

Policy Challenges in Modern Health Care



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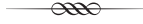
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PART I



*The Context of Health
and Health Care Policy*

Morality, Politics, and Health Policy



JAMES A. MORONE

American health care policy is different from health policy in other industrial nations. The United States has no national health insurance, of course. However, that difference simply reflects a deeper contrast in the ways we Americans think about politics and health care. European health policy analysts regularly invoke a “solidarity culture”—a staunch belief in sharing resources and concern for what might be called “the people’s health” (Morone 2000). European political cultures and institutions often reflect this collective ideal.

What most observers first notice about the American process is the unabashed pursuit of self-interest. In our dynamic (some would say raucous) system, stakeholders and interest groups jockey for advantage on every issue. One wily nineteenth-century politician put it famously after double-crossing a rival: “Politics is not a branch of the Sunday school business” (Morone 1998). This process poses a challenge for health specialists: groups pushing their own interests will stand up and oppose even the most unambiguous scientific findings.

Both scholars and laypeople usually view health policy largely through the lens of interest group politics. Stakeholders and politicians pursue their preferences. They negotiate with one another, cajole neutral parties, and mobilize their own supporters. Constitutional rules bound this process, and an elaborate network of rights protects each individual. The entire political system lurches along, operating its celebrated checks, balancing public programs with private markets, blunting radical changes, and producing incremental adjustments to the status quo. From this perspective, health science constantly wrestles with self-interested politics. Even robust findings are only as good as the policy coalition that assembles around them.

However, interest group politics is only the most obvious story. Two other traditions run through policymaking in the United States. First, Americans also share an intermittent legacy of cooperation—one that grows especially vivid during a crisis. National service programs (such as VISTA and AmeriCorps), town hall meetings (often employed by political campaigns), and attempts to stimulate citizen participation are all familiar efforts to tap the American communal legacy.

Public health advocates, in particular, often try to move beyond competition and appeal to shared interests and values.

Morality offers Americans still another powerful political framework. As foreign observers often point out, the United States remains the industrial world's foremost Puritan nation (Morone 2003a). The Puritan colonists bequeathed America a tendency to turn political differences into moral disputes. The debates that gust up around our social programs often directly concern the moral worth of the beneficiaries: Are they deserving? Such questions put vivid and contested moral images—of virtue and vice, good and evil, us and them—at the heart of American health care politics and policies.

Traditional Models of American Politics

Individualism

Why are Americans so committed to individualism (or what political theorists call classical liberalism)? One of our great national myths offers a popular answer: the first colonists sailed away from old world tyranny and settled a vast “unpopulated” land—the place almost thrust freedom on them. American settlers did not have to push aside kings or nobles to get ahead. Instead, as Tocqueville famously put it, “Americans were born equal instead of becoming so” (Tocqueville 1969, 509; Hartz 1955; Greenstone 1986). Men (and maybe women; the myth gets a bit shaky here) faced extraordinary opportunities. The land and its riches awaited; success simply required a little capital and a lot of work. The irresistible result would be the nation's celebrated individualism, a deep faith in free economic markets (some foreign observers see almost a cult), and a corresponding belief in limited government.

The U.S. Constitution organized this ideology into the nation's political rules. An elaborate system of checks and balances limited national power. But this system also offered political participants many different venues in which to pursue their interests. In the past, political systems had tried to suppress self-interest; the American founders opened the door to it. The answer to the problem of factions, or interests, wrote James Madison in *Federalist No. 10* (1787), is injecting an “even greater variety” into the political process. Today political scientists sometimes lament the hyper-pluralism of a system stalemated by competing claims, lobbyists, and lawyers. The practical result is that almost no political arenas stand above the scramble. There are only a very few nonpartisan agencies; there is no prestigious civil service trusted by all sides; and even the judiciary has become another political branch of government (McConnell 1966; Kersh and Morone forthcoming).

The sheer ferocity of this scramble for advantage poses a particular dilemma for health care policy. After all, medical science seeks objective answers to questions about health and health care. It documents, for example, the dangers of smoking, obesity, stress, unsafe sex, and delayed medical care. The surgeon general, the Institute of Medicine, and the Centers for Disease Control and Prevention might issue warnings based on good science. However, any effort to act on those findings simply triggers the politics of self-interest. No cultural mores penalize such

a reaction: in politics, economic self-interest is every bit as legitimate as medical science.

The result appears to pose a conflict between medicine and politics. No matter how robust the scientific findings, political interests routinely mobilize and often delay or derail action. The politics of individualism offers health-minded reformers unambiguous advice: use your scientific findings to mobilize your own side. In the political arena, your science is only as strong as your political coalition.

Community

During the 1980s, critics began growing uneasy about unabashed self-interest and untrammelled markets. What happens to the common good when everyone pushes only for number one? Back to early America trooped the social theorists. There they discovered an entirely different American political tradition, one grounded in a robust collective life. In contrast to the legends of rugged individualism, historians documented rich networks of communal assistance. If a barn burned down, townsfolk banded together and helped their neighbor raise another. If iron pots were expensive, families shared them—early American household inventories often list one-half or one-third of a pot or skillet (Morone 2003a, 7).

The communal story sparks enthusiasm across the political spectrum. Here, argue proponents, lies firm ground on which to imagine a renewed civic culture. Americans are not just celebrants of self but partners in a shared public life, not just individualists but communitarians. Conservatives saw an opportunity to restore traditional American values; progressives stressed our obligations to one another, our shared communal fate.

For medical reformers, the legacy of community recalls an often-overlooked public health legacy. After all, American cities have a long history of funding clinics and fighting infectious diseases. A communal heritage—if it can somehow be tapped—opens the prospect of putting self-interest in a larger, civic-minded context (Putnam 2000; Skocpol 2003).

Franklin D. Roosevelt introduced his idea of social security with the classic communal appeal for public health. “The causes of poverty . . . are beyond the control of any individual.” So much for the individualistic version of American politics. What was the alternative? Community effort. When a modern civilization faces a disease epidemic, said Roosevelt, “it takes care of the victims after they are stricken.” But it also roots out the source of the contagion. Roosevelt proposed an entire social program built on the public health model. He would put aside the “jungle law of economic competition” for “brotherly” cooperation (Roosevelt 1932, 38).

Of course, President Roosevelt introduced his program in response to the Great Depression. The communal alternative has always been the more fragile and intermittent approach, displacing individualism largely during crises and extraordinary circumstances. Moreover, political theorists warn us against romanticizing the American communal tradition. After all, that tradition also animates a painful historical legacy: the urge to reject entire groups based on race, gender, ethnicity, or religion. The Ku Klux Klan, militia groups, and a long, harsh line of nativist organizations also represent communal thinking (Smith 1997).

Still, the communal vision offers a potential rejoinder to the politics of self-interest. Communitarians were critical of the Clinton administration's health reform effort, for example, because officials tried to sell it by promising one group after another that the plan was in their self-interest. The moral of that story, warned White House advisor Paul Starr, is that with "so many people on board . . . our boat may sink from its own weight." The communitarian perspective would have appealed bluntly to the common good—to the notion that we all share values as residents of the same nation (Hacker 1997, 138).

Could such a collective appeal work? Under what circumstances? What conditions stir America's communal legacy? And what about the ugly urge to reject some Americans? We can find answers to these questions in another tradition: American morality politics.

Morality Politics

Americans take religion and morality more seriously than citizens of most other industrial countries. Some 95 percent of all Americans believe in God—a distinct contrast to Sweden (52 percent), France (62 percent), and Britain (76 percent). While other industrial nations grow secular over time, the United States keeps experiencing religious revivals (Morone 2003a, 22). That social fact has deep consequences for U.S. politics. In a nation marked by moral and religious fervor, partisans often import their faith into politics.¹ Moral fervor drove—drives—an extraordinary range of political movements: civil rights, temperance, tobacco, anti-abortion, and many others. Moral judgment seeps into all kinds of political issues in both dramatic and subtle ways.

Moral politics comes with its own founding story. "It seems to me," wrote Alexis de Tocqueville, "that I can see the entire destiny of America contained in the first Puritan who came ashore" (1969, 279). Those first settlers arrived in the New World facing the essential communal question: Who are we? Who were they? The Puritans concocted an extraordinary answer: they were the community of saints. Leadership, in both state and church, went to men who could prove that they were preordained for salvation. The saints could vote, hold office, and enjoy full church membership. (The methodology for proving salvation was complicated, but wealth and health were taken as fairly reliable indicators.) People who were morally uncertain—those who had not demonstrated salvation—were expected to follow the proven saints: they went to church, for example, but did not hold office, vote, or become full church members. And the damned were driven out: witches were hung, Native Americans slaughtered, and heretics sent packing (mainly to Rhode Island, the latrina of New England for all its noxious heresies). In short, moral standing defined leaders, allocated privileges (such as voting), defined communities, and identified the dangerous "other" (Morone 2003a).

The Puritan idea burst out of New England and spread across America (thanks to the purest Puritans, the Baptists). The essential Puritan trope still persists and flourishes: moral virtue continues to define the community, still distinguishes "us" from "them." Moral images specify privilege or punishment, inclusion

or exclusion, deserving poor or dangerous other. These images of potential beneficiaries—often shifting, constantly contested—lie under every U.S. social policy. “We” get assistance; “they” face social controls.

The traditional individualist model of American politics emphasizes a sharp line between private realm and public sphere. Constitutional rights bar any public authority from meddling in people’s private lives. “However strange it may seem,” wrote John Locke in 1689, “the lawgiver hath nothing to do with moral virtues and vices.” In this view, citizens draw on their private desires and values and then charge into the public, political realm to advance their goals. In the patois of economics, every agent maximizes her own utilities (Locke quoted in Morone 2003a, 6). In contrast, moral politics refuses to honor the private-public distinction. It explicitly enters the private sphere. Individual virtue—character—affects the public good. Citizens’ private behavior, ruled right out of politics in traditional models, now becomes crucial. Some group’s private behavior (real or imagined) seems to threaten the community.

The Puritans bequeathed the United States two distinct moral visions, two answers to that political bottom line: Whom should we blame for our troubles? I call the two answers the Puritan and the social gospel.

Puritans

The Puritan approach focuses on dangerous sinners lurking in our society. The fears tilt political debates; they sink the communal urge by eroding our sense of common values and shared fate. The policy problem turns instead to protecting us from them.

The personal transgressions—the sins—that ostensibly endanger the nation are most often public health sins. For example, the most sustained moral campaign in U.S. history targeted substance abuse. Temperance crusaders organized in the early nineteenth century, won their first statewide prohibition in 1851, managed national prohibition by 1920, and now inspire a formidable drug war that draws heavily on Prohibition-era jurisprudence (Morone 2003a).

Sexual threats pose another political perennial. The American Medical Association launched its first great political campaign against abortion—a common practice in the mid-nineteenth century, when roughly one abortion occurred for every six live births. Physicians consolidated their own role as social leaders and healers by turning abortion into a crime. Abortions, they argued, were subverting the good community by undermining the white, middle-class birth rate while foreign immigrants multiplied and threatened to swamp American blood (Storer 1867; Morone 2003a).

Similarly, sexually transmitted diseases bred in the urban ghettos and spread into middle-class families. After all, reported the *American Journal of Public Health*, “many . . . white . . . boys are going to sow their wild oats” (Allen 1915, 200). In the South, the black syphilis rate became a standard justification for Jim Crow apartheid. A similar argument reappeared during the first wave of AIDS hysteria; frightened Americans dreamed up all sorts of ways to keep homosexuals from slipping their disease into mainstream culture (Morone 1997).

In each case the same general pattern recurs. Some dangerous personal behavior—drinking, drugs, sexual practices, teen pregnancy, birth control, abortion, the list goes on—threatens the community. The questionable behavior is often associated with some group. Moral politics triggers vibrant stereotypes: Irish drink, Italian immigrants have too many babies, Muslims are terrorists, and black people commit almost every possible sin. Political leaders warn that America faces terrible decline if we don't find a way to rein in the dangerous people and their bad behavior. Standard solutions run to pledges ("just say no" to alcohol, drugs, and sex before marriage), prohibitions, restrictions, regulations, more prisons, and tougher laws.

Of course, all societies impose controls. The political key lies in the emphasis on personal discipline, in the balance between restrictive policies and social welfare benefits. I experienced a vivid illustration of the difference during a debate on the Clinton health reform proposal in 1994.

I was debating a Republican senator who opposed the Clinton plan. We were before a young, liberal audience that was giving the Republican a very chilly hearing. Then, toward the end of the debate, he abruptly turned to face me. The body language said, "Okay, let's quit kidding around." And here's what followed: "Look, professor, you can't expect the hardworking people of suburban Cook County to go into the same health care alliance [a kind of insurance pool] as the crack heads in the city of Chicago." When I turned to face the audience, all set to brush aside this fatuous dichotomy, I saw a room of suddenly sobered liberals. "Yes," they were thinking, "that is a terrible problem." "Hey," I yelled, "those uninsured people in the city of Chicago are college students and hardworking nurses and taxi drivers doing double shifts and single moms holding down two jobs." No dice. In fact, it only got worse. Crack heads and single moms. Our imagined community, struggling together to fix a troubled health care system, had vanished in an instant. Now it was a hardworking us against a drug-abusing, sexually promiscuous them. Forget about extending health care coverage—what "those people" need is moral discipline. The politics of social policy always turns on the mental images we create of the beneficiaries (Morone 2003a).

The Social Gospel

An alternative moral tradition once offered a sharp alternative to blaming individuals. I call it the social gospel (borrowing from a group of reformers at the end of the nineteenth century). Social gospel thinking shifts the focus from individual sinners to an unjust system. The neo-Puritans blame individual misbehavior for society's troubles; the social gospel approach blames society—or socioeconomic pressures—for individual troubles. The causal arrow runs in precisely the opposite direction: the economic system, race prejudice, underprivilege, and social stress put pressure on people. If those people behave badly (by using illegal drugs, for example), it is largely because social and economic forces have pushed them into a tough corner. The social gospel solution appears in countless variations, but they converge on the same familiar points: fix the system and give

every American a fair chance to prosper; don't blame those who fall by the way-side; we all share a common duty to help the disadvantaged.

