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An Introduction to Health Policy

A Primer for Physicians and Medical Students

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Manish K. Sethi, MD
Director of the Vanderbilt Orthopaedic Institute Center for Health Policy
Assistant Professor of Orthopaedic Trauma Surgery
Department of Orthopaedic Surgery and Rehabilitation
Vanderbilt University School of Medicine
Nashville, TN, USA

Senator William H. Frist, MD
Department of Cardiac Surgery
Vanderbilt University School of Medicine
Nashville, TN, USA

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We dedicate this book to our patients—may we continue to pursue an American health-care system that provides them the best care in the world.

Manish K. Sethi, MD
William H. Frist, MD

Preface

As the United States finds itself strapped with $16 trillion of debt, future generations of America's physicians can no longer enter their practices and clinics without a sound understanding of health care. In 2012, the total national health-care spending was $2.9 trillion, and it is expected to continue to increase at similar levels, potentially reaching 20 % of the GDP by 2016. Young doctors and medical students are likely to see a dramatic transformation of the manner in which America offers medical care to its citizens over the course of their careers.

But today, most physicians leave medical school without a sound comprehension of the key issues facing American health care; doctors understand the medicine, but not the policy. It is crucial that those on the front lines of medicine develop a sense of health care's evolution and understand potential directions of change.

An Introduction to Health Policy: A Primer for Medical Students and Physicians is the first of its kind, authored by physician leaders in health policy at major academic policy centers across the United States. This book allows busy physicians and medical students to quickly develop an understanding of the key issues facing American health care. It seeks to efficiently and effectively educate physicians and medical students on the past, present, and potential future issues in health-care policy.

This book is comprised of four sections. In Parts I and II, the reader will be introduced to the basic elements of health care and will become comfortable with essential concepts. Part III focuses on further developing these basic concepts into a "health-care system"—how all of the moving parts come together. Finally, the concluding section focuses on the manner in which health-care policy is created at both the state and federal levels.

Our ultimate goal is for a reader to leave with a balanced understanding of health care in America and the critical importance of health-care policy: physicians equipped to deliver the best possible care to their patients in a changing environment.

Nashville, TN, USA

Manish K. Sethi, MD
William H. Frist, MD

Contents

Contributors

Jordan C. Apfeld, BA Vanderbilt Orthopedic Institute Center for Health Policy, Vanderbilt University Medical School, Nashville, TN, USA

Elaine Besancon, MD Department of Internal Medicine, Brigham and Women's Hospital, Boston, MA, USA

Kevin J. Bozic, MD, MBA Department of Orthopedic Surgery, University of California, San Francisco, CA, USA

Phillip A. Choi, BS University of Pittsburgh School of Medicine, Pittsburgh, PA, USA

Perrin T. Considine, BS Vanderbilt University School of Medicine, Nashville, TN, USA

Alexander Ding, MD, MS Department of Radiology, Massachusetts General Hospital/Harvard Medical School, Boston, MA, USA

Walid F. Gellad, MD, MPH Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System and University of Pittsburgh, Pittsburgh, PA, USA

Daniel Guss, MD Department of Orthopedic Surgery, Massachusetts General Hospital, Boston, MA, USA

Bruce Lee Hall, MD, PhD, MBA Washington University in St. Louis—Barnes Jewish Hospital and BJC Healthcare, St. Louis, MO, USA

Andrew Han Department of Orthopedic Trauma, Vanderbilt University Medical Center, Nashville, TN, USA

Michael Hochman, MD AltaMed Health Services, Los Angeles, CA, USA

Benjamin S. Hooe, BS, BA Vanderbilt University School of Medicine, Nashville, TN, USA

Neil M. Issar, BS Vanderbilt University Medical Center, Vanderbilt University School of Medicine, Nashville, TN, USA

A. Alex Jahangir, MD Department of Orthopedic Surgery, Vanderbilt University Medical Center, Nashville, TN, USA

Sachin H. Jain, MD, MBA Boston VA Medical Center , Harvard Medical School, and Merck and Company, Boston, MA, USA

Rishin J. Kadakia, BS Vanderbilt University School of Medicine, Vanderbilt University Medical Center, Nashville, TN, USA

Jason D. Keune, MD, MBA Department of Surgery, Barnes-Jewish Hospital, St. Louis, MO, USA

Richard Latuska, BS Vanderbilt University School of Medicine, Nashville, TN, USA

Emily R. Maxson, MD Department of Internal Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston, MA, USA

Danny McCormick, MD, MPH Chief of Social and Community Medicine, Cambridge Health Alliance, Harvard University Medical School, Boston, MA, USA

Samir Mehta, MD Department of Orthopedic Surgery, Hospital of the University of Pennsylvania, Philadelphia, PA, USA

