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THE NATIONAL AGENDA FOR HEALTH CARE REFORM: WHAT DOES IT MEAN FOR POOR AMERICANS?

*Theodore R. Marmor**

INTRODUCTION

The reform of American medical care undeniably has arrived at the very top of the nation's political agenda. What health care reform means for poor Americans has not, however, had a central place within that agenda. This Symposium, therefore, deserves praise for raising this important question. My approach to addressing the health reform-poverty issue is indirect: I first want to discuss the prospects for success and disappointment in health reform generally. This is not because I believe the implications of reform for poor Americans are of secondary importance. To the contrary, I believe that the fate of poor Americans depends crucially on how adequate the architecture of reform is for all Americans, poor or rich, insured or not.

Although this Article will address the central standards by which reform proposals like it should be judged, its objective is not to describe or to evaluate the Clinton Administration's proposal. Rather, its purpose is to characterize, and criticize, the way the United States has debated medical care reform

* Professor of Public Policy & Management, Yale University School of Organization and Management. The author gratefully acknowledges the valuable research of his undergraduate Research Assistant, Jessica Bartell. Portions of this article are drawn from published and unpublished work of the author. For example, Part II. is taken in part from my article entitled *The History of Health Care Reform*, 58 ROLL CALL 20, 40 (1993). Much of the general information and argument comes from the introductory chapter of my forthcoming Yale Press Book, *UNDERSTANDING AMERICAN HEALTH CARE REFORM* (forthcoming 1994). Part IV draws on the introduction to a special issue of *The Journal of Health Politics, Policy & Law* on the disadvantaged. Deborah A. Stone & Theodore R. Marmor, *Introduction*, 15 J. HEALTH POL. POL'Y & L. 253 (1990). Though co-authored, the special issue's introduction was drafted initially by Professor Stone and is used in this article with her permission.

and to suggest ways to improve the prospects of meaningful reform for all Americans. This Article questions the structure of a workable form of universal health insurance and its proper response to the special needs and wants of the disadvantaged.

This Article begins with the question of agenda formation and examines how health reform came to the fore of public discussion by the early 1990s. Part II then considers how one can make sense of our contemporary debate and how to think about the formulation of what is at issue—the labels, the ideas, and the range of specific proposals. Part III offers guidelines for adequate reform and a restructured health care debate. Finally, Part IV addresses directly the issue of whether health reforms targeted to the problems of the poor and other disadvantaged groups are preferable to universal reforms that ignore income classes in their fundamental design of entitlement and benefits.

I. THE RISE OF THE HEALTH REFORM MOVEMENT AND THE NEED TO SEIZE THE MOMENT

Precisely how and why health reform came to national prominence in 1991-92 is not self-evident. After all, the nation had been told since at least the early 1970s that American medicine was in "crisis."¹ Polling studies indicate that most citizens accepted this critical view long before the nation's political leaders began to offer serious plans for fundamental reform.² Moreover, while inflation of medical costs outdistanced general consumer price increases in the early 1990s, this gap was even wider during the first Reagan Administra-

¹ See, e.g., Edward Kennedy, IN CRITICAL CONDITION (1972); Theodore R. Marmor, *American Health Politics, 1970 to the Present: Some Comments*, 31 Q. REV. ECON. & BUS. 32 (1990); Theodore R. Marmor, *American Medical Policy and the "Crisis" of the Welfare State: A Comparative Perspective*, 11 J. HEALTH POL. POL'Y & L. 617 (1986).

² This is a common theme in much of the polling literature. See, e.g., Robert Blendon & Karen Donelan, *The Public and the Emerging Debate over National Health Insurance*, 323 NEW ENG. J. MED. 208 (1990); see also Lawrence R. Jacobs & Robert Y. Shapiro, *Public Opinion's Tilt Against Private Enterprise*, 13 HEALTH AFF. 285, 286-88 (1994); Lawrence R. Jacobs et al., *Poll Trends: Medical Care in the United States*, 57 PUB. OPINION Q. 394 (1993); *The Duality of Public Opinion: Personal Interests and the National Interest in Health Care Reform*, 2 DOMESTIC AFF. 245 (1993).

tion, when, according to the conventional political wisdom, universal health insurance was unthinkable.³

Why major reform is not only conceivable now but also the major domestic preoccupation of the Clinton Administration has many answers, but no simple ones. By mid-1991, decreasing international pressures as a result of the end of the Cold War and the military triumph in Iraq made domestic issues far more salient. Hospitals awash in red ink, workers "locked" into jobs for fear of losing access to health insurance, fraudulent billing practices by some hospitals, doctors, and laboratories, and nightmarish stories of uninsured persons driven into bankruptcy were all part of the medical care commentary of the early 1990s.⁴ Moreover, as the data below demonstrate, the cost of medical care has continued to rise relentlessly along with the number of Americans uninsured against those costs (see Table 1 and Figure 1).

