, often, several generations of their families. Physicians collected their own bills, and set and usually adjusted their charges to their estimates of patients' ability to pay. This was the intimate physician–patient relationship the profession held sacred.

Free from outside scrutiny or interference, individual physicians had complete control over where, when, what, and how they practiced, and, not surprisingly, they preferred to do business that way. In 1934, the American Medical Association (AMA) published this statement: “No third party must be permitted to come between the patient and his physician in any medical matter.”¹ The AMA was concerned about such issues as nonphysician-controlled voluntary health insurance, compulsory health insurance, and the few capitated contracts for medical services negotiated by remote lumber or mining companies and a few workers' guilds. For decades, organized medicine repeatedly battled against these and other outside influences that altered “the old relations of perfect freedom between physicians and patients, with separate compensation for each separate service.”²

As early as the nineteenth century, some Americans carried insurance against sickness through an employer, fraternal order, guild, trade union, or commercial insurance company. Most of the plans, however, were simply designed to make up for lost income during sickness or injury by providing a fixed cash payment.³ Sickness insurance, as it was originally called, was the beginning of social insurance programs against the risks of income interruption by accident, sickness, or disability. Initially, it was provided only to wage earners. Later, it was extended to workers' dependents and other people.⁴

The drive for compulsory health insurance began to build in the United States around 1915, after most European countries had initiated either compulsory programs or subsidies for voluntary programs. The underlying concern was to protect workers against loss of income resulting from industrial accidents common at the time. Families with only one breadwinner, often already at the edge of poverty, were devastated by loss of income due to sickness or injury, even without the additional costs of medical care.

At the time, life insurance companies sold "industrial" policies that provided lump sum payments at death, which amounted to \$50 or \$100. The money was used to pay for final medical expenses and funerals. Both Metropolitan Life and Prudential Insurance Company rose to the top of the insurance industry by successfully marketing industrial policies that required premium payments of 10 to 25 cents per week.⁵

In 1917, World War I interrupted the campaign for compulsory health insurance in the United States. In 1919, the AMA House of Delegates officially condemned compulsory health insurance with the following resolution:

*The American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness or any other plan of compulsory insurance which provides for medical service to be rendered contributors or their dependents, provided, controlled, or regulated by any state or the federal government.*⁶

The majority of physician opposition to compulsory health insurance was attributed to an unfounded concern that insurance would decrease, rather than increase, physician incomes, and to their negative experience with accident insurance that paid physicians according to arbitrary fee schedules.⁷

■ The Great Depression and the Birth of Blue Cross

The Depression of 1929 shook the financial security of both physicians and hospitals. Physician incomes and hospital receipts and admission rates dropped precipitously. As the situation grew worse, hospitals be-

gan experimenting with insurance plans. The Baylor University Hospital plan was not the first, but it became the most influential of those insurance experiments. By enrolling 1,250 public school teachers at 50 cents a month for a guaranteed 21 days of hospital care, Baylor created the model for, and is credited with, the genesis of Blue Cross Hospital Insurance. Baylor started a trend that developed into multi-hospital plans that included all the hospitals in a given area. By 1937, there were 26 plans with more than 600,000 members, and the American Hospital Association (AHA) started approving the plans. Physicians were pleased with the increased availability of hospital care and the cooperative manner in which their bills were paid. The AMA, however, was characteristically hostile and called the plans “economically unsound, unethical, and inimical to the public interest.”⁸

The AMA contended that urging people “to save for sickness” could solve the problem of financing health care.⁹ Organized medicine’s consistently antagonistic reaction to the concept of health insurance, whether compulsory or voluntary, is well illustrated by medicine’s response to the 1932 report of the Committee on the Costs of Medical Care. The establishment of the committee represented a shift of concern from lost wages to medical costs. Chaired by a former president of the AMA and financed by several philanthropic organizations, a group of 45 to 50 prominent Americans from the medical, public health, and social science fields worked for five years to address the problem of financing medical care. After an exhaustive study, a moderate majority recommended adoption of group practice and voluntary health insurance as the best way of solving the nation’s health care problems. But even this relatively modest recommendation was too much for some physicians on the panel. They prepared a minority report denouncing voluntary health insurance as more objectionable than compulsory insurance. Health insurance, predicting or having predicted the minority, would lead to “destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession.”¹⁰

The dissenting physicians, however, did favor government intervention to alleviate the financial burden on physicians resulting from their obligation to provide free care to low-income populations. The AMA’s House of Delegates reiterated its long-standing opposition to health insurance of any kind by declaring in 1933 that the minority report represented “the collective opinion of the medical profession.”¹¹

From the 1930s to the present, there have been many efforts to enact various forms of compulsory health insurance. It was only when the proponents of government-sponsored insurance limited their efforts to older adults and the medically indigent, however, that they were able to succeed in passing Medicaid and Medicare legislation in 1965. Voluntary insurance against hospital care costs became the predominant health insurance in the United States during those decades.

Although the advocates of government-sponsored health insurance had little success in improving the access of patients to medical care, the Blue Cross plans effectively improved hospitals' access to patients.

Sensitive to the power of the health care industry to defeat health insurance proposals by raising the battle cry of "socialized medicine," almost all proposed plans emphasized accommodations to the interest of physicians and hospitals. Especially after World War II, when the federal government began to heavily subsidize hospital construction and medical research, the expansion of the health care industry, and particularly physician resources, became the overriding policy objective.

The government gave a huge boost to the private health insurance industry by excluding health insurance benefits from wage and price controls and by excluding workers' contributions to health insurance from taxable income. The effect was to encourage employees to take wage increases in the form of health insurance fringe benefits rather than cash.

Because insurance companies simply raised their own premium rates rather than trying to exert pressure on physicians and hospitals to contain costs, the post-World War II health insurance system pumped an ever increasing proportion of the national income into health care. Clearly, contributing to the inflationary spiral was preferable to incurring the wrath of physicians and hospitals by infringing on their prerogatives to set prices and control the costs of their work. Medicare and Medicaid followed the same pattern. In fact, the preamble to the original legislative proposals specifically prohibited any interpretation of the legislation that would change the way health care was practiced.

■ The Dominant Influence of Government

Although the health insurance industry contributed significantly to the spiraling costs of health care in the decades after World War II, it was only one of several influences. The federal government's coverage of health care for special populations played a prominent role. Over the years, the U.S. government developed, revised, and otherwise adjusted a host of categorical or disease-specific programs designed to address needs not otherwise met by state or local administrations or the private sector. Federally sponsored programs account for about 40 percent of this country's personal health care expenditures. Most physicians and other health professionals are trained at public expense, the government provides almost 6 percent of the funds available for research and development, and most not-for-profit hospitals have been built or expanded with government support. State and local governments also contribute, but in much smaller amounts.¹²

Although many of these programs are described in more detail in Chapter 7, it is important to recognize the health care policy implications of certain federal initiatives. Certainly, the Social Security Act of 1935 was the most significant social initiative passed by any Congress. The act established the principle of federal aid to the states for public health and welfare assistance, maternal and child health, and children with disabilities services. It was the legislative basis for a number of significant health and welfare programs, including the all-important Medicaid and Medicare titles.