Thinkers in the late nineteenth and early twentieth century first systematically articulated a version of the social gospel. Reformers like Jane Addams began challenging the dominant Victorian paradigm: poverty caused drunkenness, they said, as much as the other way around. Low salaries and harsh factory conditions—deprivation, not depravity—pushed women into prostitution. This way of thinking came to power with the Roosevelt administration in 1933.² Roosevelt constantly articulated the social gospel, and his administration hammered out policies that reflected that approach. The social gospel, like the Puritan perspective, turns on images of health and disease. However, while the neo-Puritans tend to fear contagions, the social gospel seizes on community health as a public policy model.

Roosevelt first introduced the idea of social security while campaigning for president in October 1932. Roosevelt began by declaring that because it was Sunday, he would not be “talking politics” but “preaching a sermon” (Roosevelt 1932, 38). True to his word, the candidate packed his address with religious quotations and allusions. As I noted, he used a public health analogy to draw a picture of the good society, one that protected the weak and the disadvantaged.

Roosevelt brought these generalities down to political earth with sad stories about good people. An 89-year-old neighbor had died while milking a cow, after a blizzard no less; now it was our collective responsibility to help his “83-year-old kid sister,” who was languishing in an insane asylum because she had nowhere else to go. Roosevelt was off and running down a roster of needy innocents who needed help: hungry children in public schools, injured workers, sick men and women, crippled children, the unemployed, and many more (Roosevelt 1932, 38). Each example came with the same political spin: poor people are virtuous neighbors who have fallen on hard times. Roosevelt was consciously displacing the past icons of depravity—undisciplined black men and lazy immigrants lounging about the saloons.

That last example, drinking, carried plenty of baggage, for these were the last days of Prohibition. In the New Dealer's hands, excess drinking turned from sin to illness; dry pledges and national prohibition gave way to treatment and education. The fault line between neo-Puritans and social gospel would run right through the next half-century: vice versus illness, crime versus public health, sin versus social responsibility. The social gospel view reached its high tide during the southern civil rights movement and the Johnson administration's Great Society. “Should we double our wealth and conquer the stars,” declared Johnson in his most beautiful speech, “and still be unequal to this issue [of racial inequality] then we will have failed as a people and as a nation. For with a country as with a person; what is a man profited, if he shall gain the whole world, and lose his own soul?” (quoted in Morone 2003a, 426).

The Reagan administration eventually buried the whole approach. Reagan scoffed at the idea of collective responsibility. Instead, he turned personal responsibility

—just say no—into a formidable policy mantra. Today the old social gospel idea that drug abuse or crime might stem from underprivilege finds almost no policy traction. Contemporary politics includes plenty of moralizing, but there is scant evidence of the old social gospel idea that we share a collective responsibility to foster social justice for everyone.

Moral Politics in Action

Morality politics are protean and pervasive, springing up in unexpected places and surprising unwary policymakers. Consider two recent cases: school health centers and the politics of obesity.

School-Based Health Clinics

Difficult health problems such as substance abuse, reproductive health, and depression can land teenagers in serious trouble.³ Given the nature of these problems, perhaps it is not surprising that they are slow to seek care. However, ignoring adolescent health leads to serious problems: one million unintended pregnancies a year, three million sexually transmitted diseases, more than four thousand suicides, and terrible incidents of school violence. The United States has a high adolescent and young adult death rate: 1.5 deaths per thousand young males (in contrast to 0.7 in England, 0.6 in Sweden, and 0.9 in Germany).

One policy response that grew increasingly popular in the 1990s sprang from a simple intuition: put the health care where the kids are. Local hospitals, community health centers, and public health departments opened health centers in schools, especially in poor neighborhoods (Morone, Kilbreth, and Langwell 2001).

Across the country school-based health centers immediately set off a political storm, as they inevitably faced issues such as substance abuse and reproductive health. Cultural and religious conservatives feared that providing treatment (possibly without parental notification) would implicitly condone illegal drug use, underage drinking, and premarital sex. Conservatives countered with calls for stronger discipline, personal responsibility (just say no), and abstinence education. By 1997 the Personal Responsibility and Work Opportunity Reconciliation Act (the welfare reform bill) had introduced abstinence education in schools across the United States (Morone 2003b).

Some liberals confronted the moral issues head on, responding that young people needed counseling on sexuality and chemical dependency. If teens were going to have sex, argued these advocates, they ought to be prepared. Dr. Jocelyn Elders set off a firestorm in her first press conference as director of the Arkansas Department of Health: “We are not going to put them on their lunch trays. But yes, we intend to distribute condoms [through] . . . school based clinics” (Elders 1996, 242).

The battle was on. However, liberals soon discovered that cultural (often Christian) conservatives had formed powerful local organizations across the nation. Those groups focused, in particular, on school boards. In the Northeast conservatives found allies in the Catholic bishops, who were chary of birth control.

In the South and West conservatives acted with the Christian Coalition. In the Pacific states they allied with anti-tax advocates. When the Christian Coalition helped Mike Foster come from far behind and win the governorship of Louisiana, the organization's first demand was an end to the school health centers.

Parental notification posed another difficult issue. When the California legislature passed a bill guaranteeing privacy in school health centers, critics charged the government with undermining parental control. More than ten thousand people rallied against the bill, which conservative talk-show host Dr. Laura turned into a highly publicized cause. Governor Gray Davis responded by vetoing the legislation.

Yet despite ardent opposition, the clinics survived and flourished. Even the school centers in Louisiana weathered the storm and spread. How? Proponents turned moral politics into a classic interest group issue. Where cultural conservatives opposed reproductive health services and sex education, the centers backed off, usually referring their student patients to other providers. But more important, advocates employed that classic political wisdom: build a constituency. As children started receiving treatment, parents, teachers, and health providers rallied around the centers, countering moral complaints with down-to-earth descriptions of kids getting care.

These respectable locals—parents, teachers, and health care providers—told their legislators heartwarming stories about children and the school clinics. Legislators are always primed to deliver concrete benefits to “responsible” community members, and school clinics have proven a prime constituent service. They combine education and health care. They do not bust the budget. They are simple to understand. They offer fine photo opportunities. And they can be doled out one school at a time (Morone, Kilbreth, and Langwell 2001).

In the end the health centers overcame the opposition and expanded, from some 150 in 1990 to more than 1,300 today. But both sides of the story are important. Although advocates defused the moral attack, the criticism powerfully shaped both the health centers and their politics. The health centers reflect the larger politics of public health. Reviewing the response to AIDS, for example, the *American Journal of Public Health (AJPH)* reported that Americans engage in far more premarital sex than their British counterparts while condemning promiscuity at much higher rates (Morone 2003a, 481–482). The colonists still adhere to the old Puritan spirit, chortled the *Economist*, reporting on the *AJPH* survey, and they pay the price (Morone 2003a).

American public health policies must steer carefully between sin and censure. When AIDS hit, the more tolerant and abstemious Europeans quickly launched forceful public health campaigns that included leaflets, television advertisements, and needle exchanges. Across the Atlantic, Americans delayed their efforts while squabbling over the exact moral nuance of their message, particularly the degree of emphasis on abstinence. U.S. incidence of AIDS soon measured ten times higher than Britain's (Morone 2003a, 481). Of course, many factors underlie such differences, and, as with the school health centers, Americans eventually sorted out the tension between education and abstinence. But moral conflict again profoundly shaped the health program and its outcomes.

Obesity

In 2001 Surgeon General David Satcher issued a startling report: over 65 percent of Americans were overweight and 30 percent were clinically obese.⁴ Obesity, rising at epidemic rates, threatened to overtake tobacco as the chief cause of preventable death. Americans (in fact, residents of almost every nation) suddenly found themselves bombarded by data on obesity's toll—on our lives, our health, and our budgets (Kersh and Morone 2002a).

The issue first provoked derisive commentaries about “big chocolate” and its “menace.” The critics drew on the familiar model of America as a nation of individualists who celebrate free markets and vehemently oppose government meddling in private lives (Kersh and Morone 2002b). What could be more personal than the food one eats? The critics were pointing to a genuine dilemma. How might eager public health advocates make a political issue out of such a private matter?

One classic response lies in the moral realm. Nothing moves the political system like a threat from greedy companies who put profits before the public's welfare. Demonizing providers regularly offers reformers a way to cross into the private sphere and control, limit, or prohibit. In the early twentieth century, temperance advocates gained considerable political mileage by charging breweries and saloons with pouring poison into the American workingman. Tobacco offers a more contemporary example. Public health officials spent years trying to publicize the danger, but for political effect nothing matched revelations that the industry had consciously misled the public about the health effects of smoking.

The same kinds of condemnation rapidly entered the obesity debates. Public health scholars explain the startling rise in obesity by pointing to an “unhealthy food environment.” For starters, portion sizes have undergone an extraordinary expansion. In his influential book *Food Fight*, Kelly Brownell describes the growth of the all-American burger. In 1957, he reports, the typical hamburger weighed in at one ounce and 210 calories. Today that burger is up to six ounces and 618 calories—and that's before the bacon, cheese, supersized fries (another 610 calories), and double-gulp (sixty-four-ounce) soft drink (Brownell and Horgen 2003, 183). Highly competitive food service entrepreneurs trumpet ever-larger portions: think Whopper, Xtreme gulp, Big Grab, and the Beast. Each innovation ups the ante in serving sizes. Even ostensibly healthy products come loaded with hidden ingredients: sugar (or high-fructose corn syrup) is the first ingredient in Kellogg's Strawberry Nutri-Grain yogurt bars, and the second in Skippy super-chunk peanut butter (Brownell and Horgen 2003; Nestle 2002; Kersh and Morone forthcoming).

Moving from these analyses to charges of corporate villainy required only a small step. As the most ardent critics put it, a cynical industry targets children and reshapes their eating habits. These companies put soda machines in schools and fast food outlets in lunchrooms. The result, argues Eric Schlosser in *Fast Food Nation*, is “a lifetime of weight problems” and “emotional pain.” And that is just the beginning. Fast food, he continues, has trashed the countryside, widened the social gap between rich and poor, and turned the meatpacking industry into a labor nightmare (Schlosser 2001, 240). Schlosser's descriptions of the food business are every bit as horrifying as Upton Sinclair's famous expose *The Jungle*.

Schlusser's book became a surprise bestseller, and a steady stream of exposes rapidly followed.

One backlash against fast food muckrakers simply shifts the blame. If some liberals demonize the industry, some conservatives blame overweight individuals. Heavy people lack willpower, they make foolish food choices, they live in unhealthy ways. Like smokers, drug abusers, and heavy drinkers, obese people have made personal choices; they should just say no and push away from the table. The distinct echo from other substance abuse controversies has another unhappy parallel: obesity tends to concentrate in poor and minority communities.

Each picture of blame—the industry versus the individual—carries different policy implications. A focus on the industry suggests requiring better food labels, rethinking school nutrition, restricting advertising, regulating fat content, punishing misleading claims, taxing unhealthy ingredients, and so on. Successfully demonizing big food—directing popular anger at the industry—may cut through the checks and balances of the political system and provoke action.

However, the politics of demonization cuts two ways. Some observers charge that food stamps and school lunches only encourage poor people—who are already fat enough—to overeat (Kaufman 2003). Others have suggested an insurance premium tax on heavy people. Once policymakers begin condemning heavy people, the list of possibilities rapidly grows.

The larger lessons from America's long moral history suggest that demonization is always tempting, since it gets political results, but always dangerous: it fractures communities, limits the range of health policy alternatives, and tends to land hardest on poor and weak populations. In the long run, public health advocates do best when they focus on policies that foster healthy lives and build strong communities.

Past efforts to regulate private behavior, such as alcohol and tobacco use, also take us completely beyond politics and into the cultural realm: Americans dramatically reduced their drinking, their smoking, and even their tolerance for secondhand smoke. When advocates detect a crisis, define a problem, and seek a solution, they are—indirectly, perhaps often unexpectedly—educating the public. The obesity wars are likely to grow, spread, and generate considerable political heat. However, if the history of drinking and smoking serve as a guide, the most important result may lie in the conclusions that citizens draw about their own lifestyles (Kersh and Morone forthcoming).

Epilogue

Moral fears and aspirations profoundly affect American politics. Franklin D. Roosevelt and Martin Luther King made moral arguments as they redefined American social policy. President Ronald Reagan asserted a very different moral framework: neo-Puritan rather than social gospel. The force with which he championed his alternative, and the success he met, may be his most enduring domestic legacy.

When it comes to moral politics, every side seizes on health care. The Puritan approach focuses on threats to public health: drinking, drug abuse, out-of-

wedlock births, sexually transmitted diseases, and more. Fears often lead to powerful public action: to restrictions, regulations, and prohibitions.

Proponents of the social gospel alternative reframe the problem away from sin and sinners. They see illness rather than crime, addiction rather than moral weakness. They would treat rather than punish; they look past personal behavior and focus on complex social causes. They constantly echo Franklin Roosevelt's Sunday sermon on social security and call for public health solutions. Puritan drug wars elicit social gospel calls for treatment, education, and harm reduction. More broadly, social gospel pushes for social justice; it promotes collective responsibility toward all members of the community. However, today's call for social gospel programs is only a weak echo of the powerful reforming tradition that dominated American politics in the 1930s and 1960s (Morone 2003a, 407).

Still, down through American history and across a wide political spectrum today, every side uses images of health to articulate its hopes and aspirations, to voice its fears and warnings. The problems we face and the solutions we contrive ultimately revolve around our definitions of health and illness and the pictures we construct of one another. In the end, American morality politics simply reminds us of the importance—the cultural power—of health, health care, and health studies in forging a good society.

