POLITICS, HEALTH POLICY, AND THE AMERICAN CHARACTER

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INTRODUCTION

The process of public policymaking is complex and often confusing to outside observers and inside participants alike. No single analytic scheme can explain or predict events in the policy process and their consequences. Underlying the dynamics of agenda setting and policy formulation, however, are relatively stable contextual conditions that set the parameters for how governmental officials will respond to public health problems. This Article, in reviewing elements of history, social science, and health policy literature, focuses on the distinctive elements of American political ideology and institutions, and how that context has shaped the nation's health policy.

We examine the relationship of core values of the American character—in particular, individualism, distrust of government, social equity, and distributive justice—to the development of health policies and a health care system that is exceptional both in the resources it consumes and in the proportion of the population excluded from its benefits. But the core values do not point policy in a uniform direction, as there is constant tension between protection of individual liberty and the aspirations for equality embodied in the American social contract. The contemporary resurgence of "conservative" ideology—in fact, a brand of classical liberalism that emphasizes individual autonomy and

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responsibility, private property, and market allocation of resources—is the impetus for a series of public policy initiatives that may further exacerbate existing social inequalities. Though many scholars argue that this was not an inevitable outcome of the nation's history, we argue that the American character is at the center of the long struggle over whether government should treat medical care as a market good or a public good. We also believe the contemporary manifestations of this struggle merit greater attention, lest our national health policymaking become even more crippled. Increasing polarization of party politics and domestic policymaking has occurred over the past twelve years and the divisive debates since President Clinton introduced his Health Security Act in the fall of 1993 reflect the clash of competing core values.

I. THE AMERICAN CHARACTER

Historians and political scientists have long focused on American exceptionalism in comparing the values, traditions, institutions, and public policies of the United States to other countries.[1] Lipset argues:

> The United States is organized around an ideology which includes a set of dogmas about the nature of a good society. Americanism, as different people have pointed out, is an 'ism' or ideology in the same way that communism or fascism or liberalism are isms. . . . [T]hat ideology can be subsumed in four words: anti-statism, individualism, populism and egalitarianism.[2]

Kingdon finds that the paramount value among Americans is liberty, or freedom, for autonomous individuals.[3] When paired with the strain of egalitarianism prevalent in our society, a philosophy emerges that allows public policies to promote equality of opportunity without a corresponding concern for the equality of results.[4] There is

> a prevailing American ideology that differs from the ideology of people who inhabit other industrialized countries. And the power of this notion of equality of opportunity, at least as an ideal, is distinctively American, at least in the sense that the American center of gravity is different from the center in other countries.[5]

Together, ideology and institutions forge a political culture that exhibits a powerful pattern of path dependence: "early events in American history started

1. *See* Seymour Martin Lipset, *American Exceptionalism Reaffirmed*, *in* IS AMERICA DIFFERENT? 1 (Byron E. Shafer ed., 1991); HERBERT MCCLOSKY & JOHN ZALLER, THE AMERICAN ETHOS (1984); Sven Steinmo & Jon Watts, *It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America*, 20 J. HEALTH POL. POL'Y & L. 329 (1995).

2. Lipset, *supra* note 1, at 16.

3. JOHN W. KINGDON, AMERICA THE UNUSUAL 26 (1999).

4. *Id.* at 35-38.

5. *Id.* at 36.

the country down the path of limited government, subsequent events reinforced that direction, and the distinctive pattern lasted to the present."[6]

In the following Part, we examine four related elements of the American character that we believe have crucially influenced the development of American medicine and health policy. They include: 1) individualism and a passion for liberty; 2) a deep-rooted distrust of authority, especially governmental authority; 3) inconsistent insistence on social equality; and 4) distributive justice through markets.

II. INDIVIDUALISM AND LIBERTY

The Constitution, the Bill of Rights, and our other laws and public policies emphasize individual freedom and the rights of individuals. John Locke's writings were an influential source of ideas concerning the primacy of the individual, the importance of individual rights, and the insistence on imposing limits on authority in general and governmental authority in particular.[7] These ideas are not solely of English origin, however. The interactions between the colonists and the American Indian tribes in the Northeast led to the sharing of many ideas rooted in tribal custom. For example: "The Iroquois Constitution prevented government interference in everyone's daily lives and enhanced individual freedom. It also separated the civilian government from the military and religious affairs; allowed many different religions and faiths to coexist; and recognized the importance of one's religious beliefs, no matter what its content or origin."[8]

Visiting the United States in the 1830s, Count Alexis de Tocqueville identified an emphasis on individualism as the hallmark of American society.[9] Individualism has long been recognized as one of the central elements of the American character. Bellah and his colleagues make the point very clearly:

> Individualism lies at the very core of American culture. . . . We believe in the dignity, indeed the sacredness, of the individual. Anything that would violate our right to think for ourselves, judge for ourselves, make our own decisions, live our lives as we see fit, is not only morally wrong, it is sacrilegious. Our highest and noblest aspirations, not only for ourselves, but for those we care about, for our society, and for the world, are closely linked to our individualism.[10]

Supporting the view that Americans emphasize individual goals and individual advancement, rather than community goals or the advancement of public or

6. *Id.* at 57.

7. ROBERT N. BELLAH ET AL., HABITS OF THE HEART: INDIVIDUALISM AND COMMITMENT IN AMERICAN LIFE 143 (1985).

8. Emory Dean Keoke & Kay Marie Porterfield, *The Great Law*, NATIONAL MUSEUM OF THE AMERICAN INDIAN, Fall 2004, at 76, 77.

9. ALEXIS DE TOCQUEVILLE, DEMOCRACY IN AMERICA (Phillips Bradley ed., Vintage Books 1945) (1835).

10. BELLAH ET AL., *supra* note 7, at 142.

collective purposes, Hofstadter observes that the United States has been "a democracy in cupidity rather than a democracy of fraternity."[11] "However much at odds on specific issues, the major political traditions have shared a belief in the rights of property, the philosophy of economic individualism, the value of competition; they have accepted the economic virtues of capitalist culture as necessary qualities of man."[12]

Voluntarism is a very positive, dynamic aspect of American individualism. To deal with social ills—because the public sector is perceived as inefficient, unresponsive, and bureaucratic—Americans often support actions initiated by individuals and private organizations, including churches and charitable organizations, and even profit-making private institutions, rather than get involved with their unwieldy government. In the field of health, notable advances through voluntary initiatives include the successful fight against polio led by the National Foundation on Infantile Paralysis and the growth of health insurance coverage through the not-for-profit Blue Cross and Blue Shield plans in the middle part of the twentieth century. Yet in many respects, these advances have made it more difficult to resolve problems, such as the HIV/AIDS epidemic and to provide coverage for the remaining uninsured population, where voluntary action is insufficient and governmental financing and regulation are necessary elements of public policy.[13]

III. DISTRUST OF GOVERNMENT

Bronfenbrenner observed, "Americans are mostly descendants of those who could not stand authority, or whom authority could not stand."[14] Distrust of government, a widely shared value in the United States, goes hand in hand with individualism. The federal government was designed, essentially, to protect individuals and minority groups from governmental policies established through a "tyranny of the majority."[15] The founders of the United States established three branches of government—legislative, executive, and judicial—with countervailing powers to ensure that no single leader or branch of government could dominate and oppress the people. The Bill of Rights spelled out many of the basic rights of citizens, including: freedom of religion; freedom of speech; the right of people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures; the right to

11. RICHARD HOFSTADTER, THE AMERICAN POLITICAL TRADITION xxx (1973).

12. *Id.* at xxx.