The government increased its support of biomedical research through the National Institutes of Health, which was established in 1930, and the categorical programs that addressed heart disease, cancer, stroke, mental illness, mental retardation, maternal and infant care, and many other conditions. Programs such as direct aid to schools of medicine, dentistry, pharmacy, nursing, and other professions and their students; support of health planning; health care regulation; and consumer protections, which were incorporated in the various 1962 amendments to the 1938 Food, Drug, and Cosmetic Act, were all part of the Kennedy–Johnson presidential policy era called Creative Federalism. The aggregate annual investment in those programs made the United States government the major player and payer in the field of health care.

Grants-in-aid programs alone, excluding Social Security and Medicare, grew from \$7 billion at the start of the Kennedy administration in 1961 to \$24 billion in 1970. President Nixon expressed his intent to undo the categorical programs and shift revenues to the state and local governments. For broad general purposes, this direction was labeled New Federalism. In spite of his efforts, grants-in-aid programs grew to almost \$83 billion in 1980. Congress had resisted block grants and allowed only limited revenue sharing to take place.¹³

In the meantime, federal and state governments were underwriting the skyrocketing costs of Medicare and Medicaid with no effective controls over expenditures. The planners of the Medicare legislation made several misjudgments. They underestimated the growing number of older adults in the United States, the scope and burgeoning costs of the technological revolution, and the public's rising expectations for the latest in every diagnostic and treatment modality.

The Medicare and Medicaid programs did provide access to many desperately needed health care services for older Americans, people with disabilities, and low-income populations. Because rising Medicare reimbursement rates set the standards for most insurance companies, however, its inflationary effect was momentous. In the mid-1960s, when Medicare was passed, the United States was spending about \$42 billion on health care, or approximately 8.4% of the

gross national product (GNP). The cost of U.S health care now exceeds a trillion dollars and consumes about 15 percent of the GNP.

The three major health care concerns—access, cost, and quality—are particularly problematic because attempts to control one or two of those problems exacerbates the one or two remaining. It is impossible to correct all three problems simultaneously. The government attempted to improve access through the Hill-Burton Act of 1946, which increased the number and size of health care facilities substantially. In addition, President Johnson’s Medicare and Medicaid legislation ensured health care payment for older Americans and low-income populations and succeeded in bringing millions of patients into a now overbuilt system. These changes, however, were made at the cost of skyrocketing expenditures and questionable quality. The health care system’s excess capacity and virtually unchecked funding improved access to competent and appropriate medical care for many, but also resulted in untold numbers of clinical tests, prescriptions, surgery, and other expensive procedures that were often of questionable necessity. Almost all of the federal health legislation since the passage of Medicare and Medicaid has been aimed at reducing the costs of health care but has focused little on the reciprocal effects of reducing both the availability and quality of health care.

■ **Efforts at Planning and Quality Control**

The federal government did not ignore the issues of cost and quality; the efforts to address those concerns were essentially doomed to be ineffectual by their very designs. To get legislation passed that might alter the existing constellation of health care services or that would scrutinize how well clinicians actually practiced, the powerful medical and hospital lobbies had to be accommodated. This meant the legislation had to be “provider friendly,” allowing physicians, hospital administrators, and other health professionals to maintain control over how the legislation was interpreted and enforced.

Two legislative initiatives of the 1960s typify the circumstances surrounding federal efforts to address the problems of the health care delivery system. In 1965 the Public Health Service Act was amended to establish a nationwide network of regional medical programs to address the leading causes of death: heart disease, cancer, and stroke. Throughout the country, groups of physicians, most of whom were associated with academic medical centers, and a few nurses and other health professionals, met to discuss innovative ways to bring the latest in clinical services to the bedside of patients. As might have been predicted, representatives of each clinical specialty argued for funds to do more of what they were already doing. As a consequence, the regional medical programs improved the educational and clinical re-

sources of their regions but did not dramatically improve the prevention or control of their target conditions.

A parallel program, the Comprehensive Health Planning Act, was passed in 1966 to promote comprehensive planning for more rational systems of health care personnel and facilities in each service region. The legislation required federal, state, and local partnerships. It also required that there be a majority of consumers on every decision-making body.¹⁴

Almost all the regional medical programs and Comprehensive Health Planning Act programs across the country soon were dominated by medical-hospital establishments in their regions. Although there were many productive outcomes from the money spent through the two programs, conflicts of interest regarding the allocation of research and development funds were common, and there was general agreement that the programs were ineffective in achieving their goals. The two programs were combined, therefore, by the National Health Planning and Resources Development Act of 1974.

Clearly, political rather than objective assessments led Congress to presume that combining two ineffective programs would result in one successful program. Nevertheless, the legislation called for a new organization, the Health Systems Agency (HSA), to have broad representation of health care providers and consumers on governing boards and committees.

After several years, nothing had changed. Data submitted to the U.S. Department of Health, Education, and Welfare by the HSA indicated that provider board members were not representative of the overall provider work force or the consumer population. The physician/hospital administrator establishment was overrepresented, and other provider groups were underrepresented. HSA board members were predominately white males, although nonwhites and females were heavily represented in the work force and consumer population. The HSA's function of recommending approvals of certificates of need for new or added facilities and equipment was compromised by the vested interests on the governing boards. The general ineffectiveness of HSA boards and committees in containing costs and preventing unnecessary duplication of services in their regions was recognized, and federal support ultimately was withdrawn.¹⁵

Several other programs besides Medicare and Medicaid were initiated during the Johnson administration to address the prevalence of mental illness and to support the education of health care professionals. The Health Professions Educational Assistance Act of 1963 provided direct federal aid to medical, dental, nursing, pharmacy, and other professional schools, as well as to their students. The Nurse Training Act supported special federal efforts for training professional nursing personnel and, during the same period, the Maternal and

Child Health and Mental Retardation Planning Amendments initiated comprehensive maternal and child health projects and centers to serve people with mental retardation. The Economic Opportunity Act supported the development of neighborhood health centers to serve low-income populations.¹⁶

The Johnson era programs, particularly Medicare and Medicaid, put the federal government deeply into the business of financing health care. President Johnson's ambitious activation of the concept of creative federalism enriched the country's health care system and improved the access of many impoverished citizens to continually improving medical care, but it also fueled the inflationary spiral of health care costs that has yet to be constrained. It is apparent that, during the last three decades, none of the attempts to correct the unnecessary duplications of facilities and services and their excessive or inappropriate use, or to contain their costs, have been successful.