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Notes

1. People often ask me about the constitutional separation of church and state. In fact, that is precisely what fostered the American religious tumult. By keeping government out of the religious sphere (and refusing to privilege any one sect or faith), the Constitution facilitates robust competition—precisely what makes the American religious culture so fluid and vital.
2. Historians would not categorize Roosevelt with the social gospel thinkers. I have redefined the category around its most salient features and applied it more generally. For details, see Morone 2003a, part IV.
3. This discussion of school centers comes from work I have done with Elizabeth Kilbreth. We are grateful to The Robert Wood Johnson Foundation for funding the research.
4. My discussion of obesity is shaped by the insights of my collaborator, Rogan Kersh.

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Cross Pressures

THE CONTEMPORARY POLITICS OF HEALTH REFORM



THEDA SKOCPOL AND PATRICIA SELIGER KEENAN

*T*he past decade has witnessed some amazing twists and turns in U.S. health care politics. Starting in 1993, President Bill Clinton attempted to push through a comprehensive reform that would have guaranteed health insurance to all Americans, extending coverage to low-wage workers who predominated in the ranks of the uninsured. Yet within a year, public opinion turned as interest groups and partisan forces mobilized against the reform proposals, leading Clinton to abandon them (Broder and Johnson 1996; Skocpol 1997). After the 1994 midterm elections, Republicans took control of Congress and redefined health care reform to mean containing costs and restructuring Medicaid and Medicare. But Republican proposals, too, proved unpopular and largely failed (Peterson 1998).

Health reform proposals then concentrated on incremental adjustments until 2003, when Republicans in control of the presidency and both houses of Congress just barely pushed through a major enhancement and restructuring of the Medicare program, which covers 40 million elderly and disabled Americans (on the politics of this episode, see Skocpol 2004). In one of the most extraordinary episodes in U.S. health care politics, Republicans sponsored the addition of a prescription drug benefit to Medicare, a public-sector program they had long questioned, while most Democrats criticized and opposed the legislation even though it mandated expanded benefits.

How are we to understand the contemporary politics of health reform? How do issues rise on the agenda, and what forces determine the shape and fate of legislative proposals? We use insights from political science research on agenda setting and policymaking to examine key episodes and trends, especially the Clinton health reform episode of 1993–1994, the attempted Republican cutbacks of the mid-1990s, and the enactment of Medicare restructuring in 2003. Proposed reforms that make headway, we argue, build on existing public-private arrangements and are more likely to be successfully enacted if they are inherently ambiguous and stress benefits and subsidies rather than cost-constricting regulations or funding cuts. We then draw upon knowledge of past episodes to speculate about the future course of health reform politics.

A Perspective on Reform Episodes

Health reform is inherently multidimensional. Reform can be defined to the public in terms of new benefits, effects on existing benefits, coverage expansions, cost reductions, access to new medical treatments, balance between government role and market-based approaches, effects on small businesses, and so forth. Because of the many dimensions to health reform issues, shifts in definition can create unexpected swings in the direction of policymaking.

The multidimensionality of health care issues—along with the public-private nature of U.S. health care financing and delivery systems—means that major bills are often highly complex. It is not uncommon for major reform proposals to include provisions that simultaneously attempt to expand coverage, contain costs, and address the quality of care—not to mention provisions designed to appeal to policymakers holding diametrically opposed preferences about markets and government. Complexity and ambiguity are necessary to forge compromises in the U.S. political system, which allows many players to exert vetoes as legislation proceeds. Yet when legislation addresses multiple aspects of an issue, it can also become increasingly tricky to reach closure. Choices regarding which element to address first create more avenues for strategic maneuvering, affecting possibilities for success and leading to continuing struggles in the aftermath of both enacted and failed legislation.

Moreover, reform attempts “feed back” into future politics (Hacker 2002; Pierson 2000). However they turn out, reform episodes affect balances of political power, which in turn influence the types of reforms next debated. New interest groups may be activated and new stakes defined. Large-scale health reforms can also alter balances of partisan power. For example, the defeat of the 1993–1994 Clinton plan helped propel Republicans back into control of the House of Representatives for the first time in four decades.

We posit three key phases during episodes of health reform: getting issues onto the agenda, debating policy, and producing outcomes. This analysis enables us to identify when and how key political factors come into play (for further elaborations, see Baumgartner and Jones 1993; Downs 1972; and Kingdon 1995). Early in a reform episode, for example, public opinion typically favors changes, especially those that improve benefits. But once policy debates begin, interest groups and partisan forces can sway public opinion in new directions.

The Public’s Influence

Because of persistent trends in the health care system—including increases in the numbers of the uninsured and rising premium and prescription drug costs—the public has favored extending insurance coverage for some time. At any given juncture, specific concerns may vary by subgroup and focus on lack of insurance, costs to those who are covered, or scope of coverage. As they become salient, these public concerns influence the reform possibilities discussed by politicians and help set the legislative agenda.

Coverage and costs were the key public concerns in the early 1990s, when an economic downturn threatened the insurance coverage of many middle-class Americans, even as the rising cost of private insurance greatly concerned employers. The Clinton proposals aimed to address such concerns by linking cost controls and new guarantees for the middle class to coverage extensions for the uninsured. By the mid-1990s, concerns about reducing the federal budget deficit had become salient among much of the U.S. voting public. After capturing control of Congress in 1994, Republicans attempted to link Medicare and Medicaid “reforms” to cutbacks in public spending, which would, they said, help reduce the deficit.

More recently, politicians have focused on another public concern: the adequacy of Medicare in an era when prescription drugs have become central to health care. The needs of low-wage workers without any health insurance coverage are arguably much greater than the needs of elderly Americans for cheaper prescription drugs, as only about a quarter of the elderly lack drug coverage of any kind. Nevertheless, elderly concerns tend to weigh heavily with office-seeking politicians. The elderly are especially attentive to politics, and older voters of all income levels participate in elections at higher levels than their younger counterparts (Campbell 2003). Older voters are a swing constituency vital to both parties, constituting about 25 percent of voters in presidential elections and about 30 percent of voters in off-year congressional contests.

When elderly concerns about paying for prescription drugs grew acute in the 1990s and early 2000s, therefore, office-seeking politicians of both parties paid attention. Indeed, President George W. Bush convinced conservative Republicans, normally opposed to public entitlements, to vote for the Medicare prescription drug benefit in 2003. Republicans believe that denying Democrats an advantage with elderly voters may be the key to retaining governing power in the years ahead.

In short, public concerns spur politicians to keep talking about extending health insurance coverage or other apparently popular goals, especially in election or pre-election years. Nevertheless, as major debates unfold opponents of change can also gain leverage with public opinion. Once proposals begin to move through Congress, considerations apart from simple public hopes play an equal or greater role—especially partisanship, interest group activity, pre-existing institutional arrangements, and budget considerations. As such factors come to the fore, public support for legislative innovations may wane, especially if there are competing proposals for reform or debates switch to a focus on possible cuts in existing benefits.

Such influences certainly sparked shifts in public opinion during the 1993–1994 debates over the Clinton health plan, when the middle class worried that comprehensive reform might threaten existing health insurance (Blendon 1995; Jacobs and Shapiro 2000). During the mid-1990s, Republican proposals for cutbacks in Medicare spending via provider payment reductions also backfired when President Clinton gained popularity after suggesting other means of reducing deficits. Public preferences for benefits thus trumped any general desire for restrained federal spending.

Changes in the focus of debates and accompanying shifts in public opinion were also discernible in the 2003 Medicare reform episode. Even though this legislation passed, public doubts grew as opponents pointed out the gaps in prescription drug coverage and highlighted the ways the new law might undermine broader guaranteed coverage in Medicare. The elderly had high hopes for adding a prescription drug benefit to Medicare (*Washington Post/Kaiser/Harvard* 2002). But by the time the legislation was on the verge of passing, a clear majority of Americans over age fifty opposed it (National Annenberg Election Survey 2003; Skocpol 2003) and doubts remained after the law was enacted (Milbank and Deane 2003). While shifts in public opinion helped to block enactment of major reforms in 1993–1994 and 1995, this time Congress acted before public worries became obvious. Yet public disillusionment may still matter in future skirmishes over issues that the legislation leaves unresolved.

The Role of Parties and Ideology

U.S. parties and legislators approach health reform issues with ideological preferences as well as concerns about elections and public constituencies. In health care, a major source of disagreement concerns the role of government in America's complex and mixed public-private system of health care financing. Liberals want to expand government guarantees and regulations because they believe that competing private insurers, left to their own devices, will tend to exclude sick or costly people. Conservatives, in contrast, believe that market competition maximizes choice and should ultimately lower costs, or at least shift them toward individuals who can make choices and trade-offs.

In recent times, ideological polarization between activists and members of Congress affiliated with the two major parties has grown considerably (Fiorina 2002, 526, figure 4; Poole and Rosenthal 2001). Although the parties are relatively evenly balanced in Congress as well as among the electorate, this polarization means that slight shifts in power can make a big difference in the shape of compromises as well as the chances for legislative success.

Enacted health care reforms tend to reflect complex compromises between public guarantees and private provision. Nevertheless, the party in power sets the framework that governs such compromises. In 1993, President Clinton and congressional Democrats tried to work out a middle-of-the-road system for universal coverage that relied on private insurers and the employer-based insurance system. Still, they aimed for an overarching framework of public guarantees, regulations, and cost containment. In contrast, during the 2003 Medicare reform episode, Republicans tried—and to some degree succeeded—in making the prescription drug benefit conditional on new subsidies for private market forces in Medicare.

Despite these considerations, there are forces that cut against ideological and partisan polarization. Ideology still varies to some degree within each major party, for example, perhaps especially in the Democratic Party, where politicians favoring market competition in public programs coexist with others who would like a unified “single-payer” health insurance system financed entirely through taxation.

Constituency pressures on elected officials also cut across the partisan divide and force them to veer from ideological preferences, especially among Republicans. Regardless of party, for example, legislators from rural areas have distinct goals from those from more populated areas. There may be only one or a few insurance providers in any given rural area; private managed care may remain undeveloped; and rural hospitals struggle to provide comprehensive, convenient services to sparse and often aging populations. Even conservative Republicans may see more limited possibilities for unfettered market competition in such circumstances. Legislators from rural areas thus demand increasing payment rates for rural providers, and the 2003 Medicare legislation could not have passed if it had not included such subsidies.

The Power of Interest Groups

A crowded universe of interest groups also shapes attempts at health care reform, with some groups likely to help set agendas and others more likely to quietly influence the details of legislation.

Since the 1960s, interest groups of many kinds have proliferated in the United States (Berry 1997). Such proliferation has been especially marked in the health care arena—in large part because of increases in federal regulation and spending (Peterson 1993; Skocpol 2003, 146–147, table 4.2; Walker 1991). A rise in the number of public interest groups representing health care consumers creates new capacity for pushing health-related issues onto the public agenda. Nevertheless, professionals run many such public interest groups out of national offices. They may be good at putting problems on the agenda, but they do not usually have the organizational infrastructure or reach to pull millions of citizens into active lobbying on behalf of health care reform (Skocpol 2003). Thus popular issues may appear on the agenda, but lack staying power when ideological divisions occur or opposing interest groups mobilize (cf. Skocpol 1997 for the story of how this happened in the 1993–1994 Clinton health reform episode).

Interest groups representing providers, medical manufacturers, and health insurers have also multiplied. Business groups are highly organized in very specialized ways and they may see huge stakes in even slight adjustments of federal subsidies or regulations. Depending on the issue, the strategies of these groups can range from behind-the-scenes negotiations to increasingly sophisticated public campaigns.

The Clinton health reform episode opened a new chapter in the strategic use of technologies by provider, manufacturer, and insurance groups to reach the general public, key legislators, and grassroots supporters (Broder and Johnson 1996). These groups are often able to affect the details of proposed new legislation as it works its way through congressional committees. Interest-group brokered compromises often increase the complexity and opacity of health care legislation, making it hard for the general public to follow the debate and outcome (Pear and Toner 2003). Pressure from provider and insurance groups may also increase the likelihood that reform proposals will contain expensive subsidies and weak federal regu-

latory authority, because business interests are looking for profits and room to maneuver in the marketplace.

The Ironies of Budget Politics

Budget constraints have been an almost constant factor in health reform politics since the 1970s. Medical care spending consumes a growing share of federal and state budgets and employer payroll expenses. Congressional rules requiring the “costing out” of reform proposals ensure that their costs play a role in the policy debate. Further complicating matters is the fact that, while budgetary pressures concern policymakers, cost containment is not popular with the public and is often opposed by provider interests as well.

For ideological reasons, politicians disagree about preferred responses to rising costs. Liberals believe in using public clout to control costs, while conservatives favor market competition. Policy experts—including those who share policy goals—may also disagree regarding preferred approaches because of the difficulty of assessing how markets work under imperfect competitive conditions. Ironically, all these cross pressures produce a situation in which politicians pay loud lip service to “cost control,” but successful legislation actually provides generous payoffs to beneficiaries and providers—leading to recurrent problems with rising costs.

Efforts to address costs in ways the public can easily perceive have proven politically risky. The Medicare catastrophic legislation of 1988 relied on financing paid by seniors themselves, but seniors soon opposed that step. Their public outcry was most dramatically illustrated by images of a group of angry seniors surrounding Representative Dan Rostenkowski’s car, and Congress soon repealed the controversial legislation (Oberlander 2003). The effort to contain costs while expanding coverage was a major factor in the unwieldy design of—and public skepticism about—the Clinton health reform plan (Skocpol 1997).

The public reacted no more favorably in 1995 to Republican legislation that attempted to reduce Medicare payments to health care providers. The widespread shift to managed care in the mid-1990s also provoked public wrath (Blendon et al. 1998). The peculiar gaps in coverage in the Medicare prescription drug legislation were clearly due to the \$400 billion ceiling for projected spending, and much of the wariness that seniors are now expressing reflects worries that their drug costs—and perhaps also Medicare premiums—may actually rise.