But it was the 1992 presidential race with the presence of a Democratic challenger committed to reforming American medicine that transformed the country's medical problems into front-page news.⁵ Given that prominence, a bidding war over policy remedies was inevitable, both among the three presidential candidates and less obviously, among the policy intellectuals who, for more than two decades, had been proposing cures for the ills of American medicine.⁶

³ I speak from experience on this matter, having been the senior social policy advisor to Walter Mondale during his 1984 presidential campaign. Literally no one in that campaign thought it possible to discuss national health insurance, although the rising costs of medical care was a theme in the Mondale campaign's attack on President Reagan. See Theodore R. Marmor & Andrew P. Dunham, *The Politics of Health Policy Reform: Problems, Origins, Alternatives and a Possible Prescription*, in CENTER FOR NATIONAL POLICY, *HEALTH CARE: HOW TO IMPROVE IT AND PAY FOR IT* (1985).

⁴ See, e.g., Paul Cotton, *Preexisting Conditions 'Hold Americans Hostage' to Employers and Insurance*, 265 JAMA 2451 (1991); Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491 (1991); Eli Ginzberg, *The Health Swamp*, N.Y. TIMES, Nov. 12, 1992, at A15; Barry Meier, *A Growing U.S. Affliction: Worthless Health Policies*, N.Y. TIMES, Jan. 4, 1992, at A1.

⁵ See, e.g., E.J. Dionne, Jr., *Democrats Get Chance to Turn Health Care Anxiety into '92 Votes*, WASH. POST, July 1, 1991, at A12; Elizabeth Kolbert, *The 1992 Campaign: Media, Candidates Learn that Attacks Attract Attention*, N.Y. TIMES, Feb. 29, 1992, at A9.

⁶ For an overview of the intellectual debate, see Theodore R. Marmor & Michael S. Barr, *Making Sense of the National Health Insurance Reform Debate*, 10 YALE L. & POL'Y REV. 228 (1992).

To be sure, the health reforms that President Clinton proposed in September 1993 could not possibly have been understood in detail from his campaign promises. As a campaigner, he understandably avoided the details of health reform or its implementation. As President, he has different obligations, opportunities and risks. The product of his unprecedented Health Task Force was but the beginning of a furious debate, one that thus far has concentrated more on labels for competing proposals than substantive policy and political choices.⁷ Whether the President's plan—or adjustments to it—can command a majority of the Congress is even more problematic than the 1993 struggles over his deficit reduction plan and NAFTA.

Yet, it is worth remembering that, despite the hoopla about new approaches to "comprehensive" medical care reform, there is practically nothing new about the problems cited or the remedies suggested by the current debate. All the reform principles now celebrated—from universal coverage to fixed physician fee schedules, from global budgets to competitive health plans, from employer-based financing to single-payer plans—were included in the battle over national health insurance in the first half of the 1970s. Indeed, President Clinton's commitment to employer-based financing—one of the central principles that distinguishes the President's plan from others—defined President Nixon's comprehensive health insurance proposal ("CHIP") in 1974.⁸

This demonstrates what we know from ample experience: American politics addresses major reform in fits and starts.⁹ The fragmented nature of American politics makes the process of reform tricky and unpredictable.¹⁰ Moreover, the current

⁷ *Id.* at 228-29.

⁸ For an extended discussion of the policy contests of the 1970s see the scholarship presented in the Urban Institute's *National Health Insurance: Competing Goals and Policy Choices* (1980). See also PAUL STARR, *SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982); Theodore R. Marmor et al., *The Politics of Medical Inflation*, 1 J. HEALTH POL. POL'Y & L. 69 (1976).

⁹ See JACK L. WALKER JR., *MOBILIZING INTEREST GROUPS IN AMERICA: PATRONS, PROFESSIONALS AND SOCIAL MOVEMENTS* 45-46 (1991) (discussing the policy world's "issue attention cycle").

¹⁰ For a discussion of the political actors and distribution of power in American politics, see JOHN W. KINGDON, *AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES* (1984).

combination of Presidential commitment, congressional readiness to act, and what might be called the public's permissive consensus about bold reform does not often arise.¹¹ Therefore, it is critical to focus upon the gap between the likelihood that some reform will pass and the real possibility that it will not work well over time. Unless the health care debate reflects an understanding of our historical legacy and the dangers of provincial naivete, we risk mythical mismatches between problem and remedy. And unless the debate and ultimate congressional decisions adequately address implementation questions, we risk squandering a remarkable opportunity to right the wrongs of a system that no one defends.¹² Agreement over the flaws of the current health care system does not assure that programmatic reforms will correct these wrongs. For this reason, flaws in the overall reform *effort* will be more detrimental to the poor than particular flaws in the reform movement's *treatment* of the poor. It is therefore important to understand the parameters of the debate.

II. MAKING SENSE OF THE NATIONAL REFORM DEBATE: LABELS, IDEAS AND PROPOSALS¹³

By 1993, the warring camps of medical care reformers and their distinguishing labels had become familiar elements of media coverage. Terms like "single-payer" or "managed competition" served as shorthand for complex arguments and ideas. This shorthand brought together groups of seemingly like-minded reformers and made the debate easier for journalists to cover and, at least in theory, for the public to follow. But the

¹¹ See Robert J. Blendon et al., *Satisfaction with Health Systems in Ten Nations*, 9 HEALTH AFF. 185 (1990). Of those surveyed, 89% reportedly agreed that the U.S. medical care system needs either "fundamental changes" or "complete rebuilding." *Id.* at 188. See generally SYSTEM IN CRISIS: THE CASE FOR NATIONAL HEALTH CARE REFORM 149 (Robert J. Blendon & Jennifer N. Edwards eds., 1991); Celinda Lake, *Health Care: The Issue of the Nineties*, 10 YALE L. & POL'Y REV., 211 (1992).