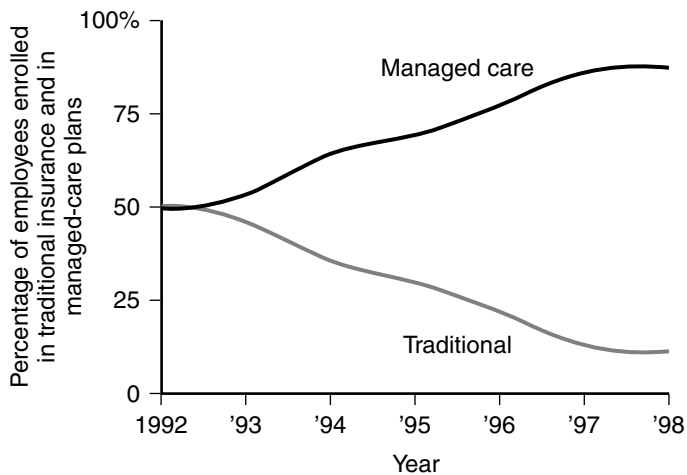
■ **Managed Care Organizations**

In 1973 the Health Maintenance Organization Act supported the development of health maintenance organizations (HMOs) through grants for federal demonstration projects. An HMO is an organization responsible for the financing and delivery of comprehensive health services to an enrolled population for a prepaid, fixed fee. HMOs were expected to hold down costs by changing the profit incentive from fee for service to promoting health and preventing illness.

The concept was accepted widely, and between 1992 and 1999, HMOs and other types of managed care organizations experienced phenomenal growth, accounting for more than half of all privately insured persons.¹⁷ (See Figure 2-1.) Subsequently, the fortunes of managed care organizations changed as both health care costs and consumer complaints increased.

Although the majority of Americans are now receiving their health care through some sort of prepaid managed care, the evidence that significant savings will be realized is fragmentary. Stiff increases in HMO premium rates suggest that the widespread application of HMO concepts will not provide the long-sought containment of runaway health care costs. In addition, both consumers and providers are suggesting that the HMO controls on costs are compromising the quality of care. Consumer concerns about restrictions on choice of providers, limits on availability of services, and quality of health care has evoked a managed care backlash and generated support for government regulation of managed care organizations.

In fact, the most recent available data from a large, nationally representative sample of privately insured persons under age 65 found little difference between HMOs and other types of insurance.¹⁸ Hospital use, emergency room visits, and surgeries did not differ signifi-



Note: Data are for companies with 10 or more employees; numbers may add up to more than 100 percent because of dual enrollment.

Figure 2-1 HMO Migration. *Source:* ASIAN WALL STREET JOURNAL [STAFF PRODUCED COPY ONLY] by LAURIE MCGINLEY. Copyright 1999 by DOW JONES & CO INC. Reproduced with permission of DOW JONES & CO INC in the format Textbook via Copyright Clearance Center.

cantly. In addition, reports of unmet need or delayed care, important indicators of access to care, differed little between HMO enrollees and people with other types of insurance. The study did find, as expected, that HMOs increase ambulatory and preventive care but reduce specialist care and raise administrative barriers to care.

The limits placed by the administrative barriers on how much health care HMO enrollees can use are considered by many patients to be an unwarranted intrusion on traditional physician/patient relationships. Public opinion polls suggest that many consumers do not trust HMOs to provide the care they need if they become sick. It is likely, therefore, that pressure by consumers for less restrictive forms of managed care will make future care management strategies and cost savings more difficult for HMOs.

■ The Reagan Administration

Beginning with the Reagan administration and continuing to this day are attempts, some successful, to undo or shrink the federally supported programs begun in the 1960s and 1970s. Unlike Nixon and Ford, Reagan succeeded in implementing New Federalism policies that were all but stymied in previous administrations. A significant reduction in government expenditures for social programs occurred.

Decentralization of program responsibility to the states was achieved primarily through block grants. Although his attempts at deregulation to stimulate competition had little success, Reagan's implementation of prospective payment to hospitals based on diagnosis-related groups, rather than retrospective payment based on hospital charges, signaled a new effort to contain health care costs.¹⁹

The conversion of categorical and disease-specific programs to block grants, the withdrawal of federal support for professional education, and the creation of a Medicare resource-based relative value scale to adjust and contain physicians' fees are but a few examples of presidential or congressional actions to reduce the federal government's financial commitment to health care.

■ **Biomedical Advances: The Evolution of High-Technology Medicine**

Health care in the United States dramatically improved during the twentieth century. In the first half of the century, the greatest advances led to the prevention or cure of many infectious diseases. The development of vaccines to prevent a wide range of communicable diseases, from yellow fever to measles, and the discovery of antibiotics saved vast numbers of Americans from early death or disability.

In the second half of the twentieth century, however, technological advances that characterize today's health care were developed. As so often happens with technological change, once the scientific concepts that underlie the initial breakthroughs are understood, the pace of technological development accelerates rapidly. Since the 1960s, the rate of technological advance has increased so quickly that the announcement of new discoveries or more sophisticated equipment has become commonplace.

A few of the seminal medical advances that took place during the 1960s were the following:

- The Sabin and Salk vaccines ended the annual epidemics of poliomyelitis.
- The mild tranquilizers Librium and Valium were introduced and widely prescribed, leading Americans to turn to medicine to cure their emotional as well as physical ills.
- The birth-control pill was first prescribed and became the most widely used and effective contraceptive method.
- The heart-lung machine and major improvements in the efficacy and safety of general anesthesia techniques made possible the first successful heart bypass operation in 1964. Three years later, the first human heart transplant took place.

In 1972 the computed tomography (CT) scan was invented. The CT scan, which, unlike X-rays, can distinguish one soft tissue from another, is installed widely in U.S. hospitals. This valuable and profitable diagnostic imaging device started an extravagant competition among hospitals to develop lucrative patient services by making major capital investments in high-technology equipment. Later, noting the convenience and profit associated with diagnostic devices such as CT scanners and magnetic resonance imaging, medical groups purchased the device and placed them in their own offices. This practice represents one example of how hospitals, physicians, and other health service providers have come to act as isolated economic entities, rather than as members of a community of health care resources established to serve population needs. The profit-driven competition and resulting redundant capacity continue to drive up utilization and costs for hospitals, insurers, and the public.²⁰

New technology, new drugs, and new and creative surgical procedures have made possible a wide variety of life-enhancing and life-extending medical accomplishments. Operations that once were complex and hazardous, requiring hospitalization and intense follow-up care, have become relatively common ambulatory surgical procedures. For example, the use of intraocular lens implants after the removal of cataracts has become one of the most popular surgical procedures (see Chapter 4). Performed on over a half million Americans annually, the procedure takes less than an hour, has very high success rates, and complications are rare. Although the ambulatory procedure costs less than it would in an inpatient setting, the aggregate costs for eye surgery will grow as demand for the operation escalates among the increasing number of older Americans.

