Chapter 8

Chapter Objectives

- Understand the history and evolution of government involvement in health care.
- Explain major government health care programs.
- Identify important health care policy issues.
- Discuss concerns over and actions to address rising health care costs.
- Describe the role of managed care organizations.
- Explain measures that can be taken to reduce health care costs.
- Identify the role that quality of care plays in the health care system.
- Analyze selected issues in health care policy.

Promoting well-being. The United States spends twice as much per person on health care as any other developed country and yet on average gets worse results. A large portion of health care spending goes to treatment of preventable illnesses, so among the actions that could make a big difference is putting more money and effort into preventive health care and wellness activities. The photo shows First Lady Michelle Obama exercising with schoolchildren at Orr Elementary School as part of a "Let's Move! Active Schools" event, held in September 2013 in Washington, D.C. (*Win McNamee/Getty Images*)

Health Care Policy

Over the last several years, health care spending has grown by less than 4 percent annually, one of the lowest rates in more than fifty years, well down from the annual average of more than 7 percent that prevailed from 2000 through 2008 and even higher rates of increase during the 1990s. The reasons for the slower spending included low growth in Medicare and Medicaid expenditures and lingering effects of the economic recession of the late 2000s, which meant lower levels of employment and health insurance coverage and reduced demand for health care services such as physical examinations, emergency room treatment, and purchase of prescription drugs. So the news was not entirely good. Moreover, the Centers for Medicare and Medicaid Services (CMS) reported that even with this modest increase in expenditures, overall spending on health care still rose, and to a record high of $2.8 trillion in 2012, or 17.2 percent of the nation's gross domestic product (GDP). The United States spent $8,915 per person for health care in 2012, a figure certain to grow substantially over the next decade. In fact, the CMS projects that per capita spending on health care by 2022 will be an astonishing $14,664, and that overall health care spending will rise to $5.0 trillion, or nearly 20 percent of GDP. Given those costs, and the continuing challenge of ensuring access to health care services, it is no wonder that President Barack Obama spent so much of his first year in office championing his proposed policy changes that eventually became the Patient Protection and Affordable Care Act of 2010, also known as Obamacare. It is equally unsurprising that the president's detractors saw the new act as yet another costly expansion of governmental authority they believed was unjustified.[1]

It is likely, however, that the high cost of health care in the United States will remain a challenge for the president and Congress regardless of which party is in control. This is particularly so as the nation continues to struggle with federal

deficits and a rising national debt, and thus needs to find ways to reduce overall federal spending and/or adjust taxes to increase revenue. Simply spending more money on health care, of course, is not necessarily the best way to deal with the nation's health care problems. The United States already spends twice as much per person on health care as most other industrialized nations, and achieves less for it. As the chief executive of the Mayo Clinic has stated: "We're not getting what we pay for. It's just that simple." Another health care expert put it this way: "Our health care system is fraught with waste," with as much as half of the money spent today doing nothing to improve health. The implication is that whether the money is spent through governmental programs or entirely in the private sector, fundamental changes are needed in the way the nation handles health and disease—that is, in the way we choose to structure and operate the health care system. As just one example, if more spending were shifted to preventive health care and wellness activities, the outcomes could be far better. This is because about 75 percent of health care costs go to treatment of preventable chronic illnesses, such as diabetes and heart disease.[2] Would you favor such a change in spending priorities that put more emphasis on wellness and disease prevention? Are there any reasons not to make such a seemingly sensible change? This chapter should help in answering such questions.

The long-recognized gap between health care spending and results remains as striking today as when it was first noticed. In a 2013 report, for example, the Commonwealth Fund found that the United States ranks poorly in terms of health care cost, access, and affordability compared to ten other industrialized countries based on a series of measures of health system performance.[3] Many similar comparisons in recent years have come to the same conclusions. One reason for these findings is that some eighty-four million people in the United States either have lacked health insurance or have been underinsured, and therefore have had limited access to health care services. Another is that the quality of health care people receive and what they pay for it depend on where they live and personal characteristics such as race, income, and education.[4] What, if anything, should the nation do to correct such an important inequity? And who should pay for the added cost of doing so?