¹² See my article on health reform implementation. Theodore R. Marmor, *Implementation: Making Reform Work*, 2 DOMESTIC AFF. 145 (1993).

¹³ Part II draws extensively from Mark A. Goldberg & Theodore R. Marmor, . . . *And What the Experts Expect: Among Health Care Factions, A Common Ground is Emerging*, WASH. POST, Feb. 14, 1993, at C3.

labels have come to block rather than enhance public understanding and have made reform more difficult to achieve.¹⁴

If such labels were ever helpful, they are no longer. Labels mask differences within categories of reform—for example, between different plans called “managed competition”¹⁵—and obscure similarities across categories. It is increasingly clear that any proposal that could command majority approval with the public or Congress will draw on understandings, and incorporate elements, from a variety of reform plans.¹⁶ These reforms should be judged not by their labels, but by their provisions and, specifically, their answers to the basic questions of who receives insurance coverage and on what terms, and how it will be financed. Indeed, what is needed and likely—as a matter of substantive as well as political wisdom—is a fusion plan.¹⁷

Before the positive case can be made for the principles of an acceptable fusion plan, there must be less confusion. The existing approaches to reform and their labels are simply inadequate. Public commentary has failed to engage deeply felt concerns about improving the financing and, for some, the access to and quality of American medical care.¹⁸ To those Americans not immersed in the arcana of medical care reform—which is to say, almost everybody, including most journalists—the catchphrases of the health insurance debate must be bewilderingly cryptic. Did any voter, for example, understand President Bush’s attack in the spring of 1992 on then-Governor Clinton’s supposed support for a “pay or play” plan or of Clinton’s equally earnest denials of this attack? Less than a year after that debate, practically no one could remember the heated exchange.

To help clarify the debate, then, several questions must be answered. What do these labels—the jargon of commen-

¹⁴ *Id.*

¹⁵ See John B. Judis, *Whose Managed Competition?*, NEW REPUBLIC, Mar. 29, 1994, at 20.

¹⁶ See Theodore R. Marmor & Jerry Mashaw, *A Little Gridlock Might Help*, L.A. TIMES, Aug. 15, 1993, at M5.

¹⁷ See *A Healthy Compromise*, ECONOMIST, Feb. 12, 1994, at 17; Robert Pear, *As Is, Clinton Health Plan Isn't Flying*, N.Y. TIMES, Feb. 24, 1994, at A1.

¹⁸ Robin Toner, *Heart of the Health Plan Has an Ever Fainter Beat*, N.Y. TIMES, Feb. 18, 1994, at A14.

tary—mean? What is the appropriate relation between a descriptive label and the central ideas about the medical reform it is meant to signify? And how are the labels and ideas linked to the details of particular reform proposals? The problem with the health care debate is that popular labels fail to specify consistently any particular idea or proposal.

For example, a single-payer plan, according to the labels, is one in which the government pays for health insurance out of funds it collects from individuals and, possibly, employers. Many of the proposals typically sorted into this category are modeled on Canada's universal health insurance. Canada's program is administered by the ten provinces and manages to insure all Canadians for all "ordinary and necessary" medical care while spending about thirty percent less per capita than America does. This model, first advanced in American politics in the early 1970s, has been through a cycle of advocacy and attack, submersion, and then reappearance.¹⁹ The insurance industry, which as a whole stands to lose the most from this reform, has been joined by the American Medical Association and a number of other groups in opposition to this plan. Organized labor, especially in rust-belt industries like steel and automobiles, has been among the most vocal advocates of single-payer reforms, and has been joined by groups like Citizen Action, *Consumer Reports*, and splinter medical groups such as the Physicians for a National Plan.

Yet many so-called single-payer plans in fact call for each state to operate its own disbursement operation, thereby involving more than 50 payers. Single-payer need not mean one plan for an entire country; it refers to one health insurance organization within a political jurisdiction. This central idea is often characterized as "too radical" for the United States.²⁰ The single-payer label, moreover, tells one nothing about how health insurance would be financed under any particular plan, what range of medical benefits would be included, how costs

¹⁹ In 1993, its leading advocates in the Congress were Senator Paul Wellstone (D-Minn.) and Representative James McDermott (D-Wash.). See Theodore R. Marmor, *Health Care Reform in the United States: Patterns of Fact and Fiction in the Use of Canadian Experience*, 23 AM. REV. CANADIAN STUD. 47 (1993).

²⁰ Then-President Bush tried to discourage public support for a Canadian-like system by encouraging fears of "socialized medicine." See Rashi Fein, *National Health Insurance: Telling the Good From the Bad*, 39 DISSENT 158 (1992).

would be controlled within the plan's budget, and other matters far too important to be considered mere details. The label itself inadequately describes both the characteristics of the concrete model to which it refers—Canada's universal health insurance program—and the central ideas that justify putting such a model into operation.