Almost every medical or technological advance seems to be accompanied by new and vexing financial and ethical dilemmas. The greater ability to extend life raises questions about the quality of life and the right to die. New capabilities to use costly and limited resources to improve the quality of life for some and not others create other ethical problems.

Whatever its benefits, the increased use of new technology has contributed to higher health care costs. However, there are those who believe that if the new technology were used properly and not overused for the sake of defensive medicine or to take advantage of its profit potential, it would actually lower health care costs.²¹

Both the AMA and the federal government have developed programs to explore these issues and provide needed information for decision makers. The AMA has three programs to assess the ramifications of medical advancements: the Diagnostic and Therapeutic Technology Assessment Program, the Council on Scientific Affairs, and AMA Drug Evaluations.²²

In the Technology Assessment Act of 1972, Congress recognized that “. . . it is essential that, to the fullest extent possible, the consequences of technological applications be anticipated, understood, and considered in determination of public policy on existing and emerging national problems.”²³ To address this goal, the Office of Technology Assessment (OTA), a nonpartisan support agency that works directly with and for congressional committees, was created. OTA relies on the technical and professional resources of the private sector, including universities, research organizations, industry, and public interest groups, to produce their assessments and provide congressional committees with analyses of highly technical issues. It was intended to help officials sort out the facts without advocating particular policies or actions.

The Agency for Health Care Policy and Research, created by Congress in 1989 and now called the Agency for Healthcare Policy and Quality, is intended to support research to better understand the outcomes of health care at both clinical and systems levels. It has a particularly challenging mission as technological and scientific advances make it ever more difficult to sort out the complexities of health care and determine what works, for whom, when, and at what cost.

■ Roles of Medical Education and Specialization

Medical schools and teaching hospitals in the United States are the essential components of all academic health centers and the principal architects of the medical care system. In addition to their research contributions to advancements in health care and their roles as major providers of health services, they are the principal places where physicians and other professional personnel are educated and trained. Year after year, professional schools graduate thousands of medical, nursing, and other professionals whose attitudes, values, and skills have been shaped by the educational and socialization process of their professional preparation. The annual infusion of new graduates of professional schools serves to continuously reinforce the values and policies of their teachers and role models.

During the last 25 years, medical education and policies regarding the size and nature of the physician work force have influenced the size, structure, and operation of the American health care industry. From post–World War II to the mid-1970s, there were numerous projections of an impending shortage of physicians. The response at federal and state levels was to double the capacity of medical schools and to encourage the entry of foreign-trained physicians.²⁴

The explosion of scientific knowledge in medicine and the technological advances in diagnostic and treatment modalities encouraged specialization. In addition, the enhanced prestige and income of spe-

cialty practice attracted the majority of medical school graduates to specialty residencies. It soon became evident that specialists were being produced in numbers that would lead to an oversupply. Also, they needed to be close to their referring doctors and to associate with major hospitals, which caused graduates to concentrate in urban medical centers. At the same time, the shortage of nonspecialists among rural and inner city populations became more serious.

Medical schools and hospitals, however, were not willing to address these related problems by giving up their high-demand, productive, and well-regarded specialist training emphasis. Instead, they developed a more acceptable physician work force policy to maintain or increase their training capacities. Schools erroneously assumed that producing an oversupply of physicians would force more physicians into primary care in underserved rural and inner city areas. Unfortunately, this trickle-down work force policy did little to change these problems and only added to the swelling ranks of specialists. Most new physicians still chose specialties in which the supply was already adequate and elected to practice where the surplus of physicians was increasing.

Hospitals added to the problem by developing residencies that met their own service needs without regard for oversupply. Supplemental Medicare payments for teaching hospitals and indirect medical education adjustments for hospital-based residents were and still are strong incentives for hospitals to add residents.²⁵

The failure of past physician work force policies is evident. In 1989, despite major increases in the physician supply, rural areas in the United States had fewer than 100 physicians per 100,000 persons, compared with up to six times that many in major cities. Further, increasing the number of medical graduates did not correct the imbalance between specialists and generalists.²⁶

The rapid growth of managed care plans in the 1990s was expected to produce profound changes in the use of the physician work force. The emphasis on prevention and primary care and the employment of generalist physician "gatekeepers" to control inappropriate or unnecessary use of physician specialists was expected to cause a significant oversupply of specialists by the year 2000. To stave off the surplus, many medical schools and their teaching hospitals endeavored to produce equal numbers of primary care and specialist physicians instead of the one-third/two-thirds ratio that had existed for years.

As soon as the effort produced a sizable increase in the number of primary care physicians, new medical work force projections refuted the prior predictions and forecast a shortage, rather than a surplus, of specialists. Current evidence indicates that the demand for specialists is exceeding the supply. Quite appropriately, a majority of new medical school graduates are once again electing to prepare for practice in

a medical specialty. Clearly, estimating a future physician shortage or surplus is a tenuous endeavor.

The forces of reform are exerting increasing pressures on schools of medicine and the other major health professions to change their curricula in keeping with the new emphasis on population-based thinking, prevention, and cost-effectiveness. The inflexibility of traditional departmental organization and the relatively narrow areas of expertise required of faculty, however, present formidable obstacles to needed educational reforms. Roger Bulger, president of the Association of Academic Health Centers, urges academic medical centers to “demonstrate a real commitment to multiprofessional, interdisciplinary team approaches to a patient centered system,” and considers the “forces that separate various health professions” and the “devalued status of teaching within our institutions” as preventing adequate responses to the changing environment.²⁷

■ Influence of Interest Groups

Many of the problems associated with U.S. health care result from a system shared among federal and state governments and the private health care industry. The development of fully or partially tax-funded health service proposals initiated waves of lobbying efforts by interest groups for or against the initiatives. Federal and state executives and legislators continue to receive intense pressure from supporters and opponents of health care system changes.²⁸ Lobbying efforts from special interest groups have become increasingly sophisticated and well financed. Since the 1970s, former congressional staffers appear on the payrolls of private interest groups and former lobbyists assume positions on Capitol Hill. This strong connection between politicians and lobbyists is evidenced by the record number of dollars spent to defeat the Clinton Health Security Act of 1993.

Five major groups have played a key role in the debate on tax-funded health services: providers, insurers, consumers, business, and labor. Historically, physicians, the group most directly affected by reforms, developed the most powerful lobbies. Although the physician lobby is still among the best financed and most effective, it is recognized as not representing the values of large numbers of physicians detached from the AMA. In fact, there are several different medical lobbies as a result of political differences among physicians.