The combination of the high cost of and unequal access to quality health care has long been a major concern in public policy. In 2013, the average health insurance premium for a family of four under employer-provided health plans reached $16,351. Increasingly, workers also are forced to pay a higher percentage of these costs and to cope with higher deductibles and co-payments.[5] It is little wonder, then, that reform of health care policy has regularly appeared at the top of issues that voters consider to be important.

Most people rely on employer-provided health care insurance, for which they pay a portion of the cost, or on government programs to meet essential health care needs. Federal and state health care policies also affect the uninsured and those who pay for their own insurance. Government policies influence not only access to and quality of health services across the country, but also the pace of development and approval of new drugs and medical technologies and the extent of

health research that could lead to new lifesaving treatments. Whether the concern is periodic medical examinations, screening for major diseases, or coping with life-threatening illnesses, health care policy decisions eventually affect everyone.

This chapter examines some of the problems associated with health care services and the public policies designed to ensure that citizens have access to them at a reasonable cost. The two major political parties disagree, often intensely, over the proper degree of government involvement and how much should be left to the private sector—to individuals, physicians, hospitals and clinics, insurance companies, and pharmaceutical houses. In addition, among the major controversies in health care are how best to deal with escalating costs, how to ensure sufficient access to health care services, and how to maintain the quality of health care services while containing costs. The chapter begins with background information about the evolution of major public policies, such as Medicare, Medicaid, and the veterans' health care system, and then turns to some of the leading policy disputes: patients' rights, the rising costs of health care, the role of managed care, the regulation of prescription drugs, and the potential of preventive health care and other strategies to keep people healthy and save money. In this chapter, we give particular attention to the effectiveness of current public policies, and we use the criteria of economic efficiency and equity to examine these disputes and recommendations for improving health care policy.

Background

Health care policy includes all of the actions that governments take to influence the provision of health care services and the various government activities that affect or attempt to affect public health and well-being. Health care policy can be viewed narrowly to mean the design and implementation of the range of federal and state programs that affect the provision of health care services, such as Medicare and Medicaid. It also can be defined more broadly and more meaningfully by recognizing that government engages in many other activities that influence both public and private health care decision making. For example, the government funds health science research and public health departments and agencies; subsidizes medical education and hospital construction; regulates food, drugs, and medical devices; regulates health-damaging environmental pollution; and allows tax deductions for some health care expenditures (which makes them more affordable). The box "Working with Sources: Health Care Policy Information" lists some useful websites to begin a policy investigation.

As a government activity, health care policy is relatively recent, even though governments at every level long ago established what we call **public health agencies** to counter the threat of infectious diseases or unsafe food and to support medical research. The work of these agencies should be clearly differentiated from what we recognize today as health care policy, which involves how we as a society decide to deal with concerns such as access to health insurance and the provision and cost of health care services. These agencies dealt with such seemingly

mundane but critical functions as providing safe drinking water supplies, sanitation, and waste removal. Many of the oldest of these public health agencies continue such work today, largely without much public notice. These include the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC).

Since 1862, when it employed a single chemist and was housed in the U.S. Department of Agriculture (USDA), the FDA has overseen the development of new drugs and medical devices as well as the nation's food supply (other than meat and poultry, which the USDA regulates). The modern FDA dates from 1906, when it was authorized by the Federal Food and Drugs Act and regulatory functions were added to the agency's scientific mission. The agency is now part of the Department of Health and Human Services (HHS). In addition to food and drugs, the agency is responsible for regulating biologics (vaccines and blood products); the labeling and safety of cosmetics once they come to market; medical devices, including contact lenses; and radiation in consumer products such as microwave ovens and cell phones. Later in the chapter we offer a steps-to-analysis exercise on how the FDA regulates the approval of new drugs.