Hassan R. Mir, MD Department of Orthopedic Surgery, Vanderbilt University Medical Center, Nashville, TN, USA

Cesar S. Molina, MD Department of Orthopedic Trauma, Vanderbilt University Medical Center, Nashville, TN, USA

Benedict U. Nwachukwu, BA Harvard Medical School, Oliver Wendell Holmes Society, Boston, MA, USA

Alexandra Obremskey University of Southern California, Los Angeles, CA, USA

Ilisa Halpern Paul, MPP Government and Regulatory Affairs Practice Group, Drinker Biddle & Reath LLP, Washington, DC, USA

David Polakoff, MD, MSc Commonwealth Medicine, University of Massachusetts Medical School, Shrewsbury, MA, USA

David A. Rosman, MD, MBA Department of Abdominal Imaging, Massachusetts General Hospital, Boston, MA, USA

Vasanth Sathiyakumar, BA Department of Orthopedic Trauma, Vanderbilt University Medical Center, Nashville, TN, USA

Manish K. Sethi, MD Director of the Vanderbilt Orthopaedic Institute Center for Health Policy, Assistant Professor of Orthopaedic Trauma Surgery, Department of Orthopaedic Surgery and Rehabilitation, Vanderbilt University School of Medicine, Nashville, TN, USA

Roshan P. Shah, MD, JD Department of Orthopedic Surgery, Hospital of the University of Pennsylvania, Philadelphia, PA, USA

Heather A. Smith, MD, MPH Department of Obstetrics and Gynecology, Yale University, New Haven, CT, USA

Audrey Smolkin, MPP Commonwealth Medicine, University of Massachusetts Medical School, Shrewsbury, MA, USA

Daniel J. Stinner, MD Vanderbilt Orthopedic Institute, Vanderbilt University Medical Center, Nashville, TN, USA

Amy L. Walker, BA Government and Regulatory Affairs Practice Group, Drinker Biddle & Reath LLP, Washington, DC, USA

Eleby R. Washington IV, BA Meharry Medical College, Nashville, TN, USA

Part I

Understanding the Basics I

1 The History of Health Care in the United States Pre-1965

Alexander Ding

Learning Objectives

After completing this chapter, the reader should be able to answer the following questions:

- Understand the history and causes contributing to the rise of the medical profession as an institution and authority.
- Understand the historical context in which health care evolved in the twentieth century, prior to the establishment of Medicare and Medicaid.
- Recognize why health care is becoming of increasing political and public interest.
- Comprehend the development of health insurance as an entity and the private/public struggles associated therewith.

Introduction

The close relationship between health care and politics and policy is not always appreciated by physicians or their patients. In fact, many medical students and resident physicians eschew the notion that the two apparently detached institutions are indeed deeply and intimately related in our society. Like it or not, health policy directly influences the practice of medicine at the clinical level.

As the health system in the United States shifts away from the doctor as the individual practitioner to systems and organizations with teams of practitioners, physicians must recognize the leadership role they must take to ensure that patient care remains the paramount priority. Understanding health policy and the history of our health system should be a critical piece in medical education because it informs us how to impact the dynamics and institutions that define our practices. The importance of the voice of physicians and medical students in health policy and politics should not be lost on the reader because our clinical perspective and ethical obligation to our patients must be present to guide policymakers and politicians.

This chapter will discuss the history of health care in the United States from the beginning of the twentieth century through the establishment

A. Ding, M.D., M.S. (✉)
Department of Radiology, Massachusetts General Hospital/Harvard Medical School, Boston, MA 02114, USA
e-mail: alexding@gmail.com

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of Medicare and Medicaid in 1965. Further discussion of Medicare and Medicaid and the evolution of these programs and health care under these programs will be covered in Chaps. 2 and 3, respectively. Despite the existence of physicians and the profession of medicine since the beginning of our colonial history, it was not until the early twentieth century that medicine became more intertwined with politics. The consolidation of authority as a profession along with new medical discoveries and treatments paved the way for the view that medicine and health care were essential, leading to their politicization. The story of health-care politics and policy focuses around provision of coverage and health insurance.

Pre-Twentieth Century: The Rise of a Profession

The profession of medicine in the United States prior to the twentieth century consisted of inconsistent training and licensure, practice by a multitude of practitioners including lay folk remedies, and lack of public recognition. Physicians aspired to attain a privileged status for the practice of medicine, comparable to the status the profession had in Europe. However, this attempt at a distinct status was met with resistance from the public in the early days of our country.

By the time the American colonies were established, medicine was a regarded profession in Europe, particularly in England. In the early years of the United States, however, the structure and culture of our newfound country set up barriers to achieving this same status. In an expansive and primarily agrarian society, dependence on a medical professional was not practical, and most of the care of the sick was considered the role of the wife [1]. Understanding of disease was also limited, with lack of effective diagnosis and treatment options. Jacob Bigelow of Harvard Medical School and the Massachusetts General Hospital noted the dearth of therapeutics in medicine at the time: "the amount of death and disaster in the world would be less, if all disease were left to itself" [2].