13. *See* MARTIN A. LEVIN & MARY BRYNA SANGER, AFTER THE CURE: MANAGING AIDS AND OTHER PUBLIC HEALTH CRISES (2000); DAVID J. ROTHMAN, BEGINNINGS COUNT: THE TECHNOLOGICAL IMPERATIVE IN AMERICAN HEALTH CARE (1997).

14. Urie Bronfenbrenner, *Child Care in the Anglo-Saxon Mode*, *in* CHILD CARE IN CONTEXT 281, 288 (Michael E. Lamb et al. eds., 1992).

15. JAMES MADISON, ALEXANDER HAMILTON & JOHN JAY, THE FEDERALIST PAPERS (Isaac Kramnick ed., Penguin Books 1987) (1788).

petition government; and the right to a speedy and public trial.[16]

The founders also vested most legal authority in the states, reflecting the original confederation of colonies and a general distrust of an omnipotent national government. The Tenth Amendment provides, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people."[17] While monetary and foreign policy belonged in the federal domain, other governmental and regulatory functions (including police protection, education, and health care) rested with the states and, at their discretion, local governments or the private sector.

While distrust of authority in general and governmental authority in particular has had a strong influence on policy throughout our history, its importance has waxed and waned. During the past century, expansions of public authority (1900s, 1930s, 1940s, and 1960s) alternated with periods of governmental retrenchment and pro-business policies (1890s, 1920s, 1950s, and 1980s and beyond). Petracca notes that during public-oriented periods, purposive and noneconomic groups interested in social and political reform proliferate.[18] During these periods, the public's trust in government has been greater than in other periods and, not coincidentally, that is when proposals for national health insurance have emerged.

Even when the American people recognize serious social problems and look to government for solutions, major reforms face long odds because the distrust of the founders and their fellow citizens in centralized authority led them to create political institutions through which it is relatively easy to block action and extraordinarily difficult to secure agreement across institutions.[19] Most health care reforms involve substantial economic redistribution and regulation of individuals and organizations, and so the fragmentation of power plays into the hands of interests opposed to those reforms.

IV. SOCIAL EQUALITY

The concept of equality is one of the most deeply held American values. The Declaration of Independence makes this clear:

> We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. That to secure these rights, Governments are instituted among Men, deriving their just powers from the

16. U.S. CONST. amends. I-X.

17. U.S. CONST. amend. X.

18. THE POLITICS OF INTERESTS: INTEREST GROUPS TRANSFORMED (Mark P. Petracca ed., 1992).

19. *See* Hugh Heclo, *The Clinton Health Plan: Historical Perspective*, HEALTH AFF., Spring 1995, at 86; Steinmo & Watts, *supra* note 1.

consent of the governed. . . .[20]

In practice, equality for all Americans, regardless of differences such as race, gender, and religion has been a subject that has divided the nation. Advances in civil rights and affirmative action have been made sporadically, often against powerful opposition.

Social, economic, and political equality were initially limited in the United States: white male landowners had privileged status, women were not guaranteed voting rights until 1920, and freedom itself was denied to African slaves from the time that European immigrants first landed on North American shores.

The Civil War was fought largely because of slavery. Despite protections supposedly guaranteed under the Thirteenth, Fourteenth, and Fifteenth Amendments to the Constitution adopted in the decade after the war, little progress was made in assuring equal treatment of blacks relative to whites. From 1883 to 1896, when it decided *Plessy v. Ferguson*, the Supreme Court struck down civil rights legislation and enshrined the policy of "separate but equal."[21] The majority in an 8-to-1 decision wrote that "equal" did not require "an enforced commingling of the two races. . . . If one race be [sic] inferior to the other socially, the Constitution of the United States cannot put them upon the same plane."[22]

Racism was widespread at the turn of the twentieth century and it persisted. A critical turning point came in 1954 when the Supreme Court, in *Brown v. Board of Education*, reversed the 1896 "separate but equal" doctrine and held that "[s]eparate educational facilities are inherently unequal."[23] Efforts to desegregate public schools were met with massive resistance in many southern states. Schools remained segregated as did over 1000 hospitals in the South. This gross inequality was to have a profound legacy. Minorities, particularly Native Americans, African Americans, and Hispanics continue to have less access to private health insurance and limited access to quality medical care, and substantial health disparities persist among groups in the population based on race and socioeconomic status.

Views began to change in the mid-1950s and were greatly influenced by the civil rights movement, which gathered momentum in the 1960s. With the committed leadership of President Johnson, the Civil Rights Act of 1964 and the Voting Rights Act of 1965 finally gave blacks the rights that had been denied since the Emancipation Proclamation.

20. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).
21. Plessy v. Ferguson, 163 U.S. 537 (1896).
22. *Id.* at 551-52.
23. Brown v. Bd. of Educ., 347 U.S. 483, 495 (1954).

V. DISTRIBUTIVE JUSTICE

Justice is ostensibly an esteemed value in the United States and most Americans believe that we live in a just and fair society. In *Habits of the Heart*, Bellah and his colleagues observe:

> As we use it, *justice* has three senses: 1) *procedural justice*, which is a matter of fairness of the rules under which society operates and disputes are adjudicated; 2) *distributive justice*, which is a matter of the fairness of the society's system of rewards, of its distribution of goods and opportunities; 3) *substantive justice*, which is a matter of the institutional order of society as a whole and its justice or fairness.[24]

Our focus is on distributive justice, and Beauchamp provides a general standard: "In the broadest sense, justice means that each person in society ought to receive his due and that the burdens and benefits of society should be fairly and equitably distributed."[25]

In the absence of a single, fixed standard of equity or justice, there are many principles of distributive justice that might guide the development and evaluation of public policies. For example, social rights, goods, and services might be allocated according to the following five principles: "1) to each person an equal share; 2) to each person according to individual need; 3) to each person according to individual effort; 4) to each person according to societal contribution; and 5) to each person according to merit."[26]

According to Beauchamp, the principle of allocating resources according to individual effort—actually, the outcomes individuals achieve in a competitive system—is the most prevalent one in the United States:

> The dominant model of justice in the American experience has been market justice. Under the norms of market justice, people are entitled only to those valued ends such as status, income, happiness, etc. that they have acquired by fair rules of entitlement, e.g., by their own individual efforts, actions, or abilities. Market justice emphasizes individual responsibility, minimal collective action and freedom from collective obligation except to respect other persons' fundamental rights.[27]

Adam Smith and other classical liberal philosophers actually viewed markets as a powerful means to abolish class, inequality, and privilege. In their time, the state represented absolute rulers, protections for inefficient producers, and corruption. Thus, they "agreed that the road to equality and prosperity should be paved with a maximum of free markets and a minimum of state

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24. BELLAH ET AL., *supra* note 7, at 334.

25. Dan Beauchamp, *Public Health and Social Justice*, *in* THE NATION'S HEALTH 248, 249 (Philip R. Lee et al. eds., 1981).