"Play-or-pay" has been an even less satisfactory moniker. It is used to describe proposals in which employers would be required either to purchase health insurance for their employees and their families (the play option) or to enroll them in a public health insurance program and pay a payroll tax toward the cost (the pay option). But plans that include the pay-or-play mechanism for financing insurance are often more different than they are similar. Thus, as with the single-payer example, play-or-pay is an utterly incomplete description. For example, some play-or-pay plans would guarantee health insurance for the unemployed, while others cover only those in the workplace. Indeed, the question in every proposal is how universal a plan should be. Some play-or-pay models would control medical costs through a combination of national and state spending targets and hospital rate-setting and physician fee schedules; others would not.²¹ Calling such different plans by the same name is no more sensible than assuming that any car with an automatic transmission is a Ford.²²

The third label, managed competition, had a far shorter shelf life than seemed imaginable at the outset of the Clinton presidency. After Clinton's use of the tag late in the presidential campaign, the expression was so much in vogue that at a January 1993 retreat for congressional staff members one speaker said, "I don't know what we're going to do, but whatever it is, we'll call it managed competition."²³

²¹ For discussion of different play-or-pay plans, see Marmor & Barr, *supra* note 6, at 264-69.

²² This particular metaphor—and much of the discussion of labels—is drawn from Goldberg & Marmor, *supra* note 13, at C3.

²³ Annapolis retreat, organized by the Alliance for Health Care Reform, January 3, 1993. Such a cynical embrace of labels—as if they need have no direct connection to the substance of proposals—is hardly surprising in American politics. Many such examples are available from recent experience; the much-touted welfare reform legislation of 1988—the Family Support Act—for example, proved to have such a disappointing gap between aspiration and results that we are again addressing the "reform of welfare" as America "knows it." A brilliant discussion of

By April 1993, however, President Clinton's advisors had withdrawn from the "managed competition" tag. According to the *New York Times*,²⁴ health task force officials who briefed the press "ridiculed" the very expression "managed competition." Officials tried to distance themselves from those who had insisted most forcefully that competition among health insurance plans—rather than limits on how much money would be available to medical care—was the core element in workable cost control. Whereas "managed competition" and "health insurance purchasing cooperatives" were once the rage, the evident effort became substituting "health security" and "health alliances" as the defining labels of the President's proposal.

But what ideas were associated with the President's earlier embrace of "managed competition"? One central idea was relatively clear: a restructured medical world would organize potential patients—"consumers" in marketplace lingo—into purchasing consortia for health insurance. Medical care providers ideally would practice in groups, much like health maintenance organizations. Associations of providers would compete for business from the consortia, and the consortia, represented by savvy purchasing agents, would use their buying power, combined with more and better information about the quality of care from local providers, to try to get good deals for their members.

But this core proposal could be part of a variety of plans. Proposals that include or are organized around the core concepts of managed care and regulated competition may differ radically from one another. For example, some plans would force doctors into group practices and consumers into buying consortia; while others would give doctors and patients the choice of opting out, but would use tax incentives to lure them in. Some managed care proposals would control the fees

this cycle of enthusiasm and disappointment can be found in Hugh Heclo, *Poverty Politics* (Mar. 16, 1994) (unpublished manuscript on file with author). See also THEODORE R. MARMOR ET AL., AMERICA'S MISUNDERSTOOD WELFARE STATE: PERSISTENT MYTHS, CONTINUING REALITIES 118-21 (1992).

But such ultimately disappointing cynicism is especially regrettable where the reform in question involves the country's largest industry, representing one out of every seven cents of American income.

²⁴ Robert Pear, *Clinton Medical Plan Calls for "Health Security" Cards*, N.Y. TIMES, Apr. 10, 1993, at A7.

charged for services patients used outside the "capitated" plans, i.e., those paid for on a per-capita budget. Other managed care plans assume that fee-for-service medicine would, like an old soldier, simply fade away, unable to compete on price with pre-paid provider groups. Some managed competition plans²⁵ would phase in universal coverage; others, such as the one proposed by Tennessee Representative Jim Cooper of the Conservative Democratic Forum in the House of Representatives, would not. And only some would put all American medical care under expenditure targets.

Clearly, these ostensibly different models of reform can have, at least in some of their variants, much in common. For instance, the public organization that purchases coverage for the uninsured and the employees of some businesses in a play-or-pay plan looks and functions a lot like the purchasing consortium in the managed competition plan favored by the Clinton Administration. Both, moreover, look and function a lot like a state board in the state-by-state version of a single-payer plan. The three reform archetypes, moreover, are by no means mutually exclusive. For instance, a plan could include universal coverage to a standard set of benefits as in most single-payer proposals, build around a base of employer-financed coverage as the play-or-pay strategy envisioned, *and* encourage the reform of medical care purchasing and provision as the managed competition strategy suggests.