The federal government also has been actively engaged in health science research for years. Generous budgets allowed the government to expand its research into the causes of various diseases and possible treatments. The NIH, the primary vehicle for federal health science research, was founded in 1887 and consists of twenty-seven separate institutes and centers. The NIH is one of eight health agencies of the U.S. Public Health Service, itself a component of HHS. The NIH supports health research across the nation at colleges and universities, at medical research centers, and on the NIH main campus in Bethesda, Maryland. The federal CDC has been part of the Public Health Service of HHS since 1973. The CDC was established in 1946 as the Communicable Disease Center. It focuses on the development and application of disease prevention and control, environmental health, and health promotion and education. The CDC has long been involved in programs dealing with immunization, the prevention and control of AIDS and other infectious diseases, chronic disease prevention, birth defects and developmental disabilities, occupational safety and health, and the compilation of a treasure trove of national health statistics.

As the work of these three agencies shows, the federal government has been active in public health, if not the actual provision of health care services, for a very long time. The same is true of state and local governments. Government involvement in funding or provision of direct health care services, on the other hand, is relatively recent.

Evolution of Health Care Policy

What we consider the core of health care policy developed in the United States only after the 1930s, with the idea of health insurance. Individuals could take out an insurance policy, much as they did for their lives, houses, or cars, that would defray the cost of health care should an illness develop or an injury occur. Most

Working with Sources

Health Care Policy Information

As is the case with other public policy issues, there are hundreds of websites providing information on health care policy. The easiest way to learn about what information is available and its reliability is to visit one or more of the leading sites listed below and at the end of the chapter. Select one of the sites and try to find information about a major health care issue such as the ones highlighted below.

- How easily can you locate the information?
- Is coverage of the issue adequate or too limited to tell you what you need to know?
- Is the information provided at the site objective or biased in some way?

www.ahip.org. America's Health Insurance Plans, a leading industry trade association, has broad and excellent coverage of and links to the full range of health care policy issues. Select the link to Issues, and then to Affordable Care Act, where you can find the industry's views on the new federal law, including the new insurance exchanges, personal coverage requirements, essential benefits, the affordable care organizations, and more.

www.citizen.org/hrg. Public Citizen's Health Research Group site, with extensive links to policy issues and citizen activism. Select a topic such as food safety, drug safety, health care delivery, or physician accountability.

www.cms.gov. The site for the federal Centers for Medicare and Medicaid Services, with links covering Medicare; Medicaid/CHIP; Medicare-Medicaid coordination; private insurance; the CMS Innovation Center; regulations and guidance; research, statistics, data, and systems; and outreach and education.

www.healthcare.gov. The leading federal government site for general information about health care and the Affordable Care Act, including topics such as health insurance basics; prevention and getting care; the marketplace; saving money on coverage; and rights, protections, and the law.

www.iom.edu. The Institute of Medicine, a component of the National Academies and a major source for reliable health care studies. Includes links to related sites for health care studies and reports. Find reports by topic, among which you will find public health; quality and patient safety; and health services, coverage, and access. Then find a particular report, such as *Improving Health Literacy Within a State* or *Essential Health Benefits: Balancing Coverage and Cost*.

www.kff.org. One of the premier online resources for coverage of health policy news and debate. Select Topics, and then Health Reform, Medicare, Medicaid, Health Costs, Uninsured, Women's Health Policy, or Global Health Policy, among other subjects.

www.nytimes.com/pages/health/index.html. The *New York Times* health news page. Select a specific news report.

www.policyalmanac.org/health/index.shtml. The *Almanac of Policy Issues* health care page, with many useful links to news, organizations, government agencies, health care statistics, and a range of health policy issues. Select a topic listed under the directory, such as abortion, health insurance, privacy, or medical professions.

of those early policies covered only catastrophic losses. Health insurance works much the same way now, although instead of individual policies, most people are insured through their jobs, and the insurance policies cover routine medical services as well as preventive health care. Employer-sponsored health insurance became popular in the 1950s after the Internal Revenue Service ruled that its cost was a tax-deductible business expense. By the early 1960s, the push was on for federal health insurance policies, primarily to aid the poor and the elderly,

two segments of the population that normally would not benefit from employer-provided health plans. It is clear that equity concerns in access to health care services were important as health care policy developed. Those efforts culminated in the enactment of the Social Security Act Amendments of 1965 that formally created the Medicare and Medicaid programs (Marmor 2000). These policies are discussed in detail later in the chapter.