Public worries about the possible effects of cost controls are magnified by the concerns of business interest groups about limits to federal subsidies or regulatory adjustments that promise to shift rising costs toward private-sector employers, insurers, or providers. Of the three recent efforts at major health care reform—the 1993–1994 Clinton plan; the mid-1990s Republican-sponsored public-sector cuts; and the 2003 Medicare restructuring—the only proposal to actually pass (the 2003 restructuring) was the one that most thoroughly combined weak cost controls on the private sector, benefit increases, and generous subsidies for businesses.

Even though Republicans sponsored and promoted this legislation, it features

higher Medicare subsidies for hospitals, physicians, and health maintenance organizations. The final legislation also prohibits federal Medicare authorities from using their regulatory and bargaining powers to lower drug prices. The bill was stripped of provisions that would have the import of cheaper, publicly regulated prescription drugs from Canada. And the final legislation also included subsidies to induce private employers to retain retiree prescription drug benefits. Finally, in adding a modest new drug benefit for all Medicare beneficiaries, the legislation was far from effective “cost control” and guarantees continuing struggles over how to fund Medicare.

Messy Compromises and Future Prospects

Budget constraints promise to loom ever larger in struggles over all aspects of government’s role in health care, given recent major tax cuts, a growing federal deficit, the coming retirement of baby boomers, and likely continued increases in health care costs above the overall inflation rate due to ongoing technological change (Newhouse 1992). With strong bipartisan support, lawmakers doubled the National Institutes for Health budget between 1999 and 2003 and enhanced resources for expedited FDA (Food and Drug Administration) review of new drugs, thus fostering the new technology that drives spending growth. These expansions, combined with popular demands for extended health care coverage, are sure to strain the federal budget, giving politicians, including some Democrats, incentives to find “reforms” that reduce costs appearing on public budgets—or at least appear to do so. The recent record, however, is not promising for actually enacting effective budget cuts or cost controls. Though the 1993–1994 Clinton legislation and the mid-1990s Republican reform proposal featured cost controls, both of these efforts fell short of enactment.

Our understanding of past reform debates suggests that if differences do not produce stalemate, compromises necessarily take the form of complex and ambiguous measures that opposing players can interpret as partial victories. From the perspective of expert policy designers, this means that carefully constructed proposals will emerge from the political process—if at all—in substantially altered form. Many provisions of complex compromise bills are designed to satisfy interest groups; while others allow both conservatives and liberals to imagine that they have received “half a loaf” and can return to fight for more or less governmental provision on another day.

Even when efforts are made to forge complex compromises, however, there is no guarantee that proposals will be enacted, or prove stable after initial enactment. Public opinion may turn against complex compromises, as it did in 1993–1994. Or the public may be disillusioned by budget-driven compromises that seek financing from beneficiaries or that limit the scope of benefits, as occurred in extreme form with the repeal of Medicare catastrophic legislation in 1989, and may occur again with the current Medicare prescription drug legislation. Research suggests that cost containment approaches are more politically feasible when they are

less visible to the public and not easily attributable to the actions of readily identifiable politicians (Arnold 1990; Pierson 1994).

Going forward, policymakers face contradictory pressures to expand health insurance coverage and benefits while, at the same time, limiting increases in federal outlays. Growing ideological polarization also ensures that partisans will want to head in opposite directions—toward or away from greater government regulation—in each wave of reform. Changes can be stymied by an inability to reach political compromise over competing approaches and goals, or by lack of commitment to allocate public funds toward expanded benefits desired by the public.

The Medicare prescription drug legislation opens rather than forecloses new rounds of debate about this vital part of the U.S. health care financing system. Left unsettled is government's role in regulating pharmaceutical prices and subsidizing health care markets. Reliance on private drug plans to negotiate pharmaceutical prices was key to convincing a Republican-led Congress to pass the legislation. But if prescription prices continue to rise rapidly, the role of government could easily expand, much as it did in the face of medical price inflation after Medicare was created in 1965.

The 2003 law reconfigures arrangements and subsidies to private health plans that serve Medicare beneficiaries and may lead to increased enrollment in HMOs (health maintenance organizations). Yet it is unclear whether the subsidies will be enough to attract health plans and Medicare beneficiaries who remain wary following their prior bad experiences with changes in the late 1990s. In earlier rounds of policymaking for Medicare, many private providers entered the Medicare HMO market, only to withdraw after government subsidies were trimmed. The new subsidies to private providers are unlikely to produce cost savings to the federal budget. If budget struggles intensify, politicians could once again find it easier to trim provider subsidies than to trim benefits or raise Medicare premiums. Republicans may approach such issues with a different mindset than most Democrats, but they, too, are subject to voter expectations and popular pressures.

Beyond Medicare, expanded coverage for the uninsured remains the great unsettled question in the mixed U.S. health insurance system. Circumstances in 2004 are in some ways startlingly similar to conditions a decade ago. Private premium increases reached double digits each year from 2001 to 2003, increasing by 13.9 percent in 2003 (Gabel, Claxton, and Holve 2003). Following recent economic slowdowns, the number of uninsured increased, reaching 43.6 million in 2002 (Mills and Bhandari 2003). A presidential election season induces politicians, especially Democrats, to address issues of coverage and costs with an eye to the concerns of average voters.

But prospects for making headway on coverage for the uninsured are at least as mixed as in 1993–1994. Public concern regarding health care costs has risen, but concerns about the economy, war, and terrorism rival health care in public priorities for government action. As with the 1993–1994 reform episode, despite signs of growing consensus on the need for expanded coverage, proposed policy approaches range widely from those that build on existing programs to those that

make more dramatic departures (Butler 2003; Collins, Davis, and Lambrew 2003; Davis and Schoen 2003; Kahn and Pollack 2001; Meyer and Wicks 2001, 2002).

Thus, even though policy elites have moved closer to consensus, it is unclear whether politicians will seek a financing mechanism for broad-based coverage expansions for the uninsured—especially given the ballooning of projected federal budget deficits (Congressional Budget Office 2003). Democratic primary voters tend to reward candidates whose proposals are more expansive and costly than the general public may be willing to support. The outcome of the 2004 election will affect the prospects for reform, though partisan divisions are sure to persist even if Democrats gain ground. If Democrats and Republicans do not find common ground on measures to aid the uninsured in low-income working families, their plight will remain unresolved. And the political cost of inaction to office seekers may be slight, because lower-income, working-aged Americans do not vote at especially high levels.

In the past, reforms that have moved from conception to enactment have somehow addressed cross pressures—usually by building on existing arrangements and incorporating compromises that give a little to all key players. Looking ahead, coverage expansions—whether in Medicare or to the uninsured—are sure to return to the political agenda because the underlying problems remain salient to the American public. Yet once on the agenda, proposals for expanded benefits tend to become entangled in sweeping visions of how to retool the health care system or reduce federal spending. This makes forging stable compromises difficult. Some reforms may survive the political process in a version that departs substantially from original proposals. But the necessary compromises lead to health policies that will never be perfect from anyone’s perspective—whether politician, payer, provider, patient, or policy analyst—inevitably setting the stage for continuing political battles.

Health care reform is certain to remain central to U.S. electoral politics and governance in the years ahead. But it is just as certain to remain unsettled, subject to messy compromises, partisan clashes, and ambiguous decisions.

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The Employer-Based Health Insurance System

MISTAKE OR CORNERSTONE?



SHERRY A. GLIED

*F*or decades, health policy analysts have voiced their disdain for employer-based health insurance. In 1961, Herman and Anne Somers referred to the system as the “‘shotgun’ marriage of medical care and industrial relations” (Somers and Somers 1961, 227). Critics routinely belittle job-based coverage as an unfortunate historical accident, the by-product of short-lived wartime wage and price controls that moved compensation toward such benefits (Hyman and Hall 2001). Analysts today see the dismantling of this illogical, inefficient institution as an essential step toward the development of universal, equitable health insurance in the United States (Fuchs 1994).

Yet employer-based coverage is a remarkably durable institution. For nearly seventy years most Americans who hold insurance have obtained it through their jobs. Nor is employer-based health insurance peculiarly American, the inadvertent consequence of U.S. policies. Internationally, employer participation in the health insurance system is more the rule than the exception. And far from impeding the development of universal, equitable coverage, the workplace is the foundation of several successful universal insurance systems.

Today American health policymakers have proposed a range of alternatives that either intentionally seek to dismantle employer-based coverage or are likely to undermine it. The orthodox view of job-based coverage implies that policies that lead to its disappearance would be desirable, or at worst benign. The historical and international persistence of this institution, however, suggests the need for a second appraisal of this venerable institution.

The Origins of Employer-Based Coverage

In 2002, 92 percent of all privately insured Americans under sixty-five obtained health coverage through their current or past jobs or through the jobs of family members. The percentage of all Americans under sixty-five who have in-

insurance coverage has fallen from 86 percent in 1987 to 83 percent in 2002, primarily because the cost of health care relative to income has risen (Glied and Stabile 2000). Among those under sixty-five who do hold coverage (private or public), however, the share covered through employment has risen. In 1987, 77 percent of the insured held job-based coverage; today the fraction is 79 percent.¹

The conventional history of employer-based coverage in the United States begins during and after World War II, when the federal government imposed price and wage controls. Employers seeking to attract workers offered health insurance and other non-wage benefits as substitutes. The inflation-control policy inadvertently contributed to vast growth in insurance coverage—from 1.3 million people in 1940 to 32 million in 1945 (Health Insurance Institute 1970, 17).

Provisions of the tax code further encouraged employer-based coverage (Thomasson 2002). The tax code does not treat employer payments for health coverage as compensation, and thus exempts them from payroll and income taxes (a practice that the Internal Revenue Service formally codified in 1954). This effective subsidy raises overall coverage but has been widely criticized as highly inequitable (favoring the highest-paid employees who are in the highest tax bracket) and often inefficient (favoring those who purchase more costly plans, including plans that encourage excessive utilization) (Glied 1994). Increases in income and payroll taxes since the 1950s have made this tax subsidy ever more valuable, fostering the expansion of employer-based coverage. Employee payments have also been exempt from tax since 1984, if they are channeled through a flexible spending account.

Although this history portrays job-based coverage as an accident, in fact, private health insurance in the United States has always been job based. In the early twentieth century, when income losses owing to ill health were much more important than coverage for medical costs, several large firms, notably Montgomery Ward, began offering disability insurance (and often medical care) to their employees (Faulkner 1940). Today's paid sick days and job-based short-term disability policies are the legacy of these early ventures. Voluntary fraternal organizations also attempted to provide disability insurance (among other benefits) to their members. Membership in the organizations was fluid, and new members attracted by the availability of these benefits tended to be less healthy than anticipated while young, healthy members often defected, ultimately dooming these plans (Witt 2001).

As the costs (and quality) of medical care rose through the 1920s, paying for medical care became a distinct concern. The Committee on the Costs of Medical Care reported that by 1932 about 670,000 workers participated in some form of industrial fixed-payment medical service (Williams 1932). As the depression deepened and paying for care became more difficult, hospitals developed Blue Cross prepayment plans. Hospitals sold these early Blue Cross plans exclusively to job-based groups, including teachers, bank employees, and newspaper workers—before the mid-1930s these plans excluded even dependents (Reed 1947). Plans typically required employer groups to guarantee a fixed level of participation, usually between 40 percent and 75 percent of their employees (Cunningham and

Cunningham 1997). Efforts to sell Blue Cross products to individuals and very small groups during the 1930s led to significant adverse selection (wherein people who anticipate high health costs dominate a risk pool) and nearly bankrupted some regional Blues (Cunningham and Cunningham 1997).

This early history suggests that while price controls and tax policies have been important to the development and persistence of job-based coverage, they were neither necessary nor sufficient. Empirical studies of the effect of tax subsidies on the institutional structure of health insurance strengthen this claim. Although the effect of these tax provisions, at the margin, is to reallocate coverage from the individual market toward the employer-based market, the magnitude of this effect is quite modest. Studies find that this structural effect operates strongly in small firms with fewer than twenty-five or so employees (Stabile 2002; Finkelstein 2002). In the absence of such a subsidy, about half of very small firm employees with job-based coverage would likely lose access to such coverage (their firms would no longer offer it). This implies that offering coverage is subsidy dependent and not fundamentally economically efficient for these small firms. The subsidy appears to have little effect on the choice of job-based rather than individual coverage among employees in larger firms, however. Even without the subsidy, most workers in large firms would continue to obtain health insurance through their jobs.

The importance of job-based coverage in a wide range of institutional contexts around the world attests to the inherent value of organizing health insurance around employment. Well before voluntary employment-based coverage began in the United States, countries with social insurance systems—most notably Germany (also France, Hungary, Czechoslovakia, and several others)—organized the delivery of many mandatory social insurance benefits, including disability and, eventually, medical insurance, through the workplace (Williams 1932). German employers not only contributed to the cost of public social insurance programs (as in the U.S. Medicare program) but also established and managed private insurance plans (or sickness funds) themselves. The German system has become less reliant on management by individual employers over time, but even today, more than a century after the establishment of universal social insurance, many of the largest German employers continue to operate their own health insurance programs (Amelung, Glied, and Topan 2003).

In countries with other forms of universal insurance, publicly financed and organized plans provide major medical coverage. These plans include the National Health Service model in the United Kingdom, the national health insurance model in Canada, and the social insurance system in France. Yet even in many of these situations, employers continue to provide supplemental insurance coverage. Voluntary job-based coverage exists in Belgium, Canada, Denmark, Finland, France, Hungary, Sweden, and the United Kingdom, among others. While such private insurance is much more limited than in the United States (where private job-based insurance pays for about 27 percent of all health care bills), the predominance of job-based coverage in these private markets is striking (Cowan et al. 2002).