26. Philip R. Lee, *Health Care: Right or Privilege?*, CONSERVATIVE JUDAISM, Summer 1999, at 80, 81.

27. Beauchamp, *supra* note 25, at 249-50.

interference."[28]

In our time, of course, markets are considered the primary means of restricting the redistributive tendencies of governments in industrialized democracies. "Liberal" or "residual" welfare states such as the United States tend to adopt social reforms that feature means-tested assistance, not entitlements distributed as a condition of citizenship. Eligibility rules are strict and benefits are typically modest, often accompanied by stigma. In addition, "the state encourages the market, either passively—by guaranteeing only a minimum—or actively—by subsidizing private welfare schemes" through appropriations or, more significantly, through tax-exempt benefits.[29]

In the United States, some health policies are based on the principle of need (e.g., Medicaid and children's health insurance), some on the principle of societal contribution and merit (e.g., Medicare), and some on individual effort or collective bargaining by similarly situated individuals (e.g., employer-sponsored health benefits). Since the New Deal in the 1930s, there has been a fairly consistent partisan divide in health and other social policies. Republicans generally have supported governmental assistance for health care, unemployment, and welfare as a last resort when individuals cannot provide for themselves in the market economy. Most, though not all, Democrats have supported what Esping-Andersen calls "decommodification" of social rights to retirement benefits and health insurance.[30]

The differences between Republicans and Democrats now seem to be more polarized on the question of market justice versus social justice, on the question of medical care as a market good (based on individual effort and ability to pay) versus a public good (based on need or societal contribution), on the balance between the private and public sectors, and on the role of the federal government in public health and health care.

In the following Parts, we turn from a discussion of the core values and political institutions that define the American character to a discussion of their impact on the development of the medical care system and health policy. We have chosen to focus on broad priorities and policies and note how efforts to establish a more equal, government-led system of health care have moved forward at times and receded at others, including the last decade.

VI. THE TRANSFORMATION OF MEDICAL EDUCATION AND MEDICAL CARE: MEDICINE AS A PUBLIC GOOD

Medical practice and medical care in the United States have deep roots in the idea of individualism. Many physicians still cling to the ideal of solo, fee-

28. GØSTA ESPING-ANDERSEN, THE THREE WORLDS OF WELFARE CAPITALISM 10 (1990).

29. *Id.* at 26-27.

30. *Id.* at 27.

for-service practice, with the physician determining the appropriate charge and the patient paying the physician directly without any third party interference. The ideas shared by many physicians reflect a distrust of government, a strong belief in professional autonomy, and an image of themselves as archetypal small business owners.[31] The American Medical Association (AMA) came to reflect these views in health policy debates at the state and federal level over much of the last century.[32] These cherished ideas persist in the face of the rapid growth of private health insurance (with large federal tax subsidies) that has paid for most physician services over the past forty years; the growth of Medicare and Medicaid since their enactment by Congress in 1965; large public subsidies for biomedical research, medical education, hospital planning, and construction; the role of the Food and Drug Administration (FDA) in drug regulation; and many state, local, and federal public health policies that have greatly advanced Americans' health and well-being (e.g., fluoridation of public water supplies, immunization, family planning, sanitation, and auto and highway safety).

A very different view began to emerge in the early twentieth century—medicine as a public good. The results of actions by both public and private institutions in support of this view tempered physicians' individualistic tendencies and dramatically improved medical education and medical care. An abridged review of the history of these changes is useful because of the light it sheds on the present day debates about medical education, medical research, and our chief focus, health policy.

Medical care in the late nineteenth century was of limited value. The physician had few effective tools for either diagnosis or treatment. Heart disease could be treated with digitalis, malaria with quinine, and pain with opium, but for most other disorders the physician could just prescribe a variety of useless potions and salves and observe. Watchful waiting was the order of the day. Although anesthesia first had been used about mid-century, surgery was still precarious and of limited value. Childbirth was even more risky and both infant and maternal mortality were high, in part, because physicians did not observe simple rules of asepsis.

President Charles Eliot of Harvard wrote about the American physician at the time: "The ignorance and general incompetency of the average graduate of American Medical Schools, at the time when he receives the degree which turns him loose upon the community, is something horrible to contemplate."[33] This sorry state of medical practice was to change. Medical education was to play a major role in the transformation of medical practice and care that

31. *E.g.*, David Rothman, *A Century of Failure: Health Care Reform in America*, 18 J. HEALTH POL. POL'Y & L. 271 (1993).

32. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 235-419 (1982).

33. *Id.* at 113.

occurred in the twentieth century.

The process of reform in medical education began at Harvard and a few other university-based medical schools, particularly Johns Hopkins. The reforms were supported by the AMA, which invited the Carnegie Foundation for the Advancement of Teaching to conduct an independent evaluation of the medical schools in the United States. The result was a report by Abraham Flexner, who conducted the study, *Medical Education in the United States and Canada*.[34] The report was a powerful factor in the closing of the proprietary medical schools throughout the country and the dramatic improvements in medical education that took place during the next thirty years.

Flexner's vision of medicine as a public good was to influence medical education, but it had little influence on medical practice. He was crystal clear:

> The overwhelming importance of preventive medicine, sanitation, and public health indicates that in modern life the medical profession is an organ differentiated by society for its own highest purposes, not a business to be exploited by individuals according to their own fancy. . . . The public interest is then paramount, and when public interest, professional ideals, and sound educational procedure concur in the recommendation of the same policy, the time is surely ripe for decisive action.[35]

The concept of medicine as a public good, not a market good, was to have a profound effect on medical education, which was transformed from an inferior proprietary enterprise to a university-based enterprise that became the envy of the world. Medical research, as a part of the university-based system, grew rapidly after World War II, largely with public support from the National Institutes of Health.

The same was not true for the practice of medicine or the health policies that were proposed to provide public funding to assure that everyone had access to necessary medical care. Physicians continued to consider medical care (now called health care) as a market good and their views were shared by most policymakers.

Organized medicine at the state (e.g., California Medical Association) and the national level (AMA) was unified, adamant, and effective in its opposition to efforts at the state and national level to provide public funding to pay for medical care. Medical care in the mind of the AMA was definitely not a public good.

The medical profession became very influential, not only in relation to medical practice and the standards for licensure at the state level, but also in its support for university-based medical education, biomedical research through the National Institutes of Health, and hospital planning and construction programs proposed by President Truman. These actions reflected a view of

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34. ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (1910).

35. *Id.* at 19.

medicine as a public good. At the same time, physicians opposed public financing of medical care.

The AMA opposed the inclusion of national health insurance as part of the Social Security Act of 1935 and President Roosevelt did not include it as part of that legislation for fear that he would lose the battle in Congress. The President did not consider national health insurance again.

The AMA opposed President Truman's proposals for national insurance in 1945 and again in 1948-1949 after his surprise election. At the state level, the California Medical Association had defeated efforts by the Republican Governor, Earl Warren, to enact universal health insurance in California.

After the defeat in Congress of proposals to provide national health insurance that were supported by President Truman, the AMA continued to be the dominant influence on federal health policies, often with the support of the pharmaceutical manufacturers and other business interests. While the AMA opposed national health insurance, it supported President Truman's proposals for federal funding of medical research and for hospital planning and construction.

The failure of the nation to enact national health insurance was not just the result of AMA influence, but also the result of strongly held values among policymakers and the public.