The American Medical Association

The AMA, founded in 1847, is the largest medical lobby with a membership of 287,000 individuals, yet it represents less than half of U.S. medical professionals. The AMA was at the height of its power from

the 1940s to the 1970s, opposing government-provided insurance plans by every president from Truman through Carter. Compromises gained in the final Medicare bill still affect today's program. In the 1980s, however, the AMA steadfastly opposed cuts in Medicare proposed by the Reagan–Bush administration. James S. Sammons, then AMA executive vice president, led the opposition and alienated several congressional members through the use of highly confrontational tactics. Since 1989, when James Todd replaced Sammons, the AMA has changed its relationship with Congress. Initially locked out of White House discussions on the Clinton plan, the AMA was later included and supported the idea of expanding health care access to all Americans. Nevertheless, cost containment, malpractice reform, and physician autonomy still remain as areas of contention.²⁹

Other Physician Groups

The American College of Physicians (ACP), founded in 1915, has 77,000 members. The ACP strongly supported the Clinton plan. The American Academy of Family Physicians (AAFP), founded in 1947, has 73,000 members, mostly in primary care. Using its Washington connection of executive vice president Robert Graham, who was at the Department of Health and Human Services during the Carter and Reagan administrations, the AAFP was able to gain larger Medicare fee increases for primary care doctors. The American Society of Internal Medicine (ASIM), founded in 1956, is also interested in promoting primary care. Although its membership of 26,000 is much smaller than either the ACP or the AAFP, it is helped by its presence in Washington. ASIM was the strongest supporter of the Clinton plan, but did not fully endorse it because of concerns about excessive cost containment. In contrast to the groups protecting the interests of primary care physicians, the American College of Surgeons (ACS), founded in 1913, has 52,000 members and serves as an advocate for surgeons. The ACS was skeptical about the Clinton plan because of its emphasis on primary care.³⁰

As in the case of physicians, the lobbying efforts of hospitals also have been weakened by a loss of unity. In the late 1970s, the powerful hospital lobby was able to defeat President Carter over the issue of increased cost containment. However, in 1983, President Reagan was able to successfully pass Medicare's prospective payment system, which benefited some providers but harmed others. Prospective payment set the more expensive hospitals against the less expensive ones, southern hospitals against northern ones, for-profit hospitals against not-for-profit ones, and urban hospitals against rural ones.³¹

The influence of the AHA has decreased as a result of the persistent competition in the hospital industry. Founded in 1898, the AHA is the largest hospital group, with a combined membership of approximately

42,000 facilities and individuals. Despite its large size, Reagan's Medicare victory caused disagreement within AHA's membership and lessened its leverage on the national scene. As differences have begun to subside, the power of the AHA has increased but never again has reached the level it attained in the late 1970s.

Other Hospital Groups

The Federation of American Health Systems (FAHS) has a membership of 1,400 hospitals and health systems and was founded in 1966 to represent the for-profit portion of the hospital population. When the AHA lost power in the mid-1980s, the FAHS was there to take over. The group staunchly opposes any government-imposed price controls. This stance decreased its influence after the first President Bush was defeated in 1992. Now that President George W. Bush has reclaimed the presidency for the Republican Party, the FAHS has regained some influence.

The Catholic Health Association of the United States, founded in 1915, represents the fewest members: 700 hospitals and 300 nursing homes. As such, it exercises little political power.³² It should be noted, however, that in the current political environment, hospital associations, individually or collectively, have little influence on the legislative agenda. While addressing the complicated problems of the U.S. health care system was one of the hottest political issues before the terror attacks of 2001, health care has dropped in political priority well below the troubled national economy and homeland security.

The American Nurses Association

The American Nurses Association (ANA) is the only major nursing interest group and serves 200,000 members. The ANA was founded in 1896, however, nurses were not very politically active until about 1980. The organization now has an elaborate network of congressional district coordinators who develop effective campaign organizations for nurses within their districts. The ANA endorsed the Clinton plan in mid-September of 1993 and earned several concessions, including elimination of state restrictions of scope of practice, direct Medicare reimbursement, and a doubling of federal support for training.³³

Insurance Companies

Even more than physicians, nurses, or hospitals, insurers' political efforts have been viewed as completely self-serving. The efforts of insurance companies to eliminate high-risk consumers from the insurance pools and their frequent premium rate hikes have contributed significantly to the focus on cost containment and the plight of the uninsured and underinsured in the debate on health care reform. Yet, the

Health Insurance Association of America, founded in 1956 and representing some 300 small companies, was responsible for that seemingly endless onslaught of television commercials featuring middle-class people worrying about limited choice of physicians and other potential dangers of cost containment in the Clinton plan.³⁴

Other insurers groups include the Group Health Association of America (GHAA), founded in 1959, and the Blue Cross and Blue Shield Association, founded in 1946. The GHAA's 1,100 individual members welcomed the idea of numerous new cash-paying customers that would have been created by the Clinton plan. The 69 organizations encompassed by Blue Cross/Blue Shield often have served as insurers of last resort for Americans, resulting in a large proportion of high-risk people in its pool of nearly 70 million. The fact that enactment of reforms would change their demographic disadvantage made Blue Cross/Blue Shield an ally of Clinton and of reform in general.³⁵

Consumer Groups

Although provider groups have been most effective in influencing health care legislation, the historically weak consumer movement has gained strength. Much of the impetus for health care reform on the national scene was linked to pressure on politicians from consumers concerned about rising costs and lack of security in health care coverage. Despite widespread disagreement among groups about the extent to which government involvement is needed, all are concerned about the questions of cost, access, and quality in the current health care system.

Better educated and more assertive citizens have become more cynical about the motives of leaders in both the political and health arenas, and much more effective in influencing legislative decisions. A prominent example is the American Association of Retired Persons (AARP). Founded in 1958, AARP is one of the most influential consumer groups in the health care reform movement. Because of its size and research capability, it wields considerable clout among legislators who are very aware that AARP's 33 million older citizens are among the most determined voters.

Although a single consumer group may have some influence in shaping a legislative proposal, consumer group coalitions that rally around specific issues are much more effective in generating political pressure. For example, a political battle over revamping the Food and Drug Administration (FDA) was initiated in 1995 when conservative think tanks and drug company officials urged a receptive Congress to make major changes in the agency's operations. These changes were intended to weaken the agency's investigative powers and reduce the time required for drug companies to introduce new drugs to the consumer market. The proposed changes would require the FDA to meet

deadlines for investigating and approving new drugs and allow pharmaceutical companies to submit one, rather than two, well-controlled studies as proof of effectiveness.