Even with adoption of these two programs, the U.S. health care system remains distinctive in comparison to other industrialized nations, where **national health insurance**, also known as **single-payer insurance** (the government pays), is the norm. Campaigns to adopt national health insurance in the United States date back to 1948, when the Democratic Party platform endorsed the idea. Members of Congress began to introduce bills to create such a program, but they were unsuccessful until the decision in 1965 to establish insurance programs for the poor and the elderly through Medicaid and Medicare, respectively.

One of the more recent efforts to create a national health insurance program occurred in 1993, when President Bill Clinton submitted the Health Security Act to Congress after extensive analysis by a presidential health care task force headed by his wife, Hillary Rodham Clinton. The plan would have guaranteed health insurance to every American, including the thirty-four million who were uninsured at the time. It proposed doing so through a system of health care alliances that would function much like current managed care organizations. The plan called for individuals to pay about $1,800 a year for coverage, and families about $4,200; both amounts were less than private insurance rates at the time for most of the population. Most employers would have been required to cover their employees under the plan (a so-called employer mandate), with subsidies for small businesses that otherwise could not afford to pay.

Republicans in Congress argued that the Clinton plan was too expensive, bureaucratic, and intrusive. The health insurance industry also criticized it. The insurance companies lobbied intensely against the plan and mounted an expensive television advertising campaign designed to turn the public against it. Some of the opponents also argued that key policy choices were made out of the public eye and were not subject to the kind of congressional review and debate expected for policy legitimation (discussed in chapter 3). In the end, the Clinton recommendations failed to win congressional approval, as did the many alternatives that members of Congress proposed (Hacker 1997; Rushefsky and Patel 1998). The failure was a classic story of the kind of policy gridlock described in chapter 2, yet divided government cannot be blamed for the result because Democrats controlled the White House and both houses of Congress at the time. However, the president was unable to persuade his party members to support him, even though a number of states (among them Hawaii, Massachusetts, and Minnesota) had set an example by establishing comprehensive health care programs that combined public and private insurance and by developing innovative approaches to controlling health care costs.[6]

With the victory of Barack Obama and gains in Democratic seats in the House and Senate in the 2008 elections, national health care policy reform once again was in the spotlight, although with competing proposals that reflected deep

differences between the two parties. President Obama had offered detailed proposals on his preferred approach to health care reform during the 2008 campaign, which he modified in 2009 in the face of Republican opposition and objections by the health insurance and pharmaceutical industries. In particular, the president abandoned what had been strong Democratic preference for a so-called public option, where the federal government would compete with private insurance companies in offering health care insurance. In 2009 and early 2010, Congress considered and eventually approved sweeping health care reforms, although on strict party-line votes. No Republican in either the Senate or the House voted for what became the Patient Protection and Affordable Care Act of 2010, and party members since then have vowed to repeal the act and replace it with an alternative policy.[7]