While such a plan may be possible, whether the American public will understand that possibility depends, in part, on how disciplined a debate we have over the President's proposal in 1994 and beyond. And it is for that reason that scholarship directed at understanding medical care reform is now so important.

Substituting programmatic fusion for policy confusion is surely desirable. But what is needed is not a new paradigm, but no paradigm—an eclectic approach to medical reform that puts much more emphasis on what works than on its label. But on what principles would a fusion plan be constructed? After all, without guiding central principles, the appeal to fusion is no improvement over the very label-mongering that

²⁵ PAUL STARR, *LOGIC OF HEALTH CARE REFORM* (1993). Professor Starr, it should be noted, was one of the key architects of the Clinton proposal of 1993.

has oversimplified and clouded the debate.

III. GUIDELINES FOR REFORM AND DEBATE

Sensible reform should build on three fundamental principles. First, the three elements of the medical crisis—cost, access and quality—are interconnected. We cannot solve one problem without attending to the other two. If we put all our emphasis on controlling health spending (now amounting to over \$900 billion a year), quality and access may well suffer. If we focus solely on making sure that everybody has health insurance coverage, costs will rise and quality may erode. And if we do nothing but improve the highly variable quality of American medical care, fewer and fewer people will have access to more and more expensive services.

Second, reform must work quickly to slow cost increases, to cover the more than 37 million uninsured, and to lay the groundwork for improvements in quality. With medical spending increasing at twice the rate of general inflation, tens of millions of Americans risk life without health insurance. With so many suffering needlessly, we ought to be impatient. Furthermore, the longer we wait to fix the medical care system, the harder the job will be.

Third, health care reform must be approached prudently. The stakes—health, psychological security and financial costs—are too high to put all our faith in one theory, model or mechanism. We should build, to the extent we can, a plan that minimizes failure in the course of seeking success. It should be a reform plan that is, to borrow a term from the computer industry, fault-tolerant.

The development of a fusion plan is in some respects easier than it appears—in part because so much of the work already has been done. Many of the reform proposals advanced in recent years—and tagged with one of the three standard-issue labels—are, more than is commonly acknowledged, admixtures of elements from the “pure” categories. For instance, the plan spelled out in September 1992 by candidate Clinton, which he, and numerous commentators described then as a managed competition strategy, was in fact something of a hybrid. Similarly, the Clinton Administration’s 1993 proposal, which uses labels like health security and health alliances

instead of managed competition and health insurance purchasing cooperatives, is a hybrid as well.

The basic characteristics of a fusion plan—one with both substantive and political merit—are literally strewn about, awaiting assemblage. They include eight basic categories of reform.

1. **Financing.** Broad-based financing is required, that is, the spreading of the costs of medical care, rather than concentrating them on the sick, the low-income, or any other particular group. Employer-based financing is one possibility. But where the government mandates payment, there is a corresponding public responsibility to limit the cost burden on any particular group.

2. **Universal Eligibility and Broad Coverage.** No one should be without insurance protection against the costs of illness, injury and disease. Beyond that, health insurance should cover what Americans regard as "ordinary and necessary" medical care. Benefits should be free of the obfuscation, nasty surprises, and exclusions patients and medical care professionals correctly regard as senseless. The core of this commitment is clear: a plan must cover acute and chronic illness, preventive care, visits to doctors and prescription drugs. The periphery is necessarily less certain, but benefits should extend to the care of the chronically mentally ill, substance abusers and the frail. These services, however, require special constraints and attention since they are particularly subject to uncontrollable expansion.

3. **Cost controls.** Tough cost controls must keep spending in bounds. This means limiting medical budgets to the nation's rate of growth, not to multiples of that rate. There are many details here that may vary, but the workable options all include a prospective budget limit on affordable outlays.

4. **Rewards for the creation of more efficient groups of providers who are responsive to patients within the discipline of limited budgets.**

5. **Measures to simplify health insurance for patients, payers and providers.** These include a standard set of benefits and a single claims form, instead of the electronic billing and thousands of different forms now bedeviling us.²⁶

²⁶ Experts estimate that as much as 20% of what Americans spend on medical

6. Clear accountability for the cost, quality and accessibility of the care provided. This includes better information about the quality of care—including increased research on the effects of alternate procedures and data that enable patients and their doctors to judge the quality of care offered by providers and provider groups—so as to reduce the amount of unnecessary or inappropriate treatment. The essential feature, however, is knowing who is to be held to account for performance. Such a requirement may well have varying forms in the diverse settings of American states. Explicit attention must be paid to monitoring the quality of care to groups that are especially vulnerable—such as the chronically ill—or especially hard to represent—such as the poor and the scattered.

7. Freedom of choice. Although reform that ignores professional concerns about autonomy is acceptable, autonomy does not extend to charging whatever one wishes. Reform that limits patients' choice of doctors is undesirable when dictated by financial pressures falling disproportionately on less affluent or more sickly Americans.