There was perhaps nothing greater to counter the push by physicians to become a proper profession than our democratic culture [3]. Professions by their nature are inegalitarian institutions, granting special rights and privileges to their members. American democratic culture espoused equality and shunned special status, particularly royalty and nobility. As a result of these various factors, medicine carried little in the collective consciousness of the public sphere.

Physicians sought to draw boundaries around their profession and to instill credibility and authority. They faced fierce competition for the healing arts with other practitioners, including apothecaries, midwives, botanists, and lay healers. Lax credentials within the profession itself eroded their attempts for a standard of care. Efforts were made for state licensure "to distinguish between the honest and ingenious physician and the quack or empirical pretender" [4]; these attempts were rejected on multiple occasions. In 1760, New York City was the first to pass licensure, but it could be considered an honorific title at best, as the act was unenforced [5]. Authority for licensure was passed to the medical societies, but their attempts remained toothless as there remained no standard for education or skill and no enforcement or penalty for practice without a license [6].

Medical societies were organized to further attempt to isolate "quacks" from learned physicians and to provide a means for establishing a floor of qualification of its physician members. The oldest continuously operating state medical society, the Massachusetts Medical Society, was incorporated in 1781 so "that a just discrimination should be made between such as are duly educated, and properly qualified for the duties of their profession, and those who may ignorantly and wickedly administer medicine" [7].

Considered prestigious for universities, medical schools proliferated without added expense, as all costs were borne by matriculants through tuition fees. Lacking standards or accreditation, medical schools had disparate curricula and variation in pedagogy, if any at all. Schools were also reluctant to fail any students due to loss of tuition fees [4].

Attempts to create boundaries in the late eighteenth and early nineteenth centuries in order to define the profession took on multiple faces, including licensed versus unlicensed, medical school diploma versus none, and medical society member versus nonmember, none of these exclusive. The proliferation of easy and quick medical school degrees and lack of barriers to practice saw the proliferation of physicians grow from 5,000 to 40,000 from 1790 to 1850 [8]. However, these attempts were largely unsuccessful until decades later when a medical school diploma was needed to earn a license to practice and medical society membership was granted once an individual was practicing in good standing [3].

In 1877, a watershed Illinois law established that the state board of medical examiners could reject diplomas from disreputable medical schools, a first attempt at establishing a minimum standard and limiting the proliferation of diploma mills [9]. Licensure was further legitimized by the Supreme Court in 1888 in the case of *Dent v. West Virginia.* The Court upheld a law requiring physicians to hold a degree from a reputable medical college and pass an examination to practice, stating that the State could protect society by imposing conditions for the exercise of that right, as long as they were imposed on everyone and were reasonably related to the occupation in question [10]. There continued a gradual extension of authority to credential physician through state board examinations and licensing authorities such that by 1901 all states had a licensing statute of some sort, all of which were enforced [11].

While the American Medical Association (AMA) was founded in 1847, its influence was limited as was its membership. However, in 1901 the organization revised its Constitution, forming the House of Delegates, and became a federation and umbrella organization of state medical societies. In the process, the AMA gained legitimacy and membership. Membership rose from 8,000 in 1900 to over 70,000 by 1910, and by 1920 included over 60 % of physicians in the US [12]. After its reorganization, it declared medical education reform its top priority, and in 1904 formed the Council on Medical Education, charged with elevating standards and requirements of medical education.

The AMA commissioned the Carnegie Foundation, which selected Abraham Flexner to report on and make recommendations for the state of medical schools in the country. Flexner and the Secretary of the AMA Council personally visited every medical school in the country and reported on medical schools not meeting standards, leading to the closure of many substandard schools. Subsequently, organized medicine set up the Federation of State Medical Boards as a voluntary association of medical boards in 1912, and the AMA Council on Medical Education began to accredit all American medical schools and medical internships [3]. This self-regulation lent legitimacy and authority to the profession.

With higher educational standards, the caliber of students increased but the number of matriculants decreased. In order to remain financially secure, medical schools had to become more interconnected with universities, whereas previously they had only been nominally affiliated. This led to the development of full-time academic positions in clinical medicine, and the training and education shifted from apprenticeships with private practitioners to internships and residencies with faculty at academic hospitals. This fundamental shift in training led doctors to be trained according to the scientific method and with deeper foundations in basic science [3].