Throughout the mid-1960s and early 1970s, efforts to reshape the medical care system reflected increasing support for social justice over market justice. In a concession to the intransigence of political leaders in the South, the federal Hill-Burton hospital planning and construction program, initiated in 1946, continued to fund separate hospitals for blacks until 1963. Hospitals, and much of medical care, were still segregated after the enactment of the Civil Rights Act of 1964 and prior to the implementation of Medicare. The desegregation of hospitals in the South took place in early 1966, when President Johnson insisted that Medicare would not pay for care in hospitals that did not comply with the Civil Rights Act. All the hospitals that participated in Medicare, nearly 7000 at the time, had to comply with Title VI of the Civil Rights Act.

In addition to hospitals, all residency training programs had to be in compliance with Title VI in order to receive Medicare funds. Only after enactment and enforcement of the Civil Rights Act were blacks, as well as women and Jews, routinely admitted to medical schools in the United States. By the late 1960s, active affirmative action programs were in place in most of the nation's medical schools.

Just as the treatment of black Americans violated the basic value of social equality, so too did the treatment of American Indians. As a legacy of wars fought late in the nineteenth century and consignment of most American Indians to reservations, the federal government has been directly involved in providing medical care for those populations since the enactment of the Snyder Act in 1923. After the Indian Health Service was transferred from the

Department of the Interior to the U.S. Public Health Service in 1955, statistical indices of the health of American Indians on reservations improved (e.g., a decline in infant mortality).[36] Objectively, however, the health care services available to most American Indians and Alaska Natives, particularly those in urban areas, are substantially inferior to the services available to the general population. The Indian Health Service remains grossly underfunded, with damaging consequences for the health of those populations.

In enacting the Comprehensive Health Planning and Public Health Services Amendments of 1966[37] at the request of the Johnson Administration, Congress declared:

> [F]ulfillment of our National purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; and that Federal financial assistance must be directed to support the marshaling of all health resources—National, State, and local—to assure comprehensive health services of high quality for every person.[38]

The long range plan to achieve this lofty goal proposed by the Department of Health, Education, and Welfare in 1968 included "a two-fold strategy: 1) To maintain and promote a strong base for improving the general health; and 2) To strive for a level of health protection and services comparable to the general population for those who are inadequately served by the existing health system."[39] During this brief period, advocates and officials alike asserted a strong role for government in assuring a more equal and just health care system.

In contrast to the health planning strategy of the Johnson Administration and a Congress dominated by Democrats, the Nixon Administration endorsed similar goals but strongly favored a private sector approach to achieving them:

> Preference for action in the private sector is based on the fundamentals of our political economy—capitalistic, pluralistic, and competitive—as well as upon the desire to strengthen the capability of our private institutions in their efforts to provide health services, to finance such services, and to produce the

36. JENNIE R. JOE, *The Rationing of Healthcare and Health Disparity for the American Indians/Alaska Natives*, *in* UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 528, 533 (Brian D. Smedley et al. eds., 2003).

37. Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, 80 Stat. 1180.

38. *Comprehensive Health Planning and Public Health Services Amendments of 1966: Hearing on H.R. 13197, H.R. 18231, H.R. 18232, and S. 3008 Before the H. Comm. on Interstate and Foreign Commerce*, 89th Cong. 2 (1966).

39. Philip R. Lee & George A. Silver, *Health Planning*, *in* INTERNATIONAL MEDICAL CARE 284, 285-86 (John Fry & W.A.J. Farndale eds., 1972).

resources that will be needed in the years ahead.[40]

The Nixon Administration did offer proposals for national health insurance, but rather than build on the social insurance, tax-funded Medicare program, it conceived of universal coverage built around employer-sponsored health benefits. In addition, it planted the seeds for the contemporary paradigm of health care competition by promoting development of private health maintenance organizations (HMOs).[41] Although most precursors to today's managed care plans offered substantially more comprehensive benefits and greater continuity of care than the traditional indemnity insurers and solo practitioners at the time, that model of HMO eroded and patients now face a system that has reverted to allocating services more on the basis of market justice than social justice.

VII. INDIVIDUALISM AND NATIONAL HEALTH INSURANCE

Health care reform, in a variety of forms, periodically rises to the top of the domestic policy agenda at the state and federal levels. In the last sixty years, proposals to establish national health insurance were considered and rejected during the presidencies of Truman, Nixon, Carter, and Clinton. Earlier, Theodore Roosevelt had supported national health insurance as part of the platform of the Bull Moose Party in 1913, but he was defeated in his bid for the Presidency. In the 1930s, President Franklin Roosevelt did not support proposals for national health insurance because he thought it might scuttle his plans for Social Security.[42]

There are three important underlying factors behind the resistance in the United States to universal health insurance. All three are related to the strong belief in individualism, a distrust of government, and acceptance of market justice. They are: a strong stress on individual responsibility, little support for government help to the poor, and an anti-regulation and pro-business perspective.

These views are supported by the voters described as on "the Right" in a recent poll by the Pew Research Center for the People & the Press.[43] Included

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40. U.S. DEP'T. OF HEALTH, EDUC., AND WELFARE, TOWARDS A COMPREHENSIVE HEALTH POLICY FOR THE 1970S i (1971).

41. *See* LAWRENCE D. BROWN, POLITICS AND HEALTH CARE ORGANIZATION (1983); JOSEPH L. FALKSON, HMOS AND THE POLITICS OF HEALTH SYSTEM REFORM (1980); STARR, *supra* note 32; Thomas R. Oliver, *Policy Entrepreneurship in the Social Transformation of American Medicine: The Rise of Managed Care and Managed Competition*, 29 J. HEALTH POL. POL'Y & L. 701 (2004) [hereinafter Oliver, *Policy Entrepreneurship*].

42. *See* STARR, *supra* note 32; Eli Ginzberg, *Health-Care Policy in the United States in the 20th Century*, *in* ETHICAL DIMENSIONS OF HEALTH POLICY 65, 66 (Marion Danis et al. eds., 2002).

43. Press Release, The Pew Research Ctr. for the People & the Press, The 2005 Political Typology: Beyond Red vs. Blue (May 10, 2005), *available at* http://people-

in the descriptions of these different voting groups were their defining values. Among the voting groups on "the Right" were so-called "Enterprisers," whose values were described as: "Assertive on foreign policy and patriotic; anti-regulation and pro-business; very little support for government help to the poor; strong belief that individuals are responsible for their own well being."[44]

Another group on "the Right," the social conservatives, "oppose government aid for the needy, believing people need to make it on their own."[45] These views were not universally held, even on "the Right." There were also pro-government conservatives who were religious and socially conservative, but favored government involvement in a wide range of policy areas, including government regulation and more generous assistance to the poor.[46] Altogether, the groups on "the Right" represented thirty-three percent of the voters in the Pew survey, a sizable proportion of the electorate.[47]

A study by the Brookings Institution suggests that the views of the enterprisers and the social conservatives about the poor may be widely shared in the United States. The study found that opinions and beliefs about the poor differ sharply between European countries and the United States.[48] For example, seventy percent of western Germans polled believe "people are poor because of imperfections in society, not their own laziness."[49] In the United States, seventy percent of the people hold the opposite view.[50] Unlike the Europeans, most Americans believe that the poor are responsible for their own poverty.