8. Means of consultation and redress. Measures that regularly and transparently express patient and provider concerns, within budget constraints, are essential. This is linked to the mechanisms of accountability, but also raises separable issues. For example, Americans have little experience in formal structures of negotiation among parties interested in the benefits and burdens of public programs.²⁷

None of this discussion of what constitutes standards of acceptable reform presumes that it will be easy to refine a reform program, develop political support for it and, not least, implement the program. But a protracted squabble among rival factions is undoubtedly a less appealing alternative to fusion and one that hampers health care equality.

care goes to pay for administration and paperwork—amounting to \$180 billion in 1993. Simplification alone ought to save tens of billions of dollars, in addition to eradicating the non-financial costs of contemporary complexity, confusion and uncertainty.

²⁷ The American penchant for disinterested umpires to resolve clashes of interest makes it difficult to legitimate instructions of bargaining. We lack Europe's vital instructions of corporatism and the participation of those who will be affected by public policy in the working out of means to settled ends, and of feeding back information about performance, glitches and needless conflict.

IV. (E)QUAL(ITY) & REFORM

This Article has not yet addressed how to incorporate the concerns of disadvantaged groups in health care reform. But, if the normative criteria of Part III are accepted, the decisive question is simply whether reform that satisfied those criteria even requires any special treatment for the disadvantaged.

The very idea of disadvantage as the focus of discussion has a 1960s ring about it, which seems incongruous and yet necessary in the 1990s. Only in America could universal health insurance sustain such a discussion. Our social policy imaginations tell us much about our political souls.

Whatever principle we use to classify disadvantage, we inevitably exclude some groups. One might frame disadvantage in various ways: by demographic age groups—the elderly and children; by illness—AIDS, mental illness or chemical dependency; or by market or governmental failure—the homeless, the hungry and the medically uninsured, all of whom suffer diminished access to specialized markets. But such categorizations may neglect blacks or other ethnic groups, immigrants, the poor, the disabled, the retarded or the chronically ill. Moreover, the principles discussed do not provide clean categories either. The homeless, the mentally ill, senior citizens and the undernourished child with AIDS defy attempts to locate them on a coherent conceptual map. These are not the exhaustive and mutually exclusive categories rationalists favor. But categorical thinking—and its ailments—are predictably called forth by American political culture and institutions.

Unlike European or Canadian health financing programs and public education legacy, American health policy has not been based on clear, universalistic principles. We have sequentially developed health policies addressed to the needs of groups with specific disadvantages. For instance, after World War II, the progression moved from veterans ("VA") to the elderly poor (the Kerr-Mills program), from the elderly (Medicare) to other groups of the poor (Medicaid), with the disabled and sufferers of renal failure added to Medicare only in the early 1970s. Such an architectural principle produces growth by accretion; since there will always be disadvantages there will always be new demands to incorporate new disadvantages. In the 1960s we stretched the American welfare state to meet

conditions its designers did not foresee in the 1930s; we must now spend the 1990s making up for the omissions of the 1960s.

The structure of the nation's social welfare policy rests, of course, on its political ideology. The core of that political ideology is based upon what the state regards as a legitimate sphere of action and what the citizenry understands as a legitimate claim to mutual aid. One's status as a member of the American community by itself has never legitimized claims to public provision of services, with the exception of education. America has not developed a strong version of what T.H. Marshall once called "social citizenship rights," analogues to the rather well-developed conception of political citizenship rights.²⁸

For every social good except education, American social policy has rested on the distinction between attachment to and separation from the labor market. The old-age pension part of Social Security was designed to help individuals with a firm attachment to the labor force ride out their detachment once they retired. Unemployment compensation is similarly predicated on prior attachment to the work force. Even Mothers' Pensions, the precursor to Aid to Families with Dependent Children ("AFDC"), was based on presumptions about attach-

²⁸ As a result, we have had rather unique political struggles over entitlements. In the 1960s and early 1970s, advocates of the poor were able to secure a legal right to Aid to Families with Dependent Children for women who would be otherwise ineligible because they could not meet the state's one-year residency requirement. The Supreme Court held that a state residency requirement placed an undue burden on the political right of citizens to travel. *Shapiro v. Thompson*, 394 U.S. 618, 629 (1969). Advocates could not, however, persuade the Court that citizens have a right to some minimum level of subsistence. *Dandridge v. Williams*, 397 U.S. 471, 476-83 (1970). To take a more current example, a federal district court in New York upheld the right of homeless people to panhandle. *Young v. New York City Transit Auth.*, 729 F. Supp. 341, 344 (S.D.N.Y.), *rev'd & vacated in relevant part*, 903 F.2d 146 (2d Cir.), *cert. denied*, 498 U.S. 984 (1990); *see also* David Margolick, *Freedom for Beggars: New Law for a New Age*, N.Y. TIMES, Jan. 30, 1990, at A1. The district court judge regarded begging as a mode of expression to be protected under the banner of freedom of speech. To interpret begging as a voluntary act of free self-expression, rather than as an indicator of dire poverty and distress, is a cruel and perverse understanding of our political ideology. Nothing could be more emblematic of our neglect of social rights and our near obsession with political rights than a constitutional ruling that civilized democracy requires handing out licenses to beg but not provision of minimal levels of food, shelter and medical care. The district court decision was later reversed. *Young v. New York City Transit Auth.*, 903 F.2d 146 (2d Cir.), *cert. denied*, 498 U.S. 984 (1990).

ment to the labor force, although, the rationale for aid was a gendered norm that mothers should *not* enter the labor force, even if their male breadwinner had died or abandoned the family.