One of the problems with early medicine was that the practice was reliant more on mysticism and dogma from preceptors and was less scientifically rigorous. This inevitably was associated with limited diagnostic accuracy and an inadequacy of therapeutics, ranging from the ineffective to the toxic and lethal, including what was known as "heroic therapy" consisting of bloodletting and administering heavy doses of mercury [3]. With the elemental shift of training to a focus on science and the development of the clinician-researcher, the advances in medical technology at the turn of the century paved the way for medicine to elucidate its effectiveness and ultimately its essential nature [3]. At the turn of the century, diagnostics were improved with the development of the microscope, X-ray, and EKG. Bacteriology made scientific leaps with the isolation of tuberculosis, syphilis, diphtheria, and typhoid, and the practice of antisepsis in surgery.

During this period, hospitals rose in parallel to the profession, and the two became more interdependent. In the early nineteenth century, hospitals were considered sick houses for the poor and destitute, while patients of means preferred to be taken care of at home. However, at the beginning of the twentieth century, hospitals, aided by advances in the nursing profession and antisepsis, had become complex organizations that provided much of the technical, capital, and supportive corporate embodiment for the medical profession [3]. The integration of the hospital and medical practice became so important, and remains so today, that the number of hospitals in this country grew from 200 in 1873 to 6,000 by 1920 [13].

From the early colonial days to the turn of the twentieth century, the profession of medicine established itself as the authority in health care. It faced significant challenges in our burgeoning nation, but through the development of licensure, educational standards, and self-regulation, it established itself as the health-care provider of the nation. This authority in conjunction with the advances in diagnosis and therapeutics led to increased public demand for medical care, which, with erected barriers to entry to the profession, led to higher costs. When the middle class began to struggle with costs, proposed solutions were brought forth in the political arena.

The Progressive Era: 1900–1920

As medicine and health care became more scientifically advanced and effective at diagnosing and treating disease, the view of medicine as a vital necessity became more adopted. While the democratic view in our early nation had been that every man can be his own healer, the democratic view had evolved in that the services of physicians should see wider distribution to the population at large [14]. The history and politics of health care in the twentieth century centered around health insurance, first becoming a political issue in the run up to World War I.

Demand for health insurance started due to the changing economic realities associated with industrialization. As families became more dependent on wages for their income, sickness could interrupt cash flow and family resources in a significant way. The initial impetus for the creation of so-called health insurance was actually disability insurance and replacement of income during sickness. And while families became more reliant on doctors and hospitals for medical treatment, insurance coverage of medical expenses was only a secondary feature of sickness insurance policies [3].

Europe was significantly ahead of the United States in the adoption of social insurance, in particular compulsory sickness insurance. Health insurance was first implemented by Kaiser Wilhelm in Germany in 1888. These efforts in Europe were more widely accepted and easier to adopt due to differences in governance structure and social culture, and in many cases was implemented to palliate social unrest and dissatisfaction. The United States, however, was more reluctant and disinterested. At this time, the government played a minimal role in social welfare and particularly in health, and most of the population agreed with this limited governmental role. The fundamental notion of a social insurance went against the founding American ideals of individualism and self-reliance.

Health insurance for the working population was first endorsed by the Socialist Party in 1904. The movement was then carried by a largely academic group of social Progressives who founded the American Association for Labor Legislation (AALL) in 1906. This group played a prominent role in the push for workers' compensation legislation, which was successfully passed in 1910. AALL saw this as a public desire for further social and labor insurance and believed sickness insurance would be the next logical path forward [15].

During the early part of the twentieth century, the Progressive movement was becoming more successful and considered social insurance an important part of its agenda. When Republican President William McKinley was assassinated in 1901, Teddy Roosevelt, his Vice President, ascended to the presidency. Roosevelt was considered a reformist in the Republican Party, and he pushed forward with a Progressive agenda. As a Progressive, Roosevelt supported social insurance, including health insurance. The Progressive movement reached its peak in 1912, when Roosevelt ran for the presidency as a third-party candidate from the Progressive Bull Moose Party, after a break with the GOP and President Taft, a fellow republican. Despite what many see as the decline of the Progressive agenda with an electoral defeat to Woodrow Wilson in 1912, Wilson's Commission on Industrial Relations still recommended health insurance for labor in its report.

In December 1912, shortly after the election, the AALL formed a committee on social insurance and organized a national conference in June 1913. It called for health insurance for the working class consisting of four main benefits to include: coverage of medical expenses, sick pay, maternity benefits, and a death benefit. Their message, rather than appealing to the traditional arguments for socialism of redistribution, focused on stabilizing incomes, preventing poverty during illness, and improving worker productivity. During this time, the AALL worked very closely with the AMA in pushing for health insurance. In fact, the two organizations had a joint office in New York.