The different beliefs contribute to substantial differences in the redistribution of wealth in the United States and Europe:

> Americans redistribute less than Europeans for three reasons: because the majority of Americans believe that redistribution favors racial minorities, because Americans believe that they live in an open and fair society and that if someone is poor it is his or her own fault, and because the political system is geared toward preventing redistribution.[51]

Individualism is also strongly reflected in health services that Americans prefer. In commenting on the wide range of hospitals and medical services in the United States, Robert Fogel relates this to our stress on individualism:

> The American passion for such individually tailored health services may be

press.org/reports/pdf/242.pdf.

44. *Id.* at 53.

45. *Id.* at 54.

46. *Id.* at 55.

47. *Id.* at 27.

48. Alberto Alesina, Edward Glaeser & Bruce Sacerdote, *Why Doesn't the United States Have a European-Style Welfare State?*, *in* 2 BROOKINGS PAPERS ON ECON. ACTIVITY 187 (2001).

49. *Id.* at 237.

50. *Id.*

51. *Id.* at 247.

> attributed to the country's wide-open spaces, evangelical religion, and longstanding hostility to government. But it also reflects income. The average American, after all, is fifty percent richer than the average British person. Hence, it is not strange that they are willing to consume services that are too expensive for poorer people. Americans are no more self-indulgent in their purchases of health care than they are in their purchase of appliances or cars.[52]

In a similar vein, David Rothman has studied the twentieth century development of the American health care system and found that middle class self-interest is closely linked to the following: extensive use of medical technology that is sometimes lifesaving but is indiscriminately used, and thus extraordinarily costly; the concomitant aversion to rationing health care; and the resistance to universal health insurance that might in any way threaten access for those already covered by private insurance.[53]

Other scholars also argue that individualism and ambivalence about the role of government are the root causes of this nation's failure to join the ranks of nearly all other industrialized democracies in providing universal health insurance to its people.[54] A recent article by James Mongan and Thomas Lee describes the failures of proposals for national health insurance by President Nixon in 1974, President Carter in 1979, and President Clinton in 1994 in this way:

> Over the past thirty years, however, we have become a relatively affluent nation of consumers who are focused more on the rights and desires of individuals than on the needs of the community. Many conservatives use the phrase "rugged individualism" to describe this outlook. Liberals might use a harsher, more grating word, "selfishness." We don't know at what point rugged individualism becomes self-centeredness and selfishness, but somewhere in that transition health care reform died in 1974, 1979, and 1994.[55]

The concentrated interests of those who opposed President Clinton's health care reform, including the insurance industry and small business, effectively used the broader climate of distrust of government to sap public support for the Clinton plan.[56] Opposition generated to President Clinton's proposed reforms in 1993 from outside interests and Republican Party leaders, and from fellow Democrats who supported even more progressive reforms, rendered

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52. Robert W. Fogel, *Who Gets Health Care?*, 131 DAEDALUS 107, 114 (2002).

53. DAVID J. ROTHMAN, BEGINNINGS COUNT: THE TECHNOLOGICAL IMPERATIVE IN AMERICAN HEALTH CARE (1997).

54. *See* LAWRENCE R. JACOBS, THE HEALTH OF NATIONS: PUBLIC OPINION AND THE MAKING OF AMERICAN AND BRITISH HEALTH POLICY (1993); *see also* Steinmo & Watts, *supra* note 1.

55. James J. Mongan & Thomas H. Lee, *Do We Really Want Broad Access to Health Care?*, 352 NEW ENG. J. MED. 1260, 1262 (2005).

56. LAWRENCE R. JACOBS & ROBERT Y. SHAPIRO, POLITICIANS DON'T PANDER 44-67 (2000).

presidential leadership impotent on the issue.[57]

Other scholars challenge the proposition that cultural values per se are at the heart of the failure of universal health insurance. Drawing upon comparative analysis of the United States and countries that eventually adopted universal coverage, Steinmo and Watts pay heed to the values of individualism and distrust in government.[58] They document, however, that the American public actually supports by a wide margin the basic assertion that access to health care is a right, as well as proposals that would provide greater health security through universal insurance coverage. In addition, strong interest group opposition was present not only in the United States, but also in nearly all other countries where universal coverage prevailed. Thus, they focus their attention not on the ideology of American politics but on American political institutions as a cause for the repeated failure of health care reforms in the United States.[59]

The distrust of concentrated power at this nation's founding has, through the constitutional design and subsequent procedural rules, so fragmented power that opposition politicians and interest groups are able to delay and ultimately block initiatives, even those with a substantial investment of political capital by the president. Theda Skocpol argues that whatever the source of failure, when a major effort at universal coverage dies it sows greater disenchantment and distrust of government among the American people, thus perpetuating a cycle of negative feedback that makes the next such effort even more improbable.[60]

VIII. MEDICARE REFORM THROUGH THE LENS OF THE AMERICAN CHARACTER

The most significant health care financing reform actually adopted in the United States, the enactment of Medicare and Medicaid under President Johnson, was thought by advocates to be a step toward national health insurance. By starting Medicare on behalf of a demonstrably needy and deserving population, advocates believed it would set in place a program that could then be extended to other groups, such as children, and eventually the entire population. Others at the time, and certainly in hindsight, saw the addition of Part B of Medicare, designed as a voluntary supplemental medical insurance to cover physician services, and certainly Medicaid, as initiatives that would broaden the original proposals for hospital insurance but would possibly prevent an even larger federal role in the financing of medical care in the future.

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57. HAYNES JOHNSON & DAVID S. BRODER, THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT (1996).

58. Steinmo & Watts, *supra* note 1.

59. *Id.*; *see also* Heclo, *supra* note 19.

60. THEDA SKOCPOL, BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS (1996).

While Medicare was designed as a public good to benefit the elderly, physicians were also beneficiaries. As Theodore Marmor notes, "The most striking development was the extent to which Medicare benefited those who opposed it most. Medicare was advocated as an insurance measure, not as an instrument of reform in the organization and delivery of personal health services."[61] Congress did not want to interfere with the practice of medicine, and the regulations written by the Social Security Administration proved to be very generous in the payments to hospitals and physicians. Medicare reflected a "middle class" benefit, with the elderly beneficiaries selected on the basis of their entitlement to Social Security and not as a means-tested "charity" program. The Medicare benefits were earned, but they were not comprehensive. To fill in the sizable gaps in covered services and financial support, beneficiaries would need to acquire private supplemental insurance ("Medigap").

The importance of individualistic values was strongly reflected in the regulations adopted to implement Medicare. The legislation treated medical care as a public good, providing the funds for basic health insurance for hospitalization through employer and employee payroll taxes (like Social Security), and for payment of physicians' services through federal general revenues, derived largely from corporate and personal income taxes, as well as a premium paid by the beneficiaries. The regulations, however, were designed to benefit the individual providers of health care, particularly physicians and hospitals. Physician and hospital claims and payments were administered by private health insurers to provide a "buffer" between the medical community and the government.[62] The initial regulations specified that physicians would be paid on the basis of their customary, prevailing, and reasonable charges. Each physician determined what the charge would be for each service rendered to elderly patients, and they were free to bill patients directly for any portion of the charges not paid by Medicare. Each hospital was paid on the basis of its costs as determined by the hospital.