Therefore, it is quite consistent that when the United States first turned to establishing a public guarantee to medical care, we looked first—in the case of Medicare—to those who had “earned” such a benefit either through prior employment or by marriage to someone with workforce experience.²⁹ Medicaid, with its grant of medical assistance on the basis of poverty, was something of an unexpected anomaly. But Medicaid provided an exception to our norms of individual self-sufficiency by tying eligibility to the same family-structure criteria as AFDC or the traditional English Poor Law categories of aged, blind and disabled.³⁰

In a society so deeply distrustful of public power and so ambivalent about income redistribution, medical services cannot be easily legitimized by claims about the essentialness of health. Nor can they be legitimized on the basis of equal treatment norms or the obligations of a community to its members. Thus, we face a plethora of categories, in part because, without a dominant principle of universalism, providing for the specially needy requires creative and specific demonstrations of why each claim to social resources is legitimate. Each “client” group turns to justifications that appear to work in the American political context: crisis, cost savings and moral desert.

Advocates typically proclaim a crisis for their group. It is a curiosity of American political rhetoric that demonstrating or projecting a rapid rate of growth in some problem seems to command more attention than qualitative descriptions of the problem itself.³¹ The problems themselves are less bothersome than the fear that the problems are growing. The public sector, it seems, can be mobilized by threats of bigness because we

²⁹ See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (1970). Even though eligibility for Medicare hospital benefits (Part A) turned out not to depend on any prior work, earnings or contribution record, the dominant image in the fight over Medicare was that of retired workers—and their spouses—who had contributed FICA taxes when working.

³⁰ *Id.*

³¹ The incantations of the number of children in poverty is my favorite example in the 1990s.

have inadequate consensus on what constitutes badness.

The rhetoric of crisis is closely tied to that of cost saving. Each population of the disadvantaged is said to represent an opportunity to save medical care funds. Money spent on community-based services for the mentally ill, for instance, could come from money saved on hospitals and emergency rooms. Every dollar spent on prenatal care or on food aid, advocates promise, can reduce future medical expenses by multiples of two or three. And, in a world of deficits, fiscal efficiency—targeting money where it helps the most—appears to be one goal that Americans can agree is worthy.

For Americans, deservingness is the most problematic of the three classic justifications for governmental action in medical care. There probably never was a golden age when sickness and sin were entirely different interpretations of human misfortune, or when the definition of a problem as illness carried with it an implicit judgment of innocence. But the years between 1920 and 1970, when the great conquest of infectious disease occurred, probably came closest to such a golden era.

It is no accident that the United States's belated, and limited, commitment to public financing of medical care was forged before the "new" perspectives on health made personal lifestyle choices a cause of disease, thus turning some of the sick into sinners once again. We have only to consider AIDS to see that there is no longer a wall between sickness and sin. Because of this confusion about the moral status of the sick person, advocates for the disadvantaged are in a paradoxical situation. There are political rewards for medicalizing social disadvantages—such as poverty, hunger and addictions—and social vulnerabilities—such as old age and childhood. But there are also political dangers. Advocates have to work hard to portray their clientele as either free of blame for their problem—which can be difficult—or as a group that was harmed by prior public policy and, thus, entitled to compensatory aid. This choice sharply limits the range of beneficiaries.

The political logic of incremental policy expansion appears quite different now that we have witnessed the unexpected repeal of the so-called catastrophic Medicare Act in the 1990s. Although complicated and incomplete when originally enacted in 1988, the Medicare catastrophic bill was a classic marriage of categorical thinking and interest group/government bargain-

ing within the Washington beltway. Never explained to a wider American public in understandable terms, and the object of shrill attack by groups that support themselves by arousing the elderly's fear of ill treatment, the catastrophic plan fell victim to one of the most extraordinary campaigns in recent American politics. Congress became terrified that significant sectors of the elderly population would regard the program's redistributive financing as an assault on the well-being of all the elderly. And this charge stuck despite the obvious fact that only a small minority among the wealthiest elderly would be financially harmed. If such confusion can dominate a small part of the health policy world, one can easily understand how the fight over comprehensive health reform has produced so much mischief.³²

The thwarted movement towards a catastrophic provision for Medicare proceeded from the same political assumptions as do those now pressing for attention to the specially disadvantaged in American medical care. Looking back, there was the assumption that Americans left out—or made worse off—during the Reagan years were, by the late 1980s, promising targets for modest reforms. The Reagan fiscal revolution—combining tax cuts with military expansion and thereby generating large deficits—has driven most non-incremental reform off the agenda of American politics. As a result, most of what now seems possible is tinkering at the edges of current policy. On the other hand, the consequences of America's flirtation with competitive models of health reform have left us with the worst of all possible combinations: the most expensive health system in the world *and* marked dissatisfaction among patients, payers and providers. What is required is serious rationalization of a financing system that is wrenchingly misdirected. What all too often appears likely is a continuation of misguided incrementalism. This is typified in public policy discussions by talk of expanding access without changing the balance of power between providers and payers, and in corporate and private health insurance circles by wishful thinking about the wonders of “managed care.”³³

³² Robin Toner, *All of the Above: Following the Crowd on Health Care, and Getting Lost*, N.Y. TIMES, Mar. 20, 1994, at D1.