However, the health insurance advocates faced opposition on many fronts, including unlikely partners in labor and business. The American Federation of Labor (AFL) and its spokesman Samuel Gompers strongly disagreed with the notion that the government should play a role in raising the worker's standard of living and represented the position that this was the role of unions [16]. He strongly held the view that government involvement would weaken the unions' role to provide social benefits for its members. Business interests were also opposed. They believed that health insurance would raise their costs and did not believe that their companies would see any of the benefits directly. On the issue of health insurance, labor and capital were united in opposition. They wanted no competition from the government to provide services that they believed would undermine their worker's loyalties to them, respectively [17]. Additionally, the inclusion of a death benefit led to opposition from insurance companies which at the time were predominantly large insurance companies such as Prudential and MetLife; most of their business was life insurance, which provided death benefits.

The year 1917 saw the defeat of the Progressive's push for health insurance. They faced strong united opposition from labor, business, and insurers. At the time, they were aligned with the AMA, who in June 1917 at its House of Delegates meeting approved a report supporting health insurance. However, the AMA faced a groundswell of opposition in unhappy doctors from the local and county medical societies and had to make an about-face in order to avoid a mutiny [18].

However, perhaps the biggest factor leading to the push for health insurance to be stopped in its tracks happened in April 1917, with the entrance of the US into World War I. Doctors went into the service, the national debate was suspended, and, because the German's had pioneered social insurance, anti-insurance propaganda made it un-American to support such measures [18]. Health insurance failed in multiple states including those taken up by the legislature and those voted on by public referendum.

Rising Medical Costs and the New Deal: The Roaring Twenties and the Great Depression

After World War I and the Progressives' attempts, much of the political and public appetite for compulsory health insurance was lost during the prosperous and politically apathetic 1920s. However, at the end of the decade, there were growing concerns over the costs of medical care. The focus, in fact, pivoted from insurance covering lost wages to that of covering medical care. More and more the notion of insurance for catastrophic medical needs shifted to that of a system for financing medical care in total. This was due in large part to the rising costs of health care.

At the end of the decade, medical costs were 85 % higher compared with the lost wages incurred by a typical middle class family. Not only were the economics such that medical care was more important than income protection, but because medicine had become so effective in treating disease, it was also considered a more important commodity than just having cash [19]. During this time, meeting the rising medical costs was the most common concern and grievance amongst the middle class [20].

Health-care costs at the time were primarily rising due to the technological developments from scientific advances. Hospitals became more costly as they transformed from lowly caretaking homes to technologically advanced, professional organizations. Physician services also increased in price as quality improved with better education, and the prestige of the profession rose as the AMA's influence grew. The first reliable estimate of medical care costs in the United States was published in 1929 and consisted entirely of private costs, as the government was not yet playing a role in financing or providing health care. The country, at the time, spent $3.7 billion a year or 4 % of the gross national product on health care.

The Great Depression occurred on Black Tuesday with the stock market crash in October 1929, greatly changing the political and social landscape. With the election of Franklin D. Roosevelt, a Democrat, the idea of social insurance was again revived. The priorities of social insurance, however, changed. In the previous generation, health insurance was the priority after the implementation of workman's compensation. Now, however, unemployment insurance and elderly pensions were of primary concern due to exceptionally high unemployment [21].

In 1934, President Roosevelt appointed a Committee on Economic Security charged to work on old-age and unemployment insurance, but with an additional charge to include health insurance in its consideration. Many, including members of the committee and even advocates of the social security movement, expressed concern that pursuing health insurance would be politically unrealistic and reinvigorate prior opposition. There was real concern that its inclusion could jeopardize and defeat the entire bill. In 1935, the Social Security Act was passed as a cornerstone to FDR's New Deal with the omission of health insurance, but with coverage of unemployment and elderly pension.

During the Great Depression, increased government financing of medical services did start to take hold, despite the lack of any clear legislation passed intently addressing this. Because of falling incomes, people were using less medical care and were simply not paying their medical bills. As a result, doctors and hospitals also fell upon hard times. But, beginning in 1930, medical care became recognized as an "essential relief need," thereby allowing for the use of public and welfare funds to pay for medical services for those who were unable to afford them [22]. With the passage of the Social Security Act, the pensions that the elderly received were also a means to indirectly pay for care. While these two practices were meant to be temporary during the Depression era, the practice remained popular well thereafter.

In the late 1930s, FDR softly pushed for a new effort for health insurance. In 1937, multiple departments within the federal government were coordinated to form a Technical Committee on Medical Care. This committee's report favored federal subsidies to the states to implement health insurance programs rather than a reliance on a national system. Furthermore, the committee recommended the expansion of public health and maternal and child health services, aid to hospitals and doctors for patients who could not pay, and a federal disability program, all supported by taxes or insurance. This report was presented at a National Health Conference in summer of 1938 [23].