It was not until 1983, after sixteen years of rising costs in the Medicare program, that Congress changed the policy for hospital payment and had the federal government determine the payment for hospitals prospectively on the basis of "diagnosis-related groups."[63] In 1989, Congress established a federally determined fee schedule for physician payment in the Medicare program. This policy was implemented by the Health Care Financing Administration (HCFA) between 1992 and 1996.[64] In both cases, the rising costs of medical care and

61. THEODORE R. MARMOR, THE POLITICS OF MEDICARE 83 (2nd ed. 2000).

62. *See Id.*; JUDITH M. FEDER, MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE (1977); JONATHAN OBERLANDER, THE POLITICAL LIFE OF MEDICARE (2003).

63. DAVID G. SMITH, PAYING FOR MEDICARE: THE POLITICS OF REFORM (1992).

64. *Id.*; Paul B. Ginsberg & Philip R. Lee, *Physician Payment*, *in* HEALTH SERVICES RESEARCH: KEY TO HEALTH POLICY 69 (Eli Ginzberg ed., 1991); Thomas R. Oliver,

the resulting rapid increase in federal Medicare expenditures prompted Republican administrations and many members of Congress to overcome their ideological bias in favor of individual physicians, hospitals, and market forces, and to impose these regulations.[65]

The evolution of Medicare exhibits many of the characteristics outlined by Paul Sabatier and Frank Jenkins-Smith in their "advocacy coalition" framework for studying long-term policy change.[66] They observe that on many, if not most, policy issues, competing advocacy coalitions are alliances of individuals and organizations with the same values and beliefs concerning what constitutes appropriate and effective public policy. Coalition members hold "deep-core" normative beliefs and "near-core" policy beliefs that are highly resistant to change. Building on these beliefs, they develop longstanding relationships with other members of the advocacy coalition and exhibit a high degree of coordination on political strategy.[67] For most of Medicare's history, the principal advocacy coalitions were organized around the interests of providers, beneficiaries, and government officials.[68] The core values centered on individual concerns: professional autonomy for the physicians, the preservation of meaningful entitlements for beneficiaries, and the protection of the public purse for government officials. Within the government coalition there was considerable bipartisanship, which was useful when countering beneficiaries' interests in expanding services and providers' interest in resisting regulation of prices.[69]

Since the mid-1990s, the advocacy coalitions involved in Medicare policy have fractured, dividing providers and government officials in particular. The new coalitions are much more aligned with the Democratic and Republican parties.

> In contemporary politics, conservative Republicans and liberal Democrats often hold fundamentally different deep-core beliefs about individual responsibility, the role of government, and the capacity of the private sector to meet social needs. They also have very different near-core beliefs that shape their policy preferences. Democrats tend to favor a government-financed system of national health insurance. They consider Medicare, along with Social Security, as the central components of a social insurance system that provides universal protection to all of the nation's senior citizens. Where

Analysis, Advice, and Congressional Leadership: The Physician Payment Review Commission and the Politics of Medicare, 18 J. HEALTH POL. POL'Y & L. 113-74 (1993) [hereinafter Oliver, *Analysis, Advice*].

65. Oliver, *Analysis, Advice*, *supra* note 64.

66. POLICY CHANGE AND LEARNING: AN ADVOCACY COALITION APPROACH (Paul A. Sabatier & Hank C. Jenkins-Smith eds., 1993).

67. Thomas R. Oliver et al., *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283 (2004) [hereinafter Oliver et al., *Political History*].

68. Oliver, *Analysis, Advice*, *supra* note 64, at 128-30.

69. *See* OBERLANDER, *supra* note 62, at 106, 133; Oliver, *Analysis, Advice*, *supra* note 64, at 132-41.

> health care is purchased privately, Democrats still favor a strong hand for federal and state regulation of providers, health plans, and the rest of the health care industry.[70]

The politics of Medicare changed dramatically following the debate on the Clinton health plan. Although President Clinton seized on "managed competition" as a synthesis of liberal goals and conservative methods, [71] opponents, including the health insurance industry, small business groups, pharmaceutical companies, and others, successfully attacked the reforms on the grounds that they represented big government intrusion into individual free choice of physicians and hospitals and that the plan would create new government bureaucracies to constrain costs if competition failed to do so.[72]

After defeating the Clinton health plan and gaining control of Congress in 1994, the Republicans had plans to dismantle many existing government programs. As Haynes Johnson and David Broder describe, "It was not consensus politics being practiced in Washington, or even conservative politics as previously defined. This was ideological warfare—a battle to destroy the remnants of the liberal, progressive brand of politics that had governed America throughout most of the twentieth century."[73]

The policy proposals by the Republicans went far beyond those related to medical care. Jacob Hacker and Theda Skocpol describe what they perceived to be the threefold strategy adopted by the Republicans: 1) reduce spending on existing programs and cut taxes to prevent future spending; 2) transfer authority for joint federal and state programs to the states (e.g., welfare, Medicaid); and 3) replace public services with the public purchase of privately delivered services.[74]

These distinct approaches are deeply entrenched, with politics tied closely to policy prescriptions: "In fact, the divisions over health care—specifically, how much to trust the private market, how much to rely on government—are among the most profound in politics today."[75] The different approaches of Republicans and Democrats also depend on whether they view medical care as a market good or as a medically determined need.

Sherry Glied points to sharp contrasts between "marketist" and "medicalist" advocates of health care reform. "Marketists" see health care as just another good or service.[76] They object to the government's financing of

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70. Oliver et al., *Political History*, *supra* note 67, at 331-32.

71. *See* JACOB S. HACKER, THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON'S PLAN FOR HEALTH SECURITY (1997).

72. *See* JOHNSON & BRODER, *supra* note 57; SKOCPOL, *supra* note 60.

73. JOHNSON & BRODER, *supra* note 57, at 569.

74. Jacob S. Hacker & Theda Skocpol, *The New Politics of U.S. Health Policy*, 22 J. HEALTH POL. POL'Y & L. 324 (1997).

75. Robin Toner, *Political Memo; Weapon in Health Wars: Frist's Role as a Doctor*, N.Y. TIMES, Jan. 11, 2003, at A12.

76. SHERRY GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS 26 (1997).

health care because it distorts the market (despite abundant evidence that the market does not function properly in health care). For "medicalists," allocation should depend on a person's needs as determined by expert providers, whose diagnosis and treatment should be guided entirely by medical science and not cost (despite abundant evidence that practice patterns of health care providers often are unscientific and excessively expensive). Glied argues that ideological differences contribute to political deadlock and undermine even incremental reform, since "every such change increases the likelihood that either the marketist or medicalist view of health care will ultimately prevail."[77]

Due to this conflict over core values, the debates over strategies to "modernize" Medicare are highly polarized and ideological. After Republicans successfully defeated the Clinton health plan in 1994 and captured majority control of the House of Representatives for the first time in over forty years, the thirty-year consensus on Medicare policy was shattered. The Republicans led efforts to convert Medicare from a defined benefit program for the elderly and the disabled to a defined contribution. They sought to cap Medicare expenditures and reduce future expenditures by $270 billion to help balance the budget (and give tax cuts to the wealthy), and proposed "transforming Medicare into a competitive market by expanding beneficiaries' options to leave the traditional Medicare system for private health insurance plans."[78] While the Republicans failed at their initial efforts during 1995 and 1996 and President Clinton was reelected in 1996, the polarization persisted. In 1997, the Balanced Budget Act included not only a reduction in future Medicare expenditures of $115 billion, but also the authorization of "medical savings accounts" in Medicare and greater choice of private health plans through the Medicare+Choice program.