Consumer groups entered the debate on both sides of the issue. The biggest and best organized was the Patients' Coalition, which is made up of more than 50 national nonprofit health groups. It includes such dissimilar organizations as the American Cancer Society, National Hemophilia Foundation, Arthritis Foundation, and several acquired immune deficiency syndrome (AIDS) organizations such as the AIDS Action Council and Gay Men's Health Crisis. The coalition rushed to the FDA's defense and urged Congress to reject the proposals that could hurt consumers. Other consumer groups support the positions of the Pharmaceutical Research and Manufacturers Association, the main industry trade group that claims that FDA reforms could be accomplished without risking safety and effectiveness.³⁶

The battle continues, however, between those who think that keeping new drugs from the market while safety and effectiveness are carefully tested is denying help to those patients who might benefit from them, and those who presume that drug manufacturers would take advantage of less rigorous testing to foist unproven or dangerous drugs on the market for profit. While the two sides continue to debate, administrative changes have taken place that shortened the assessment time for cancer-treating drugs in an effort to prolong life for dying patients. In addition, the 2003 budget of the FDA was increased over that of the previous year by 21%. The additional support during a time of severe fiscal exigency reflects both strong governmental support for the FDA and the need to strengthen its ability to respond to possible biological terrorism attacks.³⁷

Business and Labor

In the 1960s and 1970s business groups were among those that blocked health reform legislation. Today, such legislation is seen as inevitable, and employer mandates and insurance costs have become central concerns. Here, too, there is division. Small firms tend to oppose reform because they might not be able to afford to insure their workers. Large firms favor reform because their insurance coverage costs are likely to be reduced.

The National Federation of Independent Businesses, founded in 1943, has 570,000 individual members and is the largest representative of small firms. The National Association of Manufacturers (NAM) has a much smaller membership of 12,500 individuals. Founded in 1895, it represents the interests of large employers. The U.S. Chamber of Commerce was founded in 1912 and represents 200,000 individuals and businesses. The Chamber and NAM have similar views on

reform; they both generally welcome the equalizing effect of an employer mandate but are wary of intense government regulation.³⁸

Whenever business groups are involved in an issue, labor unions are sure to make their presence felt as well. The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), once over 14 million individuals strong, has had a tremendous influence on national health policy. Though job losses during the current economic downturn have reduced membership by over a million members, the influence of organized labor is significant. Intimately connected with the AFL-CIO is the Service Employees International Union (SEIU), founded in 1921. The SEIU is the largest union representing health care workers, with a membership of one million individuals, and its president, John J. Sweeney, also is chairman of the AFL-CIO's health care committee.

During the mid-1940s, labor unions began to demand health care benefits as an alternative to wage increases not possible during post-war wage and price controls.³⁹ The two major national unions, the AFL and the CIO consolidated their power by merging in 1955. During the late 1960s, they were able to address the issues of occupational safety and health and achieved passage of the Occupational Safety and Health Act of 1970. Today, occupational safety and health hold a prominent place on the national agenda, and efforts to weaken the 1970 legislation or reduce its enforcement are met with strong opposition from organized labor.

The Pharmaceutical Industry

Earlier editions of this text did not list the prescription drug industry as a major special-interest lobbying organization. In recent years, however, the profit-laden pharmaceutical industry increased its spending on lobbying tactics and campaign contributions to unprecedented levels. With prescription drug prices and pharmaceutical company profits at record highs, the industry correctly anticipated public and congressional pressure to legislate controls on drug prices and drug coverage for older adults on Medicare.

Between 1997 and 1999, the drug industry spent \$235.7 million to lobby Congress and the executive branch. As lawmakers moved to add a prescription-drug benefit to Medicare that would include price controls, the drug industry hired 297 lobbyists—one for every two members of Congress.⁴⁰ Campaign contributions also rose to almost \$14 million, a 147 percent increase over previous years. An industry that can spend that amount of money to block a comprehensive Medicare drug benefit that reins in sky-high drug costs is clearly costing the American public dearly. In fact, for the first time in the history of the U.S. health care system, insurers that cover prescription-drug costs report that pharmaceutical costs now exceed the costs of hospital care.

Public Health Focus on Prevention

Although the groups discussed in the previous section are primarily concerned with the diagnostic and treatment services that constitute over 95 percent of the U.S. health care system, there is an important public health lobby that speaks for health promotion and disease prevention. Often overlooked because of this country's historical emphasis on curative medicine, public health organizations have had to overcome several negative perceptions. Many health care providers, politicians, and others associate public health with governmental bureaucracy or link the care of low-income populations with welfarism. Nevertheless, the American Public Health Association (APHA), founded in 1872 and having an aggregate membership of 50,000, has substantial influence on the national scene. However, because the positions of public health advocates are considered liberal in nature, the influence of the APHA wanes when the Republicans are in power and rises during Democratic administrations.

The significant contributions of both governmental and voluntary organized public health agencies to the health of the American public and the political struggles that led to those accomplishments are described in Chapter 11.

■ Economic Influences: Rising Costs

The single most important impetus for health care reform throughout recent history has been rising costs. Since the introduction of Medicare and Medicaid in 1965, almost all federal health law has been aimed at cost containment, but without success. Overall health care costs rose from 5.3 percent of the U.S. gross domestic product (GDP) in 1960 to over 13.7 percent in 1998. Unless there are significant constraints on rising health care costs, economists are predicting growth to 18 percent of the U.S. GDP before 2004.⁴¹

Chapter 7 presents a comprehensive overview of the complex and interlocking systems of fiscal incentives and constraints that contribute to the rising costs of health care and the difficulties inherent in attempts to exercise control over those costs.

■ The Uninsured and Problems of Access to Medical Care

The problems of access to health care, exacerbated by rising costs and reductions in Medicaid coverage, are generally related to place of residence and employment status. The lack of easily accessible health care services in rural and inner city areas often presents serious problems for low-income and lower middle-income families. For the med-

ically indigent outside of Medicaid programs, however, the absence of adequate health insurance constitutes an almost insurmountable barrier to obtaining other than emergency medical care. The risk of being uninsured or underinsured is greater for those who are unemployed, employed at low-level jobs that do not offer group health insurance, or are unable to work and are not covered by Medicaid.

The number of Americans without adequate or any health insurance was estimated at 37 million during the health care reform debates of 1994. In 1996, that number was estimated to have grown to 40 million. In 2002, estimates of the number of uninsured individuals were around 41 million. Of most importance when considering the magnitude of the problem is that the composition of that uninsured population is constantly changing. When those on Medicaid or other unemployed persons find jobs that provide group health insurance, those individuals leave the ranks of the uninsured. They are replaced, however, by those who become unemployed or lose Medicaid coverage.