³³ Theodore R. Marmor & Jerry Mashaw, *Reality and Rhetoric*, 15 HEALTH

America remains an embattled site for policymaking in medical care. Appeals for special help to the disadvantaged chart the details of some of our victims, but not the shape of politically viable and institutionally secure remedies. For that, more than sympathy for America's unlucky and faith in the durability of altruism will be required. The experience of the rest of the industrial democracies tells us that a nation *can* have universal insurance that aids the disadvantaged. It also shows that programs concentrated on the disadvantaged become disadvantaged programs.

Table 1.
Actual and Projected National Health Expenditures, by Type of Spending,
Selected Calendar Years, 1965 to 2000

Type of Spending	Actual					Projected				
	1965	1980	1985	1990	1991	1992	1993	1995	2000	
Billions of Dollars										
Hospitals	14	102	168	258	289	321	351	421	644	
Physician	8	42	74	129	142	156	171	205	309	
Drugs, Other Nondurables	6	22	36	56	61	66	71	83	117	
Nursing Home	2	20	34	53	60	67	75	91	137	
All Other	<u>12</u>	<u>64</u>	<u>110</u>	<u>179</u>	<u>201</u>	<u>222</u>	<u>244</u>	<u>290</u>	<u>425</u>	
National Health Expenditures	42	250	423	675	752	832	912	1089	1631	
Average Annual Growth Rate from Previous Year Shown (Percent)										
Hospitals	n.a.	14.2	10.4	8.9	11.8	11.4	9.3	9.4	8.9	
Physician	n.a.	11.5	12.1	11.7	10.2	9.6	9.9	9.5	8.5	
Drugs, Other Nondurables	n.a.	9.1	10.8	9.0	9.0	8.2	8.1	7.9	7.2	
Nursing Home	n.a.	17.9	11.3	9.3	12.4	12.1	11.4	10.2	8.5	
All Other	n.a.	12.0	11.4	10.2	12.0	10.8	9.9	9.0	7.9	
National Health Expenditures	n.a.	12.7	11.1	9.8	11.4	10.7	9.6	9.3	8.4	
Memoranda:										
Gross Domestic Product (Billions of dollars)*	703	2708	4039	5522	5677	5943	6255	6942	8627	
Average Annual Growth of Gross Domestic Product from Previous Year Shown (Percent)	n.a.	9.4	8.3	6.5	2.8	4.7	5.2	5.3	4.4	
Ratio of National Health Expenditures to Gross Domestic Product	5.9	9.2	10.5	12.2	13.2	14.0	14.6	15.7	18.9	

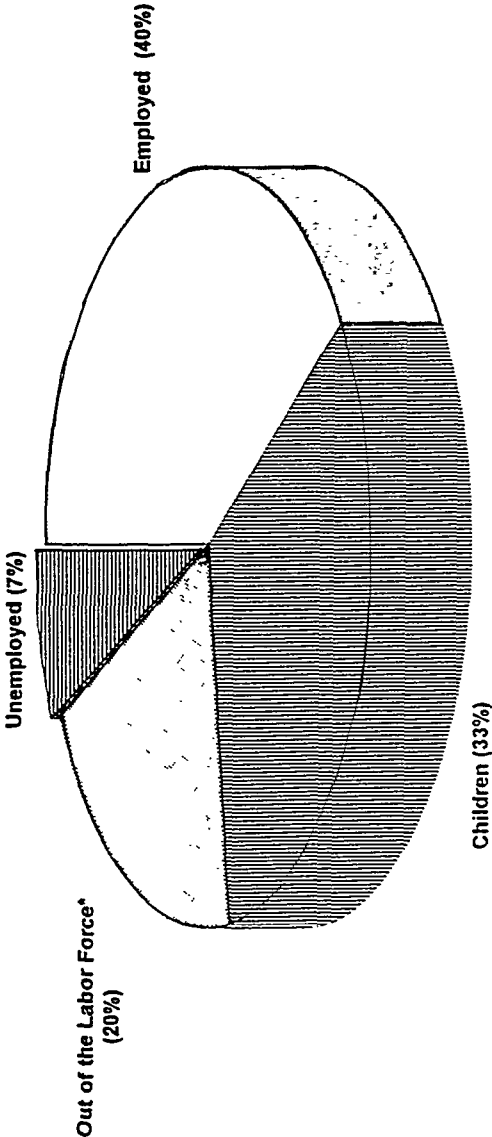
Source: Congressional Budget Office

NOTE: n.a. = not applicable

a. Economic assumptions reflect the Congressional Budget Office baseline of January 1993.

Figure 1.

A Breakdown of the 35 Million Uninsured People in the United States (1990)



*(Students under 18, homemakers, disabled, early retirees)

Source: Himmelstein and Woolhandler, 1992 (tabulation from Census Bureau, CPS data)