In the United Kingdom, for example, job-based coverage accounts for about

three-quarters of the market for private health insurance, which covers about 11 percent of residents. The high share of job-based coverage in this small private insurance market is particularly striking because employer payments for health insurance are not tax exempt and all private insurance premiums are subject to an additional tax. In France, supplemental job-based coverage accounts for about two-thirds of voluntary private health insurance (which pays for about 10 percent of total health expenditures) (OECD 2001). About two-thirds of Canadians are covered by supplemental job-based coverage, which pays the cost of medical services not covered by the national plan, including prescription drugs (Stabile 2002). The average per-employee cost of private coverage in Canada is about 10–15 percent of the per-employee cost of employer-based coverage in the United States.

Finally, job-based coverage is often the only form of health insurance available to middle-income workers in developing countries. Large firms in Brazil, India, and Indonesia (to name a few) routinely provide health insurance to their employees. In other cases, firms provide direct health services in lieu of coverage (Jack 2000; Marzolf 2002; Naylor et al. 1999).

Employment-based coverage, then, is not just an accident of history. Nor is job-based coverage merely a regrettable and inferior way-station, a stage in the maturation of the U.S. health care system on its road to—take your pick—national health insurance or universal, market-based, individual coverage. Rather, job-based coverage is a unique institution that continues to provide the only available basis for a stable private insurance market.

Why Employment-Based Coverage Works

Medium and large firms appear to provide a natural venue for the sale of health insurance. Bigger firms enjoy substantial administrative cost advantages in most of their activities, from purchasing pens and copy paper to offering paid sick leave and disability insurance (Brown et al. 1990). Obvious economies of scale accrue from the ability to make fewer sales calls and process a single payment rather than many. These administrative savings make it advantageous for firms to offer employees a range of benefits and amenities. These advantages are particularly stark in health insurance markets.

The problem of adverse selection plagues markets for all types of insurance, but it is especially difficult in markets where health risks develop over time. Most people would like protection against both the risk that they will experience a negative health event in the coming year (as in all types of insurance) and the risk that they will develop a chronic health condition that will permanently raise their health care costs. In some markets, such as the life insurance market, innovative long-term contracts encourage people to buy coverage when they are young and retain it even if they discover that they are healthier than expected. Developing sustainable long-term health insurance contracts has proven a more intractable problem. Although several economists have described potential models, no going concern has yet adopted them (Cochrane 1995; Pauly et al. 1995). Instead, nongroup health insurance contracts are annual. Thus an event that permanently raises health care

costs will permanently raise health insurance premiums—precisely the result people would like to avoid.

Job-based coverage through large firms offers the only existing long-term private health insurance. Such firms can solve both the point-in-time and long-term problem of adverse selection better than voluntary organizations because employees constitute a group formed and sustained for reasons other than the need for health insurance. The group may contain a variety of health risks, but there is little reason to expect people with an exceptional demand for health insurance to dominate. Moreover, people decide to remain at or leave firms mainly (though, noted below, not entirely) for reasons other than their health. Indeed, people whose health deteriorates are more likely to leave their jobs (or retire) than are those who remain healthy.

Voluntary organizations could (and in some instances do—witness the Amish, for example) offer stable health insurance just as effectively as firms do, if the hurdles to joining the organization and maintaining membership and the penalties for exit were as great as those for taking on and leaving a job. Employers provide health insurance mainly because employees value the benefit much more highly than the cost employers incur. The lower loading costs and other inherent advantages of group coverage enable employers to “sell” coverage to their employees at a substantial discount. Firms that do not offer this discounted benefit must pay higher wages to attract similar workers away from competitors that do offer such coverage. Thus the total cost of labor compensation is likely to be lower for firms that can offer both wages and coverage to attract workers than for firms that offer only wages (Famulari and Manser 1989).

This administrative advantage makes employers the essential building blocks of a private health insurance system. Moreover, this employer-based system can operate quite effectively without much regulation.² In the nongroup market, regulators aim to moderate rate variation and demand renewable products. By contrast, monitoring the health care costs of potential hires and current employees (and their dependents) at the firm level makes little sense (Bloom and Glied 1991), even without calculating the damage that such a policy would have to the value of the insurance benefit for all employees. Firms have no reason to offer benefits that their employees do not value, so regulation of the content of health insurance can also be minimal. Indeed, under ERISA (the federal law that covers employee benefit plans), medium and large U.S. firms can avoid virtually all substantive regulation of health insurance by self-insuring (Briffault and Glied 2002). While regulation of nongroup markets is full of pitfalls, the employer-based system has operated for about three-quarters of a century as an almost completely unregulated market.

So It Works—So What?

Private health insurance—which, as I have argued, means job-based insurance—operates differently from public insurance. Because it operates in a market, is only lightly regulated, and is highly decentralized, private health insurance can offer much more flexibility than public coverage alone. This flexibility makes

private job-based coverage relatively successful in providing insurance to the large subset of Americans who can afford to buy it at current prices, and makes it a useful alternative or supplement to public systems in other countries.

Private employers purchase health insurance in much the same way that they purchase production inputs. In purchasing inputs, employers seek those that will enable them to make, at the lowest-possible cost, products whose characteristics (including price, color, size, and quality) most appeal to consumers. Likewise, in purchasing health insurance, employers wish to obtain, at the lowest-possible cost, the package of compensation (wages, insurance benefits, and pensions) that their employees most prefer. These goals are relatively straightforward—especially compared with the multiple political and policy objectives of public health insurance programs.

The single-minded pursuit of a low-cost product that keeps employees satisfied makes private employers dismiss pleadings from providers (and, to our dismay, makes them equally dismissive of the suggestions of health policy analysts). In markets, purchasers and their dollars rule. This means that private employers can readily purchase products that reduce payments to one provider group in order to expand benefits in another area. In the 1990s, for example, employers added coverage for prescription drugs to employee benefit packages while restricting provider networks and cutting payments to physicians and hospitals (Centers for Medicare and Medicaid Services 2003; Glied 2003). Providers might justifiably complain that they have lost revenue so drug manufacturers can earn more. Employers simply saw the rise in consumer interest in prescription drugs and decided to buy a product that would satisfy their audience. As the Medicare prescription drug debate and similar struggles in Canada suggest, public health insurance programs have much more trouble redividing the pie in this way, even when such a redivision is justified.

When employers blithely select plans that limit choice of provider or fail to cover chiropractors or limit hospital stays, affected providers seek relief from regulators and legislators. Organized provider groups have clout at the legislative level that dissolves once they enter the marketplace.

Employers' disregard for organized providers allows them (or the private insurers with which they contract) to easily adopt and discard benefit, payment, and organizational innovations. Employers have not necessarily been more innovative than governments in the health care market; government researchers developed many of the most significant payment innovations of the past three decades, such as diagnosis-related groups (DRGs) and resource-based relative value scales. However, benefit, payment, and organizational innovations diffuse much differently in the public and private spheres. Governments commission and then legislate new administrative technologies. Private insurers pick and choose among such innovations.

Some private insurers adopted DRGs while others tried capitated payments, for example, but many discarded these methods in favor of others, such as negotiated per diem payments combined with utilization review (InterStudy Reports HMOs Move to per Diem Rates 2001). Employers tried covering alternative medicine in the mid-1990s, but later eliminated these services when added benefits

led to overuse and high costs (Edlin 2003). Employers also tried managed-care plans that restricted enrollees' choice of providers, but employees weren't satisfied, so employers added point-of-service options. In the early 1970s, when utilization review was new, both private insurers and Medicare began to implement it. In the 1990s, when it no longer seemed to work, private insurers were quick to dismiss it (Prince 1999).

Private plans may make precipitous decisions regarding which innovations to adopt and reject, but this flexibility can be a valuable antidote to the slow pace of public insurance systems. Dropping a previously covered benefit or changing a payment mechanism takes years of hearings and court rulings under Medicare; it takes a phone call under a private insurance plan.

Employers also gain from their ability to shop for the best prices. Health care is local, so shopping opportunities are often limited, but where national markets exist, as in pharmaceuticals, private markets can be adept at seeking out and exploiting opportunities for savings. The success of private plans in restraining drug costs has led many in Congress to favor the use of such plans in arranging prescription drug benefits for Medicare patients. Of course, government purchasers can also reduce prices, simply by exerting their monopsony clout. The advantage of private competition is that cost reduction efforts are less monolithic. Individual purchasers can negotiate lower prices by offering to purchase in bulk, but across the entire market of purchasers, a variety of similar products can remain viable. Such basic differences between government and market approaches were at the heart of the protracted policy debate about how to structure the Medicare prescription drug benefit (Huskamp et al. 2000).

Finally, private markets permit purchasers to make tradeoffs between the value and cost of new technologies. If people want more of something, or want it faster, and they are willing to pay for it, private markets are likely to arise to sell it to them. This responsiveness has costs. By behaving in this way, private markets translate inequities in income into inequities in the consumption of goods and services. Such responsiveness provides an important signal of consumer demand, however, describing not only what people want but how much it is worth to them.

These benefits—flexibility, responsiveness, shopping—are both the advantages of private insurance and the characteristics that have allowed private job-based health insurance to evolve and survive over time. Job-based coverage has accommodated the pharmaceutical revolution, the development of outpatient surgery, and many other technological changes that have altered the health care delivery system. It has endured the decline of labor unions, the rise of the two-earner household, growing international competition, and other upheavals in the American labor market. Private job-based coverage offers a viable, rapid-response mechanism that complements the ever-changing health care delivery system and labor market. These attributes have made job-based coverage the dominant choice for providing health insurance to average-income working Americans and a source of supplementary benefits in a variety of public health insurance systems.

Yet in both the United States and other nations, the role of private job-based coverage is circumscribed. It operates in contexts where its beneficiaries can pay

most of the cost of health care themselves and where the inevitable missteps of private coverage in benefit design, payment mechanisms, and organizational form are bearable. Nowhere does job-based coverage alone provide universal and comprehensive health insurance.

What Job-Based Coverage Cannot Do

Job-based health insurance is a voluntary, market institution. These attributes give the institution its characteristic strengths, but they also limit its use. Despite its strengths, the job-based voluntary private insurance system in the United States leaves over forty million people uninsured.

The most important failing of job-based coverage is in redistribution. Markets and market institutions do not by nature voluntarily redistribute resources.³ Job-based coverage does seem to foster an unusual degree of redistribution across workers of different incomes within firms (working at a firm with higher-wage colleagues raises the probability that a low-wage worker will have coverage). Structural, regulatory, and tax features all contribute to this cross-subsidization. To avoid adverse selection within the employer pool, many insurers require, as a condition of coverage, that most employees take up insurance. Nondiscrimination rules prohibit insurance arrangements that favor only the most highly paid employees. The substantial subsidies that high-wage workers obtain from the favorable tax treatment of job-based coverage may make them willing to cross-subsidize coverage if that is what it takes to maintain their tax benefit. Yet even with these advantages, the degree of income cross-subsidization under private health insurance is limited.

The job-based health insurance system—like any other private system—never provided health insurance to workers with very low earnings, including disabled workers and those with very few skills. The tax exemption for employer-based health insurance provides very little subsidy for the purchase of health insurance for low-wage workers who already face relatively low marginal tax rates. Given these low subsidy levels, many people in this group do not seek out jobs with health insurance coverage, while others turn down coverage when it is offered. In effect, low-wage workers do not trade off cash for benefits. As the cost of health insurance coverage and the employee share of that cost has risen, a growing number of workers are being priced out of the system and no longer accept job-based coverage when it is offered. Increases in the cost of benefits may lead employers to shift low-wage employees out of the pool of workers eligible for benefits, by contracting out jobs or using temporary workers.

Job-based insurance also generates inequities in the availability of coverage across firms: some firms offer better, more generous coverage than do others. These inequities mirror the many inter-firm disparities throughout the labor market. Small firms pay lower wages than large firms, firms with health insurance benefits tend to also offer pensions and disability coverage, and firms in the apparel industry pay lower wages than those in the transport industry, for example (Brown et al.

1990; Krueger and Summers 1987). Prodigious interventions would be required to smooth such deep-seated variations.

Private health insurance markets may also have difficulty redistributing resources from healthy to sick people. An enduring, and reasonable, concern about job-based health insurance is that employers will discriminate against workers whose health care costs are expected to be higher than average. The substantial value to all workers of coverage that does not drop people when they (or their dependents) become ill, however, suggests that employers may find it economically rational not to discriminate against such workers by firing them or reducing their wages.⁴

Employers might rationally avoid hiring people who are clearly likely to have high health care costs (especially if this information can be inexpensively ascertained). Yet while behaving in this way may make sense, there is little evidence that such discrimination occurs often in practice. Identifying such discrimination may be difficult because employers are unlikely to hire workers whom they anticipate will soon become incapacitated, regardless of whether they do or do not offer health insurance. Still, some evidence shows that private employers do hire people with high future health care costs if they are likely to be able to work. For example, longitudinal studies of people with HIV/AIDS find that about 10 percent who were uninsured moved into private coverage (Smith and Kirking 2001).

Problems of redistribution are the most important reason that people cannot obtain coverage through the job-based system. The connection between employment and health insurance also means that even some people who do earn enough to buy private coverage fit poorly into the system. One group of “misfits” consists of those whose employment situation does not readily lend itself to employment-based coverage. These include new-economy workers with contingent employment contracts, multiple jobs, and part-year employment. This group is relatively small and does not appear to be growing (Hipple 2001). Expanding the misfit group to include people who change jobs often (more than once a year) and those who work for very small businesses that would likely not offer coverage if the tax subsidy did not exist yields a substantially larger group.