Unfortunately for this effort, the 1938 elections brought a conservative resurgence. Republicans and southern Democrats resisted the passage of any further social policies of the New Deal through Congress. Additionally, Roosevelt never pressed that hard on this issue because he was not feeling strong pressure for health insurance from the general public or advocacy groups as he had for unemployment insurance and old-age pensions. Just as with the prior effort, timing ultimately became a significant barrier as the United States entered World War II and turned its focus from a domestic social agenda to a wartime effort and foreign attention.

The Blues: A Response to Public Insurance

Much of the medical establishment at the time was opposed to government-sponsored health insurance, but they did feel the pressure exerted by its proponents. As a result, a push for private insurance plans as the counter solution was propagated in the 1930s. Private plans, in particular, the Blue Cross/Blue Shield entities, started and grew significantly in this decade.

Blue Cross began at Baylor Medical Center in late 1929 as a prepaid plan for group hospital services. The plan covered 1,500 local Texas school teachers and provided up to 21 days of hospital care for $6 per person [24]. Soon other hospitals recognized this business strategy as a good and reliable revenue generator and started their own competing plans. These plans were issued by individual hospitals and spawned fierce competition amongst hospitals in the same locality. The logical next step would be to eliminate this competition and cooperate to produce hospital services contracts for employed groups to a community-wide or city-wide range of hospitals. Eventually, these plans came to be known as the "free choice" plans, and, with the endorsement of the American Hospital Association, they became the dominant form of private hospital insurance [24].

During the Great Depression, particularly as hospitals' unpaid care grew as people were less able to pay their bills, these plans would become a business stop-loss and promotion of these plans became more widespread. From virtually a nonexistent market at the beginning of 1930, just 10 years later by 1940, Blue Cross claimed more than six million members, and other competing private hospital insurers had 3.7 million members [25].

The Blue Cross programs covered hospital services only, as physician services were and are considered separate and therefore not covered. However, physicians were a residual beneficiary from hospital insurance, particularly during the Great Depression. Because hospital stays were covered, patients had more money left over, thereby making it more likely that they could pay for the physician services incurred [26]. Some attempts were made by hospital plans to hire physicians to provide care or to prepay for care; however, generally speaking, they were not largely successful. The first true insurance coverage of physician services came in 1939. Again, in an effort to counter government attempts at health insurance, the California Medical Association started the California Physician Service [27]. Because of its success, Blue Shield plans were formed to cover physician services and served as partners to Blue Cross. By 1945, Blue Shield covered more than two million members [28].

World War II and the Rise of the Cold War

Even though the government turned its attention from domestic issues to international and military problems during World War II, medicine and health insurance continued to forge their own paths, which had a profound impact on our country's health system decades into the future. The provision of health insurance through labor unions or employers made labor union members or company workers more loyal to the unions and employers, respectively. Employers increasingly favored providing health insurance as a fringe benefit to attract workers or encourage retention. The current American health insurance system, which is predominantly private and employer-sponsored, is the by-product of this time period.

During World War II, strict wage controls were imposed by the federal government as part of a larger price control scheme that were intended to be anti-inflationary during the wartime period. However, the National War Labor Board in 1942 declared that fringe benefits, such as health insurance, were not considered wages. As a result of what some considered a loophole, employers dramatically started to increase their offering of health insurance to attract and retain workers. Employers during the war were finding labor particularly scarce, given the deployment of so many men of working age to the European and Pacific theaters. In the years spanning World War II, the number of hospital insurance plan subscribers increased from under 7 million to over 26 million in a relatively short period of time [29].

During this time, unions began to increase their power due to their important role in collective bargaining with employers for health benefits. And in 1945, the Internal Revenue Service confirmed that health benefits provided by employers would be tax-exempt or paid with pretax earnings, thereby giving health benefits a massive implicit government subsidy and further increasing their desirability to employers and employees alike.

In 1943, just as the tide was turning in favor of the Allies, the Wagner-Murray-Dingell Bill was introduced and picked up the debate on national health insurance [30]. This Bill would extend Social Security benefits to include health insurance. Furthermore, in his 1944 campaign, FDR called for an "economic bill of rights" that included a right to medical care and insurance against sickness and accident. While it was unclear that Congress or the President would move forward on these issues during wartime, it was a signal that national health insurance would be a priority in the postwar period.

Despite FDR's death, his successor President Truman was just as enthusiastic about national health insurance. Only 3 months after the war concluded, President Truman called upon Congress to pass national health insurance as part of his "Fair Deal" program [31]. While this was yet another presidential attempt to pass national health insurance, the focus of the program was radically different. Prior proposals were focused on covering the needy people in American society, but Truman pressed for all Americans to be covered, regardless of income or wealth. The AMA opposed this proposal and instead called for expansion of voluntary insurance and public services only for the indigent [30]. Given the new focus on coverage for all instead of only the relatively needy or working class and juxtaposed to the rise of the Cold War, Truman's "socialized medicine" became a political and symbolic issue in America's fight against the Communist influence; this scenario contributed largely to the demise of Truman's plan.