The Health Insurance Reform Act, also called the Health Insurance Portability and Accountability Act (HIPAA), signed into law in 1996, was intended to address the problem of the growing number of uninsured. The legislation permits individuals to continue insurance coverage after a loss or change of employment by mandating the renewability of insurance coverage except for specific reasons, such as the nonpayment of premiums. The act also regulates the circumstances in which an insurance plan may limit benefits because of pre-existing conditions. It also mandates special enrollment periods for individuals who have experienced certain changes in family composition or employment status.

The legislation ensures portability of preexisting insurance by prohibiting insurers from declining to offer individual coverage for reasons of health status, medical condition, or other factors, such as the loss of eligibility for group coverage.⁴² The HIPAA legislation is discussed in more detail later in this chapter.

■ The Aging of America

The elimination or control of many infectious diseases through immunization and antibiotics; the implementation of basic public health measures that contribute to the safety of food, water, and living and working conditions; a far more nutritious food supply; and constantly improving medical care—all have combined to extend the life expectancy of people in the United States. Although AIDS, accidents, and violence are causing an increasing number of deaths among young people, the vast majority of Americans live to advanced ages. In

1950 individuals over age 65 constituted only 8.1 percent of the total population of the United States. The population over 65 is projected to increase to 21.8 percent by 2030, and about half of those older people will be 75 years or older. The population over 85 years of age is increasing even faster. By 2050 it is expected that one in four of those over 65 will be 85 or older.⁴³

The increased longevity of the population, particularly those with serious or disabling chronic illness, poses serious challenges to the U.S. health care system. The problems of financing and delivering an increasingly broad array of medical and other long-term care services are already serious and will become more critical as the proportion of dependent older adults grows in relation to the number still in the work force.

Although the medical model of curing illness, maximizing function, and preventing premature death has been beneficial to many older Americans, it offers little to the growing number of older citizens who are not acutely or morbidly ill, but who have irreversible physical or mental limitations that require diligent care by others. Although the number and kinds of institutionally and community-based long-term care services (described in Chapter 9) have increased, many are struggling to balance actual and perceived patient needs against their allowed benefits, rising costs, and limits imposed by third-party payers.

Of increasing importance is the need for mechanisms to support caregivers as elder care becomes the responsibility of more and more Americans. Changes in U.S. social structures have increased the stress on today's adults because they are required to provide financial, functional, or emotional support to aging family members. More women working outside the home, a high divorce rate, the geographic dispersion of family members, an increase in the number of adults simultaneously caring for both children and aging relatives, and the rise in the proportion of older adults taking care of even older relatives make respite services, adult day care, and other strategies to reduce stress and caregiver "burnout" mandatory.

■ Values and Assumptions That Guide Priorities

Under the leadership of the U.S. Department of Health and Human Services Public Health Service, a consortium of 300 organizations collaborated in a process that led to the design of a decade-long national plan for reducing preventable deaths, disabilities, and diseases. The 1990 plan was called *Healthy People 2000: An Overview of the National Health Promotion and Disease Prevention Objectives*. Most states have developed their own *Healthy People 2000* objectives tailored and targeted to their own populations.

Healthy People 2000 contains the following impressive statements:

The greatest opportunities for improvement and the greatest threats to the future health status of the people reside in certain subpopulations that have historically been disadvantaged economically, educationally, and politically. "Healthy People 2000" calls for special attention to reducing—and finally eliminating—disparities in death, disease, and disability rates experienced by these groups compared with the general population. . . . For the coming decade, perhaps no challenge is more compelling than that of equal opportunity for good health.⁴⁴

Unfortunately, Americans seem to hold values that shape their responses to proposals for changes in health delivery or financing that put the goals of *Healthy People 2000* out of reach. There is a moral commitment to the uninsured population, but much of that concern is self-serving and results from the fear of unexpected unemployment. There is a genuine desire to achieve personal peace of mind, and empathy for those without it. However, there also is a lack of self-blame. As in other endeavors, there is an absence of personal accountability among both providers and consumers in the fields of health care.

Nothing illustrates the unrealistic posturing of the public health sector better than the latest set of 10-year targets for health improvement in the United States. Assembled by a consortium of over twice as many national, professional, and voluntary organizations as produced *Healthy People 2000*, *Healthy People 2010* essentially ignores the failure to meet 85 percent of the last decade's goals and establishes several hundred more equally unattainable objectives. Notably lacking in these monumental efforts to establish health improvement goals is either the organizational commitment or the strategies to make them happen.

It is indicative of a self-indulgent society that there is a limited willingness to take personal responsibility, to sacrifice for the benefit of others, and to judge each proposed change in the health service structure in terms of reasoned self-interest. The result is a basic incongruity in the U.S. system of health care. The system strives to improve an already superb ability to care for the individual patient, but it fails dismally to address the problems of the larger society.

In a country facing epidemics of teenage pregnancy, sexually transmitted diseases, drug addiction, drive-by shootings, and crack-addicted infants, there seems to be a striking capacity for ignoring the truth about matters of public health and public good. Warren Bennis, author of *Why Leaders Can't Lead*, attributes this disregard in large part to the United States's historical commitment to individual freedom. He explains why the decline in societal concern for the less fortunate that started in the 1980s was so well accepted.

*The conflicts between individual rights and the common good are far older than the nation, but they have never been as sharp or as mean as they are today. In fact, as the upwardly mobile person has replaced the citizen, we have less and less that is good. The founding fathers based the constitution on the assumption that there was such a thing as public virtue. James Madison wrote, 'The public good . . . the real welfare of the great body of people . . . is the supreme object to be pursued.' At the moment, we not only cannot agree on what the public good is, we show no inclination to pursue it.*⁴⁵

Even the institutions in which health care providers work reflect similar values. Rosemary Stevens, author of *In Sickness and in Wealth*, writes:

*By 1980 hospitals seemed obsessed with the language of management. Instead of an increased emphasis on chronic care and social services after the advent of Medicare and Medicaid—not an unreasonable expectation in programs dedicated to the older adult and low-income populations—hospital administrative training programs began to require courses in financial management. Administrators became managers, presidents, or CEOs; and the hospital journals rang with news of “product lines” (patient care), of capital financing, of diversification and innovation and of the “bottom line.”*⁴⁶

Under pressure to adjust to rapidly changing economic circumstances, many hospitals are engaging with providers in joint investments that raise serious questions about conflicts of interest. Ventures into the construction of privately owned high-technology diagnostic facilities by providers who refer patients for those services proliferate in competition with hospital facilities, apparently without concern for the ethical issues involved.