The **Affordable Care Act** is a highly complex and multifaceted policy in addition to being politically controversial. The 1,200-page law affects virtually every component of the U.S. health care system, and it survived a major legal challenge when the Supreme Court in 2012 upheld its constitutionality in a close vote.[8] Its major purpose was to increase health insurance coverage and access to health care services, and it does so through a number of key actions: (1) expanding Medicaid and the Children's Health Insurance Program (CHIP) and making eligibility and benefits more uniform across the states (although the Court allowed for states to opt out of the Medicaid expansion part of the law); (2) mandating that individuals who are not covered through their employers or by public programs purchase a minimal level of health insurance, with tiered plans that must offer standard packages of benefits, or pay a penalty for failing to do so; (3) subsidizing the costs of such insurance for low- to moderate-income families; (4) offering tax credits to encourage small businesses to provide health insurance to their employees and instituting a penalty for larger employers (with fifty or more employees) who do not offer health insurance benefits; and (5) creating new regulations for health insurers to deal with several long-standing concerns, such as prohibiting insurers from excluding children and eventually all individuals with preexisting medical conditions, preventing them from setting annual and lifetime limits on coverage, and requiring them to cover family members (such as college students) up to age twenty-six. Other provisions in the act set new limits on allowable administrative costs to encourage insurers to improve efficiencies in billing and health care management. The various components of the act take effect over a seven-year period between 2011 and 2018. A summary of them and how they apply to individuals can be found on the federal government's webpage (www.heathcare.gov), where the full text of the act is posted.[9]

Among the act's more intriguing and promising elements are requirements to study ways to improve the efficiency of health care service delivery and to reduce costs. A new CMS Innovation Center is to oversee such studies and to devise ways to reward health care providers for improved quality and gains in efficiency. Similarly, a new independent federal advisory board is to identify cost savings in the Medicare program, and the new Patient-Centered Outcomes Research Institute is to conduct research on the comparative effectiveness of health care services—that is, to determine which procedures and drugs work best and at the

least cost, a widely endorsed but still controversial proposal.[10] Other provisions in the act seek ways to reduce costly medical errors and hospital-acquired infections by rewarding hospitals with better patient outcomes, and to promote the use of disease management programs and preventive health care. Despite the partisan rancor over the bill, the two parties were largely in agreement on the need to increase emphasis on preventive health care through both governmental and private insurance programs.[11]

The costs of the Affordable Care Act are sizeable, and yet they are expected to be offset in part by a variety of new revenues, including a 0.9 percent increase in the Medicare payroll tax for high earners (household income of greater than $250,000 a year) and a new 3.8 percent tax on so-called passive income such as dividends and capital gains that took effect in 2013, also only for high-earning households. The act's critics, however, argue that net costs nonetheless are likely to rise because they believe that Congress may not agree to all of the new taxes and fees or make the expected reductions in some health care spending, and that younger people in particular might not sign up for insurance plans in sufficient numbers to balance older and less healthy segments of the population. In late 2013 and early 2014, many critics also anticipated that prices some will pay for insurance coverage might well increase substantially, at least in the short term.[12]

As noted in chapter 6, implementation of the new act did not go as smoothly as the government had hoped. In addition, it soon became clear that each state would choose whether or not to offer a state insurance exchange or to defer to the federal government. Many states controlled by Republican legislators and governors chose not to offer their own exchanges as one expression of their dislike of the federal program.[13] In addition, following the Supreme Court's 2012 decision, many states chose not to expand Medicaid services under the Affordable Care Act even though the federal government was covering nearly all of the costs of doing so. These choices will affect the law's implementation, its success in persuading large numbers of people to sign up for insurance, and the anticipated cost savings.

Many of the uncertainties over how well the new provisions of the act will work, what they will cost, and how they will be paid for may well be reduced over the next several years as some of the remaining conflicts over the act's provisions are resolved and more individuals sign up for insurance plans under the law; by May 2014, the Obama administration reported that enrollment in the new plans exceeded expectations, at over eight million people.[14] Continuing conflict over the law in Congress and the states, however, also tells us that we can expect persistent and sometimes intense disagreements between the two parties over both the law itself and the larger issue of what role the federal and state governments should play in health care insurance and the delivery of health services to the public.