Postwar Prosperity and the Vast Expansion of Health Care

Post–World War II United States saw a rapid increase in its wealth and economic status both as a country and for individual Americans, even as Europe was picking up the pieces and rebuilding. During this time, the United States engaged in its first proxy fight of the Cold War on the Korean peninsula. Once again, war would turn the country and politicians' attention from domestic issues such as health insurance externally toward war efforts.

American postwar prosperity, however, would lead to huge growth in medicine largely funded by research and discovery from unprecedented economic growth. From 1950 to 1970, the healthcare workforce expanded from 1.2 million to nearly 4 million people. Health expenditures rose from $3 billion in 1940 to $12.7 billion in 1950, and then to $71.6 billion in 1970. This represented 4.5–7.3 % of American GNP from 1950 to 1970 [32].

Medical research expenditures from all sponsors swelled from $18 million in 1941 to over ten times that amount a mere decade later in 1951 at $181 million [33]. During this period of prosperity, government investment in the sciences exploded. The National Institutes of Health budget inflated from $81 million in 1955 to over $400 million in 1960 [34]. The economic model of science laboratories changed dramatically from one predominantly funded by private monies to government-run laboratories to, as is presently the case, academic labs funded by government extramural grants. And, as this was immediately after World War II, pains were taken to eschew the German model of political priorities dictating research endeavors. As a result, the government funds did not come with an attached dictum, and academic and scholarly freedom to decide was a major victory for scientists.

Virtually everything within the realm of health care was expanding during this time period.

The construction of hospitals was rapidly ramped up, thanks to the Hill-Burton Act, also known as the 1946 Hospital Survey and Construction Act. $75 million a year for 5 years was provided to aid in the building of local hospitals. Since two-thirds of the funding was to be paid by the community itself and the remainder one-third from federal funds, most of the local community hospitals erected at this time went to middle-income neighborhoods [35].

Medical schools and medical education saw their own unprecedented expansion in the 1940s and 1950s. Faculty positions at teaching hospitals increased 51 % from 1940 to 1950 [36]. Medical school income exploded from $500,000 per school in the 1940s to $15 million per school by 1960 [37].

As more medical staff practiced in centralized hospital settings, specialization accelerated, especially as research had led to an exponential growth in medical knowledge. In 1940, 24 % of physicians were specialists compared with 55 % in 1960 [38]. Medical education with internship and residency positions grew from 5,000 spots nationally in 1940 to over 25,000 in 1955 as a result of government subsidies and the relatively cheap labor cost of internships and residencies to hospitals [39]. In 1959, a government report detailed the shortage of health-care workers, particularly doctors and nurses. In response, Congress adopted legislation to aid and expand medical education in 1963; the government remains the primary payer of medical training in this country [40].

The United States earned a new global confidence, and Americans believed that future success in the world and leadership during the Cold War could be won with scientific progress. We saw firsthand during World War II the power of the atomic bomb and the lifesaving power of antibiotics. During this time, the combination of effective and widespread antibiotic use coupled with prosperity shifted the health concerns of the day from primarily infectious diseases to chronic diseases, such as diabetes, heart problems, and cancer. The expansion of health care at the time was seen as a greater good and as a sign of prowess and success.

The Prelude to Medicare and Medicaid

During the tumultuous 1960s, the good feelings from the 1950s quickly subsided and gave way to a time of rebellion and turmoil in the era of the Vietnam War. Once again, the issue of national health insurance, now a longtime holy grail for the Democratic Party, was pressed. Some politicians believed that perhaps the implementation of social policies would pacify some of the public's discontent.

Due to the failings from the Truman proposal for universal nationalized health insurance, a more modest plan was proposed. In 1958, Representative Aime Forand of Rhode Island proposed legislation covering hospital expenses for the elderly on Social Security. By this time, this plan was starting to attract more traction because of its limited scope and also because care had continued to increase in cost, particularly for the retired population. Hospital care had doubled in the 1950s, and, of those aged 65 and older, almost 20 % needed hospital care and tended to stay twice as long compared with younger patients.

In 1960, two very powerful members of Congress, Senators Robert Kerr and Representative Wilbur Mills, put forward a competing proposal. Theirs proposed expanding welfare to cover medical costs for the poor by subsidized state programs already in effect. At the time, the Democrats had opposed this legislation because they opposed means testing [41].

Despite President Kennedy's support, Medicare legislation remained short of the needed votes to enact. It was not until a Democratic sweep in 1964 that President Johnson, riding off of the post-assassination goodwill, made health coverage again a top domestic priority under his Great Society Program.