■ Oregon Death with Dignity Act

November 8, 1994, was a pivotal date for U.S. social legislation. By a slim margin, Oregon voters approved Ballot Measure 16, the Oregon Death with Dignity Act, also known as the Oregon Physician-Assisted Suicide Act. The act legalized physician-assisted suicide by allowing “an adult resident of Oregon, who is terminally ill to voluntarily request a prescription for medication to take his or her life.”⁴⁷ The person must have “an incurable and irreversible disease that will, within reasonable medical judgment, produce death within six months.” The Death with Dignity Act was a response to the growing concern among medical professionals and the public about the extended, painful, and demeaning nature of terminal medical care for patients with certain conditions. An

additional consideration for some voters was the worry that the extraordinary costs associated with lengthy and futile medical care would exhaust their estates and leave their families with substantial debts.

A survey of Oregon physicians showed that two-thirds of those responding believe that physician-assisted suicide is ethical in appropriate cases, and almost half of the responding physicians (46 percent) said that they might assist in a suicide if the patient met the criteria outlined in the act.⁴⁸

The issue of euthanasia and physician-assisted suicide has been debated for years in other countries. Although among westernized countries only Northern Australia has legalized physician-assisted suicide, the Netherlands has a long history of allowing euthanasia within the medical community.⁴⁹ Although technically illegal, there are specifications guiding the practice, and doctors following the guidelines are not prosecuted.⁵⁰

Provisions of the Oregon Death with Dignity Act

A physician must meet multiple requirements before he or she can write a prescription for a lethal combination of medications. After the initial request, the physician must ensure that the patient is fully informed about the diagnosis, the prognosis, the risks, and the likely result of the medications and the alternatives including comfort care, pain control, and hospice care. Then, a consulting physician must confirm that the patient's judgment is not impaired by a mental condition and that the decision is fully informed and voluntary. The patient will then be asked to notify next of kin. Family notification is not mandatory, however, and physician-assisted suicide will not be denied if the patient chooses not to notify his or her family. After a 15-day waiting period, the patient must again repeat the request. If the patient does so, the physician is then permitted to write the fatal prescription.⁵¹

The Fourth Annual Report on Oregon's Death with Dignity Act, issued by Oregon Public Health Services, Center for Health Statistics, covered the period from the program's inception in 1997 through 2001.⁵² In 2001, a total of 44 prescriptions of lethal doses of medication were written by 33 physicians. Thirty-nine such prescriptions were written in 2000. Although the number of prescriptions written increased, the number of terminally ill patients who ingested lethal medication remained small. Just 19 of the 44 patients that received lethal prescriptions in 2001 actually ingested the legally prescribed medication.

Physicians reported that multiple end-of-life concerns contributed to the patients' requests for lethal medication. The most frequently reported concerns included losing autonomy (94 percent), decreasing ability to participate in activities that make life enjoyable (76 percent), and losing control of bodily functions (53 percent).

The Health Insurance Portability and Accountability Act (HIPAA)

Enacted in 1996, HIPAA is a complex law that has already begun to restructure health care. The effect of its Title 1 was to ensure the health insurance coverage of workers and their families when they change or lose their jobs. The law also prohibits cancellation of coverage because of pre-existing medical conditions.

More sweeping, however, is the part of the law called "Administrative Simplification," which required medical records to be computerized by October 2003. It is intended to reduce the costs and administrative burden of health care by standardizing the electronic transmission of many administrative and financial transactions. The standardization must also maintain the privacy of health information. As a result, the entire health care industry is involved in a costly high-tech upgrade of complex medical and financial documents to comply with the legislation.⁵³

The Internet and Health Care

Data collection and information transfer are critical elements of the health care system, so it is not surprising that the Internet has become a major influence in U.S. health care. Ninety-eight million Americans are now using the Internet to find health care information.⁵⁴ Consumers now have access to vast resources of health and wellness information, have the ability to communicate with others sharing similar health problems, and are able to gain valuable data about medical institutions and providers that permit well-informed choices about services and procedures. The number of people who have successfully completed an Internet search for answers to health care questions has almost doubled since 1998.⁵⁵ Internet users are becoming more educated and participatory in clinical decision making. Physicians and other providers are now challenged by the need to deal with a more knowledgeable and involved patient population.

Health care consumers turn to the Internet, at least in part, because of dissatisfaction with the amount of information available from traditional sources. A host of Web sites offer everything from interactive health assessments to personalized diet and fitness programs. Internet use also provides the benefit of anonymity, convenience, and freedom from inhibitions. For those reasons, it is becoming a growing alternative to traditional in-office counseling, particularly in the field of mental health. The mental health field has initiated a variety of forms of on-line therapy for consumers who are more comfortable with the impersonal nature of Internet communication.

Providers also are entering the online world of health care communication. After a slow start, provider-sponsored Web sites are proliferating at a rapid pace. In addition to information for consumers about the provider's training, competencies, and experience, many providers encourage e-mail exchanges that invite queries and provide opportunities to respond to consumer informational needs.

A wide variety of other Web-based entrepreneurial ventures have also begun to take advantage of the huge and growing market of Internet surfers. Both dependable and questionable entrepreneurs are offering consumers opportunities to cyber-shop for pharmaceuticals, insurance plans, medical supplies and equipment, specific physician services, and other health-related commodities. The public is well advised to be cautious in making commitments on the Internet. A listing of some of the most reliable consumer-oriented Web sites may be found in Appendix B.

■ The Basic Issues

The basic issues underlying efforts to improve the U.S. health care system remain, as they have for decades, concerns for costs, access, and quality. Although knowledge, technology, and resources have developed so that superb and dramatic medical care can be provided to meet even the most formidable needs of this country's population, such care is provided at unacceptable cost, with unnecessary duplications of effort, and to the exclusion of the health maintenance and preventive activities that might have reduced the incidence of the medical conditions that required those curative efforts. It is, by every assessment, a health care system focused on providing excellent care for the individuals within it, while virtually ignoring the more basic health service needs of the larger populations outside of it.

Emeritus Professor of Public Health at Yale University School of Medicine George Silver described the current health care dilemma with these observations:

The pressures on Congress, professional groups such as the American Medical Association and the American Hospital Association, and the health care insurance companies are directed toward developing a legislative package that will ameliorate the suffering of the underserved, provide coverage for the uninsured, control costs, and satisfy doctors and hospitals without huge tax increases or intolerable additional wage assessments.

Physicians are sullen and discontented under the burden of regulations and constraints that seriously impede their flexibility and ability to utilize professional judgment freely. Patients are angry with inflated costs, rising insurance premiums, and various impediments and obstacles to maintaining a comfortable, friendly

*relationship with doctors. Other patients are unable to obtain needed medical services to the extent required, or at all. Critics and reformers attack the medical profession as greedy, uncaring, and even incompetent. Malpractice accusations proliferate, and costs and judgments soar.*⁵⁶

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