A very generous estimate of this expanded group would include all workers in firms of twenty-five or fewer workers (although, in fact, many small, stable firms would continue to find it efficient to offer coverage even without the subsidy). This expanded group accounts for just under half of the active U.S. labor force. Some two-fifths of all Americans under sixty-five live in households that either do not include any workers or include only workers of this misfit type. Even in a system with substantial subsidies for the purchase of insurance, this group would probably not find job-based coverage attractive and would prefer to obtain coverage in a regulated individual market. By contrast, about one-half of all Americans under sixty-five have incomes high enough to afford job-based coverage without a subsidy and are attached to a job that could efficiently offer such coverage.⁵

A system of job-based coverage may find it difficult to accommodate households that deviate from the traditional family. The employer-based system dates from an era when families typically included only one wage earner supporting a

spouse and children. Today fewer than 15 percent of households fit this traditional mold. The problems entailed in matching a job-based system to the changing family are apparent in mandatory systems with job-based financing, such as the German health care system (Amelung, Glied, and Topan 2003). The “spousal tax” of job-based coverage can be substantial under these systems because households with two workers subsidize those with only one worker.

The voluntary employer-based health insurance system has, to some extent, adapted to these changes. In particular, by raising the employee share of spousal coverage, private employers have effectively reduced the marriage tax for two-earner households (these households no longer subsidize single-earner households to the same extent). But individually based systems with non-job-based financing (whether private or public) manage such changes in family structure more easily.

Other criticisms of job-based coverage focus on the effects on the labor market of tying health insurance to employment. Many observers have criticized job-based coverage for making U.S. producers less competitive internationally, but this is unlikely in a voluntary system (Reinhardt 1989). Employers have little reason to continue offering coverage unless workers value it enough to pay for it, and if workers pay for coverage through lower wages than they would otherwise receive, health insurance costs cannot affect competitiveness.

More recently, economists have expressed concern that the link between health insurance and the labor market may diminish job mobility—a phenomenon called job lock (Madrian 1994). Job lock can occur if people who anticipate high health care costs are reluctant to leave jobs with health insurance. Job lock implies that current employers treat workers who anticipate high health costs more favorably than nongroup insurers and potential future employers (evidence that job-based coverage offers insurance whose premium does not vary over time). While job lock is very important to individual workers, the best estimates reveal that its impact on the overall U.S. economy is quite small—below 0.1 percent of GDP (gross domestic product) (Gruber and Madrian 2002).⁶

A final set of concerns relates to the effect of job-based coverage on the health care delivery market. Some analysts have argued that employment-based insurance insulates workers from the true cost of health coverage, leading to a more costly health care system than individuals would select on their own. More recently, other critics have argued that in selecting health plans, employers weight cost considerations more heavily than quality measures. In fact, job-based coverage tends to be more generous—in the sense of having greater actuarial value—than coverage that individuals purchase in the nongroup market, but the difference is only on the order of about 10 percent of actuarial value at the median (Gabel et al. 2002).

The greater generosity of employer plans is a predictable result of the open-ended structure of the tax exemption for employer payments, and may not stem from the employment link itself. Studies of plan selection typically find that employers place a lot of weight on price considerations and pay less attention to quality measures (Quality vs. Costs? 2000). In doing so, however, employers mimic the

behavior of most workers, who are also typically very sensitive to price and less sensitive to quality (Scanlon et al. 2002). Some workers would undoubtedly prefer higher-quality coverage than their employers select, but most apparently would prefer lower prices. Employers appear to do a fairly good job of mediating between these two virtues. The poor state of information on health care quality—not the role of employers in processing that information—seems paramount in explaining the lack of sensitivity to quality in both public and private health care.

Employer-Sponsored Insurance in a Reformed Health Care System

The prevailing view of employer-based coverage as a regrettable accident has had important consequences for health policy. By implying that the job-based system is an outgrowth of tax policy rather than a naturally occurring form, this view leads conservative reformers to imagine that a similar, simple tax-based subsidy could trigger development of a large, stable, lightly regulated market offering individual health insurance with stable premiums. This imagined institutional form has never naturally existed anywhere, however. Likewise, by suggesting that employers' role is merely the result of a wartime misstep rather than a flexible vehicle for channeling consumers' demands, this view encourages liberal reformers to believe that a carefully formulated national system can provide a single, equitable level of insurance that covers all the care people desire and will willingly pay for, even as medical care continuously evolves. This structure is also quite uncommon.

A more useful perspective is to see employer-based health insurance as a valuable institution that has unique strengths but is by nature limited in scope. Conservative and liberal reformers are correct that job-based coverage cannot be the sole basis for a universal health insurance system. The most important reason is that the high and rising cost of health care makes it very difficult for lower-income people to purchase insurance coverage, whether in the nongroup market or through employers. The high cost of care implies that expanding the number of people covered by any type of insurance will require substantially raising the level of public redistribution. Even if combined with an appropriate subsidy system, however, employment-based coverage will not be available or appropriate for some people.

What, then, should be the role of job-based coverage in a universal health insurance system? One job-based model considered in the United States is an employer mandate. Hawaii has had such a mandate for nearly twenty years. A mandate, however, would force small, transient firms to provide coverage although it would not be economically efficient for them to do so.

The regulations needed to make a mandate work—including rules about whom employers must cover, how they must treat dual-earner households, and what coverage must include—would erode the flexibility of job-based coverage. The Hawaiian experience also confirms that even with a mandate, a job-based system alone cannot easily produce universal coverage: the state ranked only seventeenth

in the nation in 2001 in the proportion of residents with job-based coverage. Building comprehensive universal coverage on an employment base would diminish the strengths of this institution—its flexibility and responsiveness—and accentuate its weaknesses, particularly its poor compatibility with misfit workers and households.

Instead, reform strategies that maintain job-based coverage as a voluntary marketplace would make better use of this institutional form. Conservative and liberal proposals (as well as many other arrangements) for expanding health insurance can adapt such a voluntary market.

Many conservative proposals include refundable tax credits (which may either offset tax obligations or, for people without tax obligations, make direct payments) for the purchase of nongroup coverage. For most of the target population, these proposals offer more generous public subsidies for coverage purchased in the nongroup market than for coverage in the group market. This subsidy design would encourage some uninsured people to purchase coverage, but it would also lead some insured people to shift from employer-based coverage to nongroup coverage, and may induce some employers to stop offering coverage. Shifts in coverage may be appropriate, because some tax credit beneficiaries will be a better fit in the nongroup market. For most others, however, the desirability of shifting out of group coverage will depend on the quality of the new, subsidized nongroup coverage, and this market has never before played a significant role in providing private health insurance.

A better option would be to ensure that the value of subsidies remains the same regardless of where people purchase coverage. One step toward achieving this would be to convert the existing favorable tax treatment of health insurance into a tax credit system (Pauly et al. 1992). Unfortunately, simply offering income-based tax credits might not preserve the long-term risk-pooling benefits of job-based coverage. Healthy beneficiaries would be tempted to leave the employer's health insurance pool and seek inexpensive coverage in the nongroup market. Such defections would likely lead to greater "experience rating" within employer groups and undermine pooling. To preserve pooling, any system must permit (and perhaps even encourage) employers to require employees to participate in their job-based health plan.

Combined with a mandate that individuals purchase coverage (either through work or in the nongroup market) and a publicly regulated or provided fallback option, such as an expanded state employees' purchasing pool or a Medicaid buy-in program, a tax credit system might achieve near universal coverage. Most employers who now offer coverage would probably continue to do so. Job-based coverage would probably be of higher quality than nongroup coverage because of economies of scale, but such a system would be much more equitable than the current one, and likely more equitable than the distribution of virtually any other good or service in the United States.

An alternative model would permit job-based coverage as an alternative or supplement to a universal health insurance program financed by progressive taxation. The tax-financed program would automatically enroll all Americans, but they could choose to opt out of the program. Those who did so might receive a tax

credit (set at some fraction of the cost of public coverage) toward the purchase of private insurance.

In this arrangement, job-based coverage would offer a private safety valve for the public system, as in the United Kingdom and Germany. The size of the private job-based market would depend on consumer perceptions of the generosity of public insurance and on the size of the tax credit. Changes in private insurance benefits would reflect consumer demand for new benefits or more generous coverage.

The need to incorporate a voluntary, job-based private market into any public system would complicate its design. A hybrid system would be messy at its edges, where public coverage and private coverage overlapped. The availability of a public insurance system might, for example, lead employers to dump unhealthy workers out of their job-based plans. Regulations could forestall some of this dumping, but some risk selection would likely exist even in a tightly regulated system. Some degree of complexity and inefficiency may be a reasonable price to pay for flexibility.

Permitting private insurance to substitute for public insurance would also inevitably reduce equity relative to an ideal universal system. One option would be to add equity protections to the hybrid system, such as by imposing a redistributive health tax (Glied 1997). Recognizing that retaining parallel systems may be the only practical way to extend coverage in an inequitable society may be more realistic, though. Maintaining job-based coverage will reduce government involvement in the health insurance system and limit explicit redistribution—both features that are likely to make a hybrid system more politically acceptable and easier to implement than a unitary system.

The United States could move toward universal health coverage in several ways. Recognizing and incorporating the strengths of voluntary job-based coverage will likely enrich any of these approaches. Treating employer-based coverage as a historical blunder weakens health policy analysis and proposals. A system that recognizes the near-inevitability of job-based coverage is likelier to prove sturdier, more feasible, and ultimately simpler than one that seeks to design it away.

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Notes

1. Author's tabulations of the *Current Population Survey*, Bureau of the Census, Washington, DC, 2003. Note that this fraction declined slightly between 2000 and 2002 after growing steadily through the 1990s. The survey questions changed in 1994, leading to increases in estimates of the proportion of people with employer-based coverage. The proportion has also grown if we use 1994 as the base year, however.
2. By contrast, individual-based private health insurance markets, such as that in the Netherlands, are heavily regulated.

3. A small percentage of firms do adjust health insurance premiums so subsidies are greater for lower-income workers.
4. The situation may be different if fellow employees believe that workers are responsible for their own poor health, as when employers penalize workers who are overweight or smoke, or when employers provide financial incentives for weight reduction and smoking cessation (Aeppl 2003).
5. Author's tabulations of the *Current Population Survey*, Bureau of the Census, Washington, DC, 2002.
6. In part, this is because of federal legislation passed in 1986 (COBRA) and in 1996 (HIPAA). Together these laws mandate that workers who leave their jobs may continue their job-based coverage (by paying 125 percent of its full cost) for up to eighteen months, and that workers who move from one insured job to another are not affected by clauses excluding preexisting conditions.

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Entrepreneurial Challenges to Integrated Health Care



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*T*he U.S. health care system is an ongoing experiment in the effort to achieve social goals through market mechanisms—to pursue the public good through private interests. The era of managed care encouraged competition among insurers, capitation contracting between health plans and providers, and the organizational integration of physicians and hospitals to contain costs and foster access to primary care. The ensuing consumer and provider backlash and the failure of many diversified organizations to deliver improvements in quality and efficiency have today substituted a different set of social goals. These include the unwinding of many consolidated organizations, unconstrained access to specialty services, and a commensurate reversion to broad insurance networks and fee-for-service payments. As before, much of the energy for change comes from the private sector. Rather than focus on reducing costs and integrating organizations, however, the entrepreneurial emphasis today is on enhancing revenue and creating niche organizations such as ambulatory surgery centers and single-specialty hospitals.

The record of the private sector during managed care was mixed. That sector marshaled the energy to overcome the organizational fragmentation of the indemnity era but then engaged in overconsolidation. The contemporary drive toward specialization is producing an analogous mix of desirable and undesirable effects. Unbundled services foster managerial and clinical focus, learning-curve efficiencies, and competition within an otherwise consolidated industry. Yet entrepreneurial entrants are targeting only services and patients whose payment rates exceed treatment costs, thereby undermining the implicit subsidies for underpaid services and underinsured patients.

Specialized niche firms also threaten to create a new form of corporate conglomerate by establishing chains of facilities across geographic regions and the nation. Despite talk of focus, the entrepreneurial drive for more revenue is pushing firms into new markets and new products, with the axis of growth shifting from diversification across services within markets (the integrated physician-hospital organization) to diversification across markets within service lines (chains of ambulatory centers and specialty hospitals).

In this environment, integrated delivery systems are shrinking, hobbled by the diseconomies of scope that attend efforts to incorporate services with distinct technologies, professions, customers, and regulatory regimes. Service-specific chains are expanding but face new challenges as they seek to penetrate new geographic markets. Multiservice hospitals—both nonprofit and for profit—are defending themselves by creating subsidiaries and physician joint ventures to achieve the efficiencies attributed to their focused competitors without losing the benefits of diversification. Policy responses—in the form of certificate-of-need regulation and bans on physician referrals to facilities where they have an ownership interest—protect both the public interest (by supporting general hospitals that subsidize care for the needy) and private interests (by sparing general hospitals the rigors of competition).

The remainder of this chapter analyzes the rise of single-specialty hospitals and freestanding ambulatory facilities, emphasizing product and market diversification as alternative strategies for growth. Emphasis is placed on the entrepreneurial, for-profit firms that inject most of the creativity and chaos into the health care delivery system and on responses by nonprofit, full-service institutions. I conclude by highlighting the tendency of every good idea to be pressed too far and every innovative startup to expand beyond the products and markets where it has a distinctive advantage.

Diversification across Services

Depending on one's perspective, the health care ecosystem is either very stable or in a state of continual turbulence. Despite innumerable proclamations of social and corporate transformation, most physicians continue to practice in very small groups, and most hospitals remain full-service, nonprofit institutions. Yet the organizational structure of medicine has seen major experiments in recent decades—some successful and most not. Particularly salient were efforts to integrate professional and institutional services both vertically and horizontally. This entailed creating “integrated delivery systems” (IDS) composed of primary care and specialty physicians, acute and subacute inpatient facilities, ambulatory surgical and diagnostic centers, and other major components of care.