After enactment of the Balanced Budget Act, President Clinton and a number of members of Congress proposed the inclusion of prescription drug benefits in the Medicare program. None of these proposals were successful until after the 2002 election when the Republicans controlled the White House, the Senate, and the House of Representatives. The result was the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which represented the most significant reform in health care financing since the enactment of Medicare in 1965.[79]

With senior citizens spending an average of more than $2000 annually on prescription drugs, why did it take the federal government so long to address the need for coverage of this critical component of medical care? And why did our political leaders decide to allocate over $500 billion over the next decade for a limited drug benefit for the elderly when there were forty-five million Americans uninsured, many of them working in low-wage jobs and millions of

77. *Id.* at 34-35.

78. OBERLANDER, *supra* note 62, at 1.

79. *See* Oliver et al., *Political History*, *supra* note 67.

whom are children who remain uninsured despite private health insurance, Medicaid, and the State Children's Health Insurance Program (SCHIP)?

In an earlier analysis, we describe why the opportunity for policy change arose in 2003 and how ideological conflict played a major role in blocking proposals for Medicare drug benefits in the decade following the failure of President Clinton's proposal for health care reform in 1993 and 1994.[80] In the years shortly before the reforms of 2003, efforts to add prescription drug coverage to Medicare failed—even when it appeared that the coverage could easily be funded by federal budget surpluses—because of the seemingly irreconcilable core beliefs guiding public policy in general and Medicare in particular. Even when Republican leaders accepted the need for government subsidies of prescription drug costs, they favored the marketist approach, particularly in relation to the role of the private sector in administering the program. Most Democrats favored the traditional Medicare approach with the government administering the drug benefit. Similarly, key interest groups also took polarized positions: the AARP, representing retirees, focused on adequate benefits for all Medicare beneficiaries—ruling out a strictly marketist approach—and the Pharmaceutical Research and Manufacturers of America, representing drug companies, vetoed any steps that could easily lead to government-administered price controls.

The context shifted after the election of 2002, when the Republicans retained control of the White House and the House of Representatives and regained control of the Senate. A variety of political factors—most particularly, the impending presidential election in 2004 and resurgent federal budget deficits that might preclude large spending increases in the future—as well as rapidly rising drug prices led the President and the Republican leadership in Congress to concede some of their market-oriented agenda on Medicare in order to strengthen their broader political agenda.

In a process filled with extraordinary tactical maneuvers and political arm-twisting, Congress approved the MMA and its complex package of reforms. It established an expensive new entitlement within a federal government program. The most direct benefits of the legislation went to low-income Medicare beneficiaries who had no supplemental source of insurance coverage through retiree benefits, Medigap plans, or Medicaid.

But to achieve a greater measure of equality in access to drugs, policymakers still adhered to a program design that was consistent with other core values of the American character. Participation in the new Part D drug benefits was voluntary for beneficiaries. The primary coverage was to be offered through, and administered by, either private managed care plans or private drug plans. In the short term, the new reforms appear to be a boon for pharmaceutical manufacturers, who could now expect higher demand among

80. *Id.*

their best customers without direct federal administration of benefits, explicit cost control measures, or legalization of drug reimportation. Other private sector entities also received substantial aid: employers, managed care plans, rural health care providers, and teaching hospitals would receive over $125 billion in short-term subsidies. In the eyes of one analyst, it was "a classic election-year giveaway, a year early."[81] Another was even more critical:

> Here's another bit of insanity: The bill pays private insurance companies to take elderly patients. You know how one of the tenets of conservative philosophy is that private companies can always deliver a product better and cheaper? So why does the Medicare bill offer billions in subsidies to private insurers to induce them into the market? That's not competition; that's corporate welfare.[82]

Finally, the legislation expanded ways for employers and individuals to establish tax-free "health savings accounts" (HSAs), measures eagerly sought after by pro-market advocates for years. The HSAs built on the earlier, largely failed efforts to promote private medical savings accounts. They were viewed as the best means for individuals to decide on how they would like to purchase health care, and they drew considerable support for the potential tax breaks they offered as well.

After years of unsuccessful efforts to combine new prescription drug benefits with some market-oriented restructuring of the Medicare program, "the unprecedented momentum for action forced members of both advocacy coalitions into concessions in policy design that challenged their core values."[83] The decision by the AARP to endorse the MMA, after negotiating a limited demonstration of competition between the traditional fee-for-service program and managed care plans, was a critical event. It broke up the long-standing alignment of the competing advocacy coalitions and gave lawmakers political cover to vote for the reform package and, if necessary, disregard their ideological convictions.

IX. THE TRANSFORMATION OF MEDICAL CARE FROM A PUBLIC GOOD TO A MARKET GOOD

The views of policymakers about medical care changed dramatically after the late 1960s, following the enactment of Medicare and Medicaid and the rapid increase in the costs of medical care. The idea that medical care was a market good began to take hold strongly and to dominate the policy debate. The role of the market and competition was seen as a panacea by many federal

81. Reed Abelson & Milt Freudenheim, *Medicare Compromise Plan Won't Cut Costs, Critics Say*, N.Y. TIMES, Nov. 18, 2003, at A5.

82. Cynthia Tucker, *Prescription Drug Plan Is Expensive Boondoggle*, BALT. SUN, Dec. 1, 2003, at 15A.

83. Oliver et al., *Political History*, *supra* note 67, at 334.

policymakers, economists, and even physicians.

Medical care was moving from a cottage industry based in the solo practitioner's office and small community hospitals to one dominated by large corporations and by purchasers rather than providers. As noted earlier, the process began in the early 1970s with the endorsement of HMOs by the Nixon Administration and the passage of the Health Maintenance Organization Act of 1973. It was followed in the late 1970s by Alain Enthoven's advocacy of his "Consumer Choice Health Plan," a forerunner to later reforms based on "managed competition."[84] In the 1980s, the process expanded with the growth of for-profit managed care plans, catering to large employers attempting to contain labor costs to keep their products affordable in international markets.[85] In the 1990s, private businesses and state policymakers attempting to contain the burgeoning costs of Medicaid aggressively pursued the market-based, competitive strategy, adopting part of the systemic reforms proposed in the Clinton Administration's Health Security Act even as the centerpiece of the reforms, universal coverage, died in Congress.

It was not until the 1990s, following the debate on President Clinton's health care reform proposals in 1993-1994, that the idea of medical care as a marketable commodity became the dominant paradigm for the public and, in polls of public opinion, medical care as a societal right declined sharply for the first time in twenty-five years. The views about medical care as a market good, the importance of individualism, negative attitudes toward the poor, and the distrust of government still prevail in most discussions of health care policy.

Many of these views are still evident in the debates among federal and state officials over Medicaid in 2005. Since 2000, Medicaid enrollment has grown by thirty percent as employers have dropped their coverage, particularly of low-wage workers. In proposing changes in Medicaid policies, the National Governors Association has noted: "These rules, which have not been updated since 1982, prevent Medicaid from utilizing market forces and personal responsibility to improve health care delivery."[86] The rules in question concern the ability of states to require at least some Medicaid beneficiaries to pay premiums for their coverage, copayments for using individual services, or both.