The Republicans countered with a plan to expand voluntary health insurance for retirees; this plan would be subsidized according to a sliding scale on par with the Social Security benefits the individual received. Interestingly, while hospital services had been a proposed benefit, physician services were not included largely because of prior AMA opposition and the fear that including physician fees would be controversial and put the legislation at increased jeopardy. The AMA reacted by stating that physician fees should also be included under the voluntary private health insurance for the elderly, called Eldercare.

In a grand omnibus and compromise bill, a three-pronged plan was offered. The federal government would start Medicare with two parts: Part A to cover hospital expenses and Part B to cover physicians' bills; then Medicaid would cover the indigent through the expansion of the states' existing welfare programs. It is because of this political compromise of competing resolutions that we have these various parts of Medicare and Medicaid as they are structured today. Since then, various amendments have been made, including adding a Part C for a managed care option and Part D to cover drug costs. Medicare and Medicaid passed Congress in a bipartisan manner and were signed by President Johnson in 1965.

Conclusion

Medicine and health care in the history of the United States present an interesting narrative about the rise of a profession and the scientific advancement of medicine. Studying this history also provides insight into the evolution of politics in health care, the multiple struggles to increase access to care, and the factors leading to the organic growth of a health industry, presenting an explanation of why our health system is structured as it is presently.

Through the colonial times and the history of our nascent nation, the medical profession and physicians sought to establish and consolidate medical authority and fight for legitimacy and arguably, supremacy over other healing practitioners. Because of the professions stringent adherence to the scientific method, remarkable medical progress and health improvements have been achieved in just the last century. Life expectancy in 1900 was 47 years for the average American. By the time Medicare and Medicaid were enacted in 1965, life expectancy was 70 years. Certainly, medicine alone does not explain the remarkable progress made. However, it is impressive to think that in approximately three generations, life expectancy increased nearly 50 %.

With improvements in medical technology and care, however, medical services, which were once a relative luxury that provided more comfort and less healing, became a necessity and, to many, a human right. Such a shift in medicine in conjunction with its continuing increasing costs put the issue of medicine on the list of political priorities. In the twentieth century, no fewer than six American Presidents, from Teddy Roosevelt to Barack Obama, have pushed for efforts to expand national health insurance.

While this chapter ends with the passage of Medicare and Medicaid, the story of health care and the complexities involved continues in the subsequent chapters of this book. At the time of this writing, President Obama's Patient Protection and Affordable Care Act had withstood a Supreme Court challenge, the American Medical Association had made an about-face and supported national health reform, Accountable Care Organizations were introduced with much fanfare and concern, and a new national focus on implementation of electronic health record systems and medical quality and patient safety programs was being ushered into practice. We encourage all readers of this book to remain engaged in their clinical practices while keeping an eye on how health systems, governments, academia, and professional organizations are addressing some of the greatest challenges facing health care today. We strongly encourage you to take a proactive and leadership role in these efforts, as the importance of a patient-centric and clinical perspective cannot be emphasized enough.

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Medicare and Its Evolution to 2011

2

Kevin J. Bozic and Benedict U. Nwachukwu

Learning Objectives

After completing this chapter, the reader should be able to answer the following questions:

- What is Medicare and who qualifies for it?
- What are the origins of the Medicare Program?
- What benefits were originally available under Medicare?
- How has Medicare changed up to 2011?
- What are the major challenges facing Medicare beyond 2011?

Introduction

In 1965, the United States Congress created Medicare under Title XVIII of the Social Security Act. The aim of the program was to provide health insurance coverage to all Americans aged 65 years and older. This chapter describes the evolution of Medicare from passage in 1965 to 2011. It is useful for both health-care practitioners and practitioners-in-training to understand the history of Medicare. Medicare has been in constant evolution and will continue to face serious challenges as health-care spending outpaces inflation and as the US elderly population increases.

Passage of Medicare

The Elderly as a Priority

Medicare was passed during an era that was best known for large-scale social programs aimed at combating poverty in the United States. The elderly segment of the population became a target for social intervention when it became apparent that older Americans were significantly poorer than the rest of the population. In the 1960s, the poverty rate for households headed by someone aged 25–54 years was 13 % while the poverty rate for households headed by an elderly head of household was 47 % [1]. This level of impoverishment was thought to be largely due to disproportionate health-care expenditures by the elderly. The elderly faced disproportionately

K.J. Bozic, M.D., M.B.A. (✉)
Department of Orthopedic Surgery, University of California, San Francisco, CA 94143-0728, USA
e-mail: kevin.bozic@ucsf.edu

B.U. Nwachukwu, B.A.
Harvard Medical School, Oliver Wendell Holmes Society, Boston, MA 02115, USA
e-mail: Benedict_Nwachukwu@hms.harvard.edu

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