Such integrated entities pursued the administrative and clinical economies of scope that can accrue to organizations that offer mutually supportive products and services (Panzar and Willig 1981; Teece 1980). These efficiencies included cheaper procurement of supplies and information technology; coordination of care from outpatient to inpatient to subacute settings; elimination of excess capacity and duplicate equipment; use of evidence-based guidelines for managing chronic disease; enhanced branding and cross-marketing of services; and financial gains from capitation payments for a full range of services.

The profit opportunity latent in clinical and administrative integration did not escape the notice of those whose mission it is to seek out such opportunities. Investor-owned hospital chains and physician practice management (PPM) firms recognized that most existing delivery systems combined moneymaking with

money-losing activities, with losses dissipating any gains. By targeting remunerative services and avoiding services that suffered from below-cost payment, firms could avoid undermining their gains and lay the financial foundation for regional or national expansion.

Investor-owned firms thus adopted a somewhat narrower scope of services than the traditional IDS, focusing on inpatient facilities (hospital chains), physician services (multispecialty PPM firms), or one form of care (specialty PPM firms and rehabilitation or ambulatory surgery chains). These firms expanded by diversifying across markets, thereby obtaining new opportunities while reducing their exposure to the economic and political idiosyncrasies of each region (Lutz, Grossman, and Bigalke 1998; Lutz and Gee 1998; Coddington, Moore, and Clarke 1998; Burns and Robinson 1997; Robinson 1999). The logic of growth then drove many investor-owned firms to diversify across services as they approached the limits of diversification across markets. PPM firms that once focused on primary care added multispecialty clinics, multispecialty PPM firms added independent practice associations and emergency room physician services, hospital chains acquired physician practices, and rehabilitation chains moved into ambulatory services.

The rest is history. The perceived profit opportunity that drew venture capital and entrepreneurial energy into the health care system also attracted the attention of governmental and corporate purchasers, who naturally believed that any surplus should remain with them. The aggressive stance of private purchasers toward health insurance plans in the mid-1990s, compounded by the federal Balanced Budget Act of 1997, cut payments to hospitals and (via the HMOs) to physician organizations.

These moves transformed the profit opportunity from coordinating a full range of services to selectively targeting those that continued to enjoy advantageous payment rates. The squeeze on revenues was accompanied by accelerating costs for multispecialty consolidators, and economic fate was especially harsh for systems that had grown through mergers and acquisitions. Such organizations often found themselves owning overlapping, noncooperative, and overpriced physician and hospital properties, and afflicted with excess capacity, low productivity, and culture clashes.

Many consolidations occurred through bidding wars in which organizations overpaid even for well-performing units, and the practices and facilities most willing to sell were those consolidators should have been least willing to buy. Such acquisitions transformed physician practices from mom-and-pop enterprises—where every dollar saved was a dollar earned—to multispecialty bureaucracies that spread rewards and penalties over the entire system rather than focusing them on responsible parties (Robinson 1999, 2001). Rather than spurring coordination, the amalgamation of primary, specialty, inpatient, outpatient, and ancillary services often led to a financial and cultural war of all against all (Burns and Pauly 2002). Many nonprofit systems and for-profit chains found that the whole of their overbuilt organizations was worth less than the sum of the parts, and they began to divest.

The refocusing of the health care system was nasty, brutish, and short. As

usual, Wall Street first sensed the change in industry prospects from high growth to no growth and made an expeditious exit. The collapse of share prices and an inferno of shareholder litigation destroyed PPM firms, which dumped their medical groups onto the market. Many hospital systems also divested the physician practices and ancillary facilities they had acquired, albeit in a more deliberative fashion to retain patient admissions. Investor-owned hospital chains retrenched from national expansion and spun off facilities in markets they could not dominate. Bankruptcy courts opened their arms to embrace the fallen, and one cycle of organizational growth and contraction was complete.

Diversification across Markets

In the aftermath of managed care, a new set of organizational strategies and structures emerged in the health care delivery system. Rather than seek growth and profits by reducing costs under capitation, health care organizations now seek growth and profits by increasing revenues under fee-for-service. Rather than trying to coordinate a continuum of clinical providers and services, entrepreneurial energies now focus on particular specialties, facilities, and procedures where the price-cost margin is most attractive. Primary care physicians and full-service hospitals have been displaced by specialty physicians and single-specialty hospitals, ambulatory surgery centers, and freestanding diagnostic facilities as the heralded components of a new consumer-oriented health care system (Herzlinger 1997; Weaver and Waugh 2002; Triple Tree 2003).

Freestanding Ambulatory Surgery Centers

While much attention has recently focused on single-specialty inpatient facilities, the more important challenge to full-service hospitals is the freestanding ambulatory surgery center. Outpatient procedures as a proportion of total surgeries rose from 20 percent in 1981 to 80 percent in 2003, with almost half of these procedures performed in freestanding facilities or physician offices rather than hospital outpatient departments.

Outpatient surgery has risen partly because changing technologies and incentives have spurred more procedures per capita (Schramm and Gabel 1988; Kozak, McCarthy, and Pokras 1999). The growth in freestanding centers, meanwhile, derives partly from their ability to schedule procedures free from emergency interruptions, enhanced roles for physicians in governance, better architectural designs for operating rooms and supporting facilities, and smaller-scale and more convenient suburban locations. The prospects of these ambulatory surgery companies fluctuate with the financing and regulatory environment. The late 1980s and early 1990s saw an investment surge, as Medicare's payment system reduced the attractiveness of inpatient alternatives, while the late 1990s brought a major contraction owing to pressure from the Balanced Budget Act. Over the past several years the number of freestanding centers has grown dramatically, rising from 2,314 in 1996 to 2,755 in 2000 to 3,400 in 2002 (Cain Brothers 2003; Triple Tree 2003).

Many ambulatory surgery centers are owned by individual physicians or physician partnerships (including specialty group practices), but a growing number are consolidating into national investor-owned chains, including both multiservice hospital chains (such as HCA, Tenet, Universal Health Services, and Triad) and outpatient chains (including AmSurg, United Surgical Partners International). The strong and committed presence of multiservice hospital chains indicates that diversified conglomerates can seize growth opportunities outside their core model. Still, the majority of chain facilities are not affiliated with inpatient hospitals.

HealthSouth, the nation's premiere "focused factory," dwarfs all these ambulatory surgery companies. HealthSouth has fallen on hard times owing to its exceptionally aggressive growth strategy. Formed in 1984 with an emphasis on inpatient rehabilitation, HealthSouth quickly diversified into outpatient rehabilitation and then outpatient diagnostic services, owning 50 outpatient centers by 1990 and 250 by 1994. In 1995 it acquired Surgical Health Corp., the nation's second-largest chain of ambulatory centers, with 37 facilities, plus 12 surgical centers from the nonprofit Sutter Health system in California. The following year HealthSouth acquired Surgical Care Affiliates (67 surgical centers), Health Images (55 diagnostic imaging centers), ASC Network Corp. (29 surgery centers), and National Imaging Affiliates (8 diagnostic imaging centers). In 1998 HealthSouth acquired HCA's ambulatory surgery subsidiary (34 centers) and National Surgery Centers (40 centers).

The firm's acquisitions and growth then stalled, in part because of slowing revenue growth attributable to the Balanced Budget Act and in part because of the inherent difficulties of integrating this many acquisitions so quickly. Throughout the growth period HealthSouth was acclaimed in industry circles as the leading example of what single-service focus and geographic diversification could achieve. However, much of HealthSouth's apparent success was fraudulent, disguised by senior management to its benefit and the detriment of shareholders. Under a wave of government investigations and shareholder lawsuits, all senior managers were replaced (many facing criminal indictments), the firm faced bankruptcy, and creditors insisted that the company divest its surgery centers to cover its financial obligations (Mollenkamp 2003).

Specialty Hospitals

Specialty hospitals resemble ambulatory surgery centers in that they focus on a narrow range of surgical procedures, but the former add inpatient beds and hence can provide more intensive and expensive treatments. The General Accounting Office identified 92 specialty hospitals operating as of February 2003—up from 29 in 1990, with 20 more under development (U.S. GAO 2003a). These facilities included 17 focused on cardiac procedures, 36 on orthopedics, 22 on general surgery, and 17 on gynecology. Three-fourths of the facilities had physician investors or co-owners, and 20 percent were owned completely by physicians. While the ownership stake of any one physician in a specialty hospital is low—usually less than 2 percent—half the facilities with some physician investment reported group ownership stakes of 25 percent or greater (U.S. GAO 2003a). In some

markets specialists are merging their practices into larger single-specialty groups precisely to purchase clinical equipment and ambulatory surgical suites (Casalino, Devers, and Brewster 2003). Nonphysician investors in specialty hospitals include nonprofit full-service hospitals, privately held for-profit entities, and one publicly traded corporation. Some one-third of specialty hospitals are independent, one-third are owned by chains, and one-third are owned by general hospitals—the latter usually in the form of joint ventures with local physicians (U.S. GAO 2003b).

The Indianapolis experience illustrates the dynamics of the specialty hospital market, which involves local specialists, outside chains, and incumbent full-service hospitals (Cain Brothers 2003; Katz, Hurley, and Devers 2003; Abelson 2003). In that city a proliferation of heart hospitals began with the threat of a joint venture between local cardiologists and a specialty hospital chain. Two of four multiservice hospital systems then created their own freestanding heart hospitals: St. Vincent Health, in collaboration with the Care Group physician organization, and Community Hospitals Indianapolis, with its staff physicians. Indiana University and Methodist Hospitals then created a cardiac hospital-within-the-hospital, and St. Francis Hospitals moved its heart program to a new facility.

The Center for Studying Health System Change identified ten specialty hospitals in three of the twelve communities it has tracked since 1996 (including Indianapolis). Of these, one was physician owned (medical group), three were owned by local hospitals, two were joint ventures between physicians and local hospitals, and four were joint ventures between physicians and investor-owned chains. The presence of a large single-specialty physician group and the absence of certificate-of-need legislation (under which regulators approve new facilities and equipment) at the state level facilitated the creation of specialty hospitals (Casalino, Devers, and Brewster 2003).

As the sole publicly traded chain of specialty hospitals, MedCath has received the greatest attention, evoking both praise as the harbinger of a new disaggregated health care delivery system and criticism as a financial drain on community hospitals that rely on cardiac surgery profits to subsidize money-losing services such as trauma care. The evolution of MedCath exemplifies the impetus for growth and diversification (Cain Brothers 2003).

Founded in 1988, MedCath went public in 1994 as an operator of mobile cardiac catheterization laboratories; its first heart hospital opened two years later. Caught in the firestorm of investor disillusion with specialty physician practice firms, MedCath went private in 1998 through a management-led leveraged buyout, and then returned to the public capital market with its second initial public offering in 2001. It now co-owns nine facilities with local cardiologists and/or a local hospital, with its stake ranging from 51 percent to 71 percent, and has another three facilities in various stages of development. The newest MedCath facility departs from the smaller, cardiac-only prototype, which averages 58 beds: it contains 112 beds, 12 labor/delivery suites, 16 ICU (intensive care unit) beds, and 36 pure cardiology beds.

The successes enjoyed by the specialized firms reflect astute selection of services and markets as much as efficiency in delivering care. If the business model

of a limited range of services were itself the source of competitive advantage, we would observe niche firms in every health care sector. In practice, focused factories concentrate in surgical and diagnostic services where clumsy payment mechanisms by Medicare and private insurers leave money on the table, creating profit for all participants. Traditional hospitals object to the new freestanding entrants precisely for this reason.

Yet the reliance of specialty chains on payment inefficiencies and operating efficiencies leaves them exposed to an eventual waking of the sleeping giant. There is no reason to assume that Medicare will not slash payments to ambulatory surgery and specialty hospital chains just as it balanced the federal budget on the backs of nursing home and home health chains a few years ago. Implicit but important in the business model of all entrepreneurial health care firms is an exit strategy. Diversification across products and services enables nimble firms to refocus their activities and revenue streams as payment and profit opportunities rise and fall across sectors.

Organizational Hybrids

Rather than the single-service, multi-market chain or the multiservice, single-market hospital dominating the health care delivery system, hybrid organizational forms will likely play a prominent role and share the market with their more focused competitors. In the major non-health sectors of the economy, corporate holding companies with multiple divisions—each responsible for its own products, suppliers, customers, and profit-and-loss accounting—have balanced the virtues of focus and specialization with the virtues of scale and scope. In the language of organizational economics, M-form firms (with multiple semi-autonomous divisions) often dominate U-form firms (those with unitary organizational hierarchies) (Chandler 1962, 1990; Williamson 1985). It is hard to find a single-product firm in any sector, and hard to find a single-market firm among any but the smallest organizations. The M-form firm pursues the advantages of specialization by establishing divisions that mimic the focus of single-product competitors, but it supplements these with the financial, political, and managerial resources of a larger entity.

The M-form organization is already evident in health care. Full-service community hospitals and academic medical centers are experimenting with subsidiaries and physician joint ventures for services most attractive to chain competitors: surgery centers and specialty hospitals. Nonprofit hospitals can create for-profit subsidiaries in which physicians invest, though care must be taken to avoid violating legal and cultural prohibitions on self-referral and fee-splitting.

These subsidiaries take the form of cardiac and orthopedic surgery hospitals, women's health centers, and MRI (magnetic resonance imaging) facilities, among others. They can be located near the mother facility or at other locations that are convenient for physicians and patients. They feature intimate settings for patients and efficient throughput for physicians, who participate as referral sources as well as clinicians. Such facilities can refer more difficult cases to the full-

service facility without raising charges of patient dumping. Physicians share governance and net earnings in proportion to their investment and referral volume, rather than equally across the larger hospital's medical staff. Management can be compensated based on the financial performance of the subsidiary in addition to that of the entire organization.