Although there is little movement toward universal coverage—indeed, the proportion of the population with insurance coverage continues to erode with each passing year—the economic and social consequences of being uninsured are receiving greater attention. A group of private sector interests have been

84. Thomas R. Oliver, *Health Care Market Reform in Congress: The Uncertain Path from Proposal to Policy*, 106 POL. SCI. Q. 453, 457 (1991); Oliver et al., *Policy Entrepreneurship*, *supra* note 41, at 302.

85. LINDA A. BERGTHOLD, PURCHASING POWER IN HEALTH: BUSINESS, THE STATE, AND HEALTH CARE POLITICS (1990).

86. Robert Pear, *States Proposing Sweeping Change to Trim Medicaid*, N.Y. TIMES, May 9, 2005, at A1.

meeting to try to develop a consensus approach on how to provide health insurance coverage for the uninsured. Yet their approach reinforces how entrenched individualism remains in the American character:

> The twenty-four-member group takes a pragmatic approach, members said, looking for incremental steps. "People are uninsured for different reasons," said Dr. Mary E. Frank, the president of the American Academy of Family Physicians and a participant in the talks. "No one solution will work for everyone. We need different solutions for different groups of the uninsured."[87]

This state of affairs demonstrates how the market paradigm dominates public discourse today. In 1965, Medicare seemed appropriate at least for all of the elderly. It is also true that while other countries, among them Canada, France, and Germany, have different approaches, they have uniform national policies; everyone is insured or provided services. All socioeconomic groups are subject to the same policies and laws—save for the super-wealthy who must pay progressive income taxes to support the system, but can of course privately purchase high-end services either at home or abroad.

The growing role of large corporations in medical care and the wide acceptance of medical care as a market good during the past few decades have prompted an increasing number of critical articles and books. Barlett and Steele contend that, "[o]ver the last few decades, American health care has radically changed. A system that was largely not-for-profit has become a field where the profit motive and market forces affect every decision."[88]

A number of prominent physicians have spoken out forcefully. George Lundberg, the former editor of the *Journal of the American Medical Association*, argues, "the first step is to rein in the business of medicine . . . . We have to get back to basics. Physicians must be rewarded for their scientific and clinical expertise, not for their investments in high-tech devices and peripheral services."[89] In his review of the Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Arnold Relman, the former editor of the *New England Journal of Medicine*, expressed a similar view:

> In my view, the central problem is that the system is being directed mainly by market forces, which are as ill suited to the achievement of the quality goals envisioned in this report as they are to the attainment of the equally important goals of cost control and universal access. The notion that health care is basically an economic commodity represents a radical change from earlier assumptions about the social purpose of health care. It has gained currency only during the past ten to twenty years, but it has already produced public policies that are rapidly converting our health care system into a vast

87. Robert Pear, *Health Leaders Seek Consensus over Uninsured*, N.Y. TIMES, May 29, 2005, at 1:1.

88. DONALD L. BARLETT & JAMES B. STEELE, CRITICAL CONDITION: HOW HEALTH CARE IN AMERICA BECAME BIG BUSINESS--AND BAD MEDICINE 2 (1997).

89. GEORGE D. LUNDBERG, SEVERED TRUST 12–13 (2000).

competitive marketplace.[90]

The idea that medical care is a market good still predominates among political elites in the United States, if not the general public.[91] It manifests itself in health policies at the federal and state level. The results have been reported on and deplored in recent years, particularly the rising costs of care, the variations in quality and the rising number of the uninsured. Since 2000, the number of uninsured Americans has risen by five million to forty-five million or nearly sixteen percent of all Americans. The lack of health insurance coverage exacts a large personal financial toll, running up debt and making uninsured health care expenses the leading cause of personal bankruptcy. It also results in billions of dollars in uncompensated care costs that get passed along through the health system. While a recent poll by the Pew Research Center for the People & the Press found that sixty-five percent of the population favors a governmental guarantee of health insurance for all Americans, even if it means raising taxes, there is no leadership on this issue at the federal level.[92]

SUMMARY AND CONCLUSIONS

What we have learned from tracing the evolution of health care policies is that the inefficiency and inequity of our current system exist in large part because of our values. Without doubt, individualism remains the most potent value in American culture and is the touchstone of American politics. Many observers, both here and abroad, have remarked that Americans emphasize individual goals and individual advancement rather than community goals or the advance of the public, or collective, purpose. The latter gained greater attention during the progressive era early in the last century, during Roosevelt's New Deal in the 1930s and Truman's Fair Deal in the 1940s, and during the Kennedy-Johnson era of the Great Society in the 1960s. But in the past quarter-century, efforts to promote social equality and public goods have retreated in concert with the successful mobilization of business and conservative groups and the resulting electoral gains by the Republican Party.

Americans' endorsement of individualism and market justice tends to blame the poor for their poverty, in contrast to the view in Europe that poverty is a societal problem, not an individual failing. In addition, racism in many

90. Arnold S. Relman, *The Institute of Medicine Report on the Quality of Health Care*, 345 NEW. ENG. J. MED. 702, 702 (2001) (reviewing COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA OF THE INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001)).

91. Mark Schlesinger, *On Values and Democratic Policy Making: The Deceptively Fragile Consensus Around Market-Oriented Medical Care*, 27 J. HEALTH POL. POL'Y & L. 889 (2002).

92. Press Release, The Pew Research Ctr., *supra* note 43, at 40.

forms continues with serious health consequences. Distrust of government waxes and wanes, but it remains a major barrier to effective action.

Unlike every other advanced industrialized democracy, we consider medical care a market good, not a public good. We prefer voluntary arrangements to compulsory arrangements, and even when health needs are both obvious and serious, we bicker at the margins over which groups are deserving of mutual assistance based on their age, employment, income, or marital status.

Under these circumstances, is it even possible to assure all Americans access to a reasonable level of medical care? Can the United States take the creative power of individualism, which has proved to be such a positive force in many sectors of our society, and match it with Flexner's higher purpose to create medicine as a public good and "not a business to be exploited by individuals according to their own fancy"?[93]

This is a country that was able to transform medical education and medical care in the last century; create the National Institutes of Health and the strongest, most innovative biomedical research in the world; enact the Social Security Act in 1935; create the basis for retirement, disability, and unemployment insurance; mobilize for and fight World War II; enact the GI Bill in 1944 and subsidize the education of millions of veterans; enact Medicare and Medicaid in 1965; and pass the Civil Rights Act of 1964, the Voting Rights Act of 1965, and the Civil Rights Act of 1968. Few Americans would contest the value of those initiatives.

Thus, the challenge is to tap the values that supported those policies through a new series of initiatives to increase the return on our social investment through systematic improvements in quality and a reduction of health disparities. It will not happen unless we recommit ourselves to the concept of medicine as a public good. It also will not happen without leadership.

We believe that a process that begins to consider more openly our values and their application to medicine and health policy could contribute significantly to a better understanding of why we have the policies and the problems that we do today. It would also point to broad solutions instead of the piecemeal responses of contemporary health policy. If we were able to balance the importance we attach to individualism with the economic and social benefits of greater equality, we believe the result would be a less costly and far more just health care system and society at large.

93. FLEXNER, *supra* note 34, at 19.