Besides mimicking the potential advantages of single-specialty chains, M-form health care organizations can gain the economies of scale and scope of multi-product firms. The single-specialty subsidiary can be viewed as contributing to the success of the larger organization rather than undermining it—important to physicians, patients, and politicians who worry about the sustainability of institutions that offer unprofitable teaching, safety net, trauma, and primary care services. The M-form is also less likely than the out-of-town chain entrant to evoke the ire of hospital labor unions, philanthropists, and state regulators.

While highlighting the autonomy and accessibility of its subsidiaries, the M-form organization can impose some system-wide requirements, such as that physician-investors also provide care in the mother facility and that some of the subsidiary's profits subsidize money-losing patients and procedures elsewhere. The M-form organization can pursue the "economic credentialing" of its medical staff, denying admitting privileges to physicians who refer their profitable patients to a single-specialty competitor. The M-form firm can tap the larger system's cash flow and borrowing capacity to obtain financial capital, though the value of the diversified firm as an internal capital market varies by its operating margin, debt burden, and credit rating (Standard and Poor's 2003).

The multidivision organization can also plan capacity in a unified manner, responding to rising demand by channeling new beds into specialty facilities rather than expanding the multispecialty hospital. If specialty chains have attracted superior managerial talent through their culture of entrepreneurship, the M-form firm can contract with them to manage their specialty facilities.

The new M-form hospital organizations may be more efficient than the organizations built during the 1980s and 1990s, despite their often diversified, holding-company structures, as they are designed with a clearer emphasis on return on investment. As shown outside the health sector, the least efficient form of diversification is that pursued by large entities in declining industries, where consolidation permits high operating profits, but where possibilities for growth within traditional sectors are limited (Jensen 1986; Jensen and Ruback 1983). Firms with free cash flow (earnings beyond profitable investment opportunities in the industry of origin) are tempted to expand into adjacent products and markets.

Rarely, however, do managers who are well adapted to one set of products, technologies, and customers prove equally successful in new contexts. Much more common are low or negative returns in the new lines of business that must be subsidized by traditional profitable activities. In a competitive economy, these conglomerates will be challenged and ultimately brought down by more focused and efficient competitors, or by hostile takeover (leveraged buyout). In the nonprofit health care sector, competitors in the product market appear in the form of spe-

cialty chains, while competitors in the capital market appear through conversions and acquisitions by investor-owned chains (Voelker 2003; Robinson 2000).

During the 1980s and 1990s, the inpatient hospital sector suffered from excess capacity and a lack of internal growth opportunities because of technological changes and capitation payments favoring outpatient care. Many an IDS was built by hospital managers unwilling to fade quietly into the background of the health care industry they once dominated. The acquisition of primary care practices—to say nothing of unproductive mergers with other over-bedded hospitals—were consummated in apparent disregard for financial returns. Now, however, the industry has sweated out excess inpatient capacity, utilization rates are rising, and many hospital organizations need to finance core services (Robinson 2002).

The renovation and expansion of physical facilities, continual updating and replacement of expensive clinical machinery, and long-deferred investment in information systems are making hospitals ever more attuned to the perspectives and priorities of capital markets. The sector has no more free cash flow. Operating surpluses are substantial, at least in consolidated markets with rising hospital admissions, but every dime earned can be invested profitably in the core business. Now hospital systems, both nonprofit and for profit, must justify their capital strategies to investment bankers, equity analysts, bond rating firms, bond insurers, and the other entities that collectively promote the accountability of borrowers to creditors (Gordon, Federbusch, and Nelson 2003). The emerging M-form hospital conglomerate will be subject to line-of-business financial analysis to an extent unknown in previous decades.

The Pyramiding of Regulation

The success of ambulatory surgery chains and specialty hospitals in some markets, coupled with the evident willingness of Wall Street to finance a national expansion, has prompted a virulent response by general multiservice hospitals. The industry has promoted state certificate-of-need (CON) legislation and the extension of federal bans on physician referrals to facilities in which they have an ownership interest. These two types of regulation, singly or in combination, would stifle the challenge from specialized upstarts; almost all specialty facilities are in states without CON legislation, and almost all have physician investors. Proponents of these policies argue that they redress imperfections in the marketplace, while opponents argue that they merely protect incumbents from the rigors of competition.

Certificate of Need

CON statutes date back thirty years to the era when the perceived problems in health care were excess capacity and high-cost technologies in general hospitals, which prompted states to require regulatory approval of new facilities and equipment. CON laws were only partially effective in achieving their goals, as incumbent hospitals lobbied through their desired expansions. Academic critics labeled such influence a form of regulatory “capture,” but it appears to have stopped

specialized facilities from entering the market (Payton and Powsner 1980). Today incumbent hospitals have an interest in the effectiveness rather than the impotence of regulatory commissions.

The policy argument in favor of CON oversight of specialty facility construction is that general hospitals rely on patients and procedures whose payments exceed costs to subsidize patients and procedures whose payments fall below costs. Specialty facilities that focus their services on the most profitable patients and procedures undermine this cross-subsidy and ultimately may force denials of care in multispecialty general hospitals. More broadly, CON constitutes a form of capacity planning or “upstream rationing,” which, in the eyes of its supporters, is needed owing to rampant technological diffusion and cost-unconscious consumer demand. Whereas health planning and regulation fell into disfavor during the two decades of enthusiasm for market-oriented health policy, they now may revive in the wake of the backlash against capitation, vertically integrated delivery systems, and other features of managed care (McDonough 1997).

Critics of CON acknowledge inefficiencies in the mix of health care payment methods in the health care market but despair at the form of entry regulation that CON represents. The standard history of regulation in other industries begins with one market imperfection for which regulatory intervention is the proffered solution. The ensuing regulatory equilibrium is then undermined by changes in technology, consumer demand, and competing products. The declining efficacy of the original regulatory structure generates calls by the regulated industry to limit competition from new sources that heretofore had escaped control (Posner 1971; Banks, Foreman, and Keeler 1999).

Rate regulation of railroads, for example, was justified originally as a response to the potential for exploitive pricing by natural monopolies, and then was used to finance subsidies from highly traveled inter-urban lines to thinly traveled rural lines. The nascent trucking industry targeted inter-urban routes where regulators maintained rates above costs, thereby undermining subsidies to rural routes and leading to an extension of rate regulation to trucks. The regulation of interstate trucking led to high prices, excess capacity, and a range of inefficient practices until it was repealed in the face of intense opposition from the trucking industry and labor (Peltzman 1989; Winston 1993).

The extension of CON to cover specialty hospitals follows a parallel logic, even if the specifics are different. The reliance on administered pricing by Medicare creates categories of profitable and unprofitable procedures, and of profitable and unprofitable patients within each diagnostic category (as hospitals are paid the same rate for patients with illness of different severity levels). The unwillingness of the polity to finance universal health insurance deepens the disparities among profitable (insured) and unprofitable (uninsured) patients. Reliance on general hospitals as the locus of subsidies for unprofitable procedures and patients makes it difficult to subject them to market pressures, as the institutions with the strongest commitment to serving the underserved are most hampered in the effort to attract insured patients. Yet protection of general hospitals from competitive entry

by specialty facilities and ambulatory surgery chains also protects them from pressure to improve their performance and hold down their costs.

Over the past decade many hospital markets have become increasingly concentrated through mergers among former competitors, leading to more bargaining power and higher prices (Cuellar and Gertler 2003). The Federal Trade Commission has been unsuccessful in limiting this consolidation. The best hope for competition in local health care markets may come from ambulatory centers and specialty facilities that compete for limited types of services, as new full-service hospitals face high barriers to entry in all but the fastest-growing metropolitan areas.

The pyramiding of regulation is clear. Administered pricing and incomplete insurance coverage create the social need for cross-subsidies, which are threatened by competitive entry. CON limits entry to protect these subsidies but also defends consolidation and monopoly power. Monopoly power in the hospital sector then generates demands for more complete regulation of pricing, presumably through rate setting for all payers. Rate regulation would create new opportunities for cross-subsidies, requiring broader regulation of price and entry for physician services and ancillary providers whose activities might endanger the regulatory equilibrium.

Bans on Referrals to Physician-Owned Facilities

Regulatory prohibitions on physician referrals of Medicare patients to outpatient diagnostic, laboratory, and ancillary facilities in which they have a financial interest date back ten years to reports of excessive and inappropriate referrals (Mitchell 1995; U.S. GAO 1994). Ambulatory surgery facilities and specialty hospitals have been exempt from these so-called Stark regulations—an omission that facilitated their growth. General hospitals support an extension of the self-referral ban to all types of facilities. The 2003 Medicare drug benefit legislation imposed an eighteen-month moratorium on the construction of new specialty hospitals, giving the Medicare Payment Advisory Commission time to study the economic impact of these facilities on general hospitals, and could prompt a permanent extension of self-referral prohibitions to the entire hospital sector. However, these proposed bans pose both conceptual and policy dilemmas, as they undermine the integration between physicians and facilities, thereby throwing out the baby of clinical coordination along with the bathwater of abusive referral practices.

The relationship between a referring physician and a facility in which the physician has an ownership stake is a form of partial vertical integration, intermediate between the extremes of no ownership relationship and full organizational integration (physician as employee of the hospital organization). The ban on physician self-referral would not affect the referral practices of physicians employed in multispecialty medical groups and integrated delivery systems, which expect physicians to refer patients to the facilities of the larger organization.

Indeed, the promotion of vertical integration between physicians and hospitals was premised on the principle that it would facilitate capacity planning, higher utilization rates, attention to a continuum of care, and the ability to measure and reward performance at the system rather than the “silo” level. Stark regulations

embody a completely different perspective—one that is skeptical of organizational integration and favors arms-length relationships that do not influence physicians' choices of where to refer patients.

In economic language, the regulations embody a “spot contract” approach to physician and facility relationships. A spot contract is one in which payment and delivery are clearly defined and occur in the same period—as opposed to relational contracts in which price, quantity, and quality are less certain and determined in the future, and depend on long-term mutual dependence among the trading partners (MacNeil 1978). The investment by a physician in an ambulatory surgery facility or specialty hospital provides an incentive for the physician to cooperate with that facility without becoming an employee. Partial integration through investment (targeted by Stark regulations) may not be less desirable than full integration through employment (vertical integration) or arms-length relationships with no ownership incentive (spot contract). Full integration through employment within an IDS potentially creates the same incentive to overutilize a service as investment in a freestanding facility, whereas arms-length spot contracting creates no incentive for coordination between physicians and facilities.

Extension of Stark regulations to ambulatory surgery and specialty hospitals cements one form of organizational relationship—the arms-length spot contract—that has contributed to the fragmentation and inefficiency of the system and is now being superseded by more integrated organizational relationships. The logic of the ban on referrals to services and facilities in which a physician has an ownership interest would prohibit surgical procedures done in a physician's office as well as the ownership of radiological and other clinical equipment by a physician practice. Taken to the extreme, these regulations would prohibit the dual role of the physician as an agent who both diagnoses conditions and recommends treatments, on the one hand, and actually provides (some of) those treatments, on the other. A surgeon who evaluates a patient and recommends a procedure, for example, could be seen as having a conflict of interest if he or she were also a candidate to perform that procedure.

Physicians' opposition to extending self-referral bans stems in part from a longstanding reluctance to become employees of hospitals, which they term the corporate practice of medicine. Bans on physician referrals, state bans on corporate practice of medicine, and CON entry barriers all contribute to the rigidity of the health care system and its difficulty in fostering new organizational forms in response to changes in epidemiology, clinical technology, and patient preferences.

The Health Care Market as Roller-Coaster Ride

Specialty hospital and freestanding ambulatory facilities—combined in multi-market chains, partnered with local physicians, and fueled by venture capital—challenge the organizational status quo in health care. The excessively diversified health care organization presents inviting targets to entrepreneurial entities that target markets, procedures, and patients offering the widest divergence between price

and cost. Specialty hospitals and ambulatory facilities potentially reap the administrative and clinical benefits of specialization and replication, doing more of the same thing with the goal of finding ways to do it better and cheaper. The chain structure permits the upstarts to obtain economies of scale in purchasing supplies, hiring managerial talent, and performing back-office functions. More importantly, the chain structure offers the potential for developing benchmarks to monitor, improve, and reward performance across the enterprise. Scale economies and geographic diversification combine with growth opportunities afforded by changes in demography and technology to make the specialty inpatient and outpatient chains the hottest health care sector among capital investors.

But if specialty hospitals and ambulatory facilities offer potential efficiency gains to the U.S. health care system, they also pose new challenges through their tendency to undermine the fragile system of financial subsidies and physician professionalism. The health care system manifests a chaotic mix of payment mechanisms for particular procedures and patients, relying on general hospitals to serve as the locus for the social pooling of health risks. Hospitals earn financial surpluses on services such as cardiac surgery and incur losses on services such as burn care, and hence are imperiled by competitors who provide the former but not the latter. Hospitals tend to earn income from patients covered by commercial insurance and often lose money on patients covered by Medicaid, and hence are imperiled by competitors who focus on the former and avoid the latter. Tensions also arise from the roles of physicians as both referral agents and clinicians, and from the fact that they may earn more money based on their decisions about which patients to refer to which facility than for the care they personally provide.

The health care system manifests numerous inefficiencies that attract entrepreneurial talent and venture capital willing to take high risks for the possibility of reaping high rewards in the largest industry in the largest economy in the world. Once incubated and launched into the delivery system, startups face internal and external expectations for continued growth, which drive them to diversify outside their original niches to new products and new markets. Diversification strategies—whether across products (as in multi-product hospitals) or across markets (as in specialty chains)—inevitably lead startups into domains where their comparative advantages are weak and incumbent competitors are strong. Ignoring warning signs and the lessons of business history, entrepreneurial firms often press forward rather than fall back, apparently pursuing growth as an end in itself. We thus can expect continued cycles of innovation, expansion, and diversification, followed by periods of crisis and contraction, in turn succeeded by new cycles of experimentation, excitement, disillusion, and misery.

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