A Hybrid System of Public and Private Health Care

Another way to consider the history of health care in the United States and the nation's present health care system is to note that it relies largely on the private

market and individual choice to reach health care goals, as we indicated in the chapter's opening paragraphs. Even following enactment of the Affordable Care Act, the U.S. government plays a smaller role in health care than, for example, the governments of Great Britain or Canada, nations that have national health insurance programs that provide comprehensive health services. Their systems have been criticized for delays in providing health services for some patients as well as the quality of care, although these weaknesses appear to be less important today than previously, and most citizens in these and other developed nations appear to be well served by such health care systems.[15]

In contrast to such government-run systems, most health care services in the United States are provided by doctors and other medical staff who work in clinics and hospitals that are privately run, even if some are not-for-profit operations. Indeed, the United States has long had the smallest amount of public insurance or provision of public health services of any developed nation in the world (Patel and Rushefsky 2006). The result is a health care system that is something of a hybrid. It is neither completely private nor fully public. It does, however, reflect the unique political culture of the nation, as first discussed in chapter 1. Americans place great emphasis on individual rights, limited government authority, and a relatively unrestrained market system. Those who favor a larger government role to reduce the current inequities in access to health care services are in effect suggesting that health care should be considered a so-called **merit good** to which people are entitled. In short, they tend to believe that normal market forces should not be the determining factor in the way society allocates such a good.

The majority of nonelderly U.S. adults (about 168 million people) have employer-sponsored, private health insurance, and others purchase similar insurance through individual policies. Those over age sixty-five are covered through Medicare, discussed later in the chapter. But with rising costs and a less-than-robust economy, employer coverage is likely to be less widely available in the future. About 57 percent of employers offered health benefits to at least some of their employees in 2013; the rate was higher for companies with unionized employees and higher for larger firms.[16] The annual premium for covered workers in 2013 averaged $5,884 for single coverage and $16,351 for family coverage—an increase of 4 to 5 percent over premiums in 2012. Family premiums have increased some 80 percent in the last decade. Employees with health insurance, on average, pay 18 percent of the insurance cost for single coverage and 29 percent for family coverage.[17] These premiums have been rising substantially for the past several years, leading employers to cut back on some benefits and to shift more of the cost to employees. That trend will likely continue.

Employer and other private health insurance policies generally cover a substantial portion of health care costs, but not all. Some services, such as elective cosmetic surgery, generally are not covered, and only partial payment may apply to others. The federal government can specify particular services that must be included in private insurance plans, but there are major gaps in coverage, such as assistance with expensive prescription drugs and provision of long-term care in nursing homes and similar facilities that may follow a disabling injury or illness, or simple aging. People are living longer, and the demand for these services

is expected to rise dramatically in the future as the U.S. population ages. Most policies historically also have had a lifetime cap on covered expenses that could be exceeded in the event of serious medical conditions, but the Affordable Care Act eliminated such caps.

The Perils of Being Uninsured

The number of individuals and families without any insurance coverage rose significantly between 1990 and 2010, and this was a major driver in congressional approval of the Affordable Care Act. In 2013, about forty-eight million individuals had no health insurance. The percentage of people without health insurance is not uniform around the nation but instead varies widely from state to state. In some states (e.g., Florida and Texas), more than 21 percent of the nonelderly population was uninsured in recent years, but in several states (Connecticut, Vermont, Hawaii, and Massachusetts), the rate was less than 10 percent; in Massachusetts, it was only 4 percent because of that state's comprehensive health care policy.[18]

As the cost of medical care continues to grow, what happens to the uninsured? The consequences for them can be devastating—a higher lifelong risk of serious medical problems and premature death. A widely cited review of the health consequences for uninsured, working-age Americans conducted by the Institute of Medicine (IOM) in 2002 found that they are more likely than the insured to receive too little medical care, to receive it too late, to be sick, and to die prematurely. Indeed, they are 25 percent more likely to die than those with insurance coverage. That difference translates into an estimated eighteen thousand deaths per year that can be attributed to being uninsured. These estimates may even be too low. An Urban Institute study that sought in 2008 to update the IOM report put the number at twenty-seven thousand preventable deaths in the United States each year attributable to being uninsured.[19] Studies like these on the consequences of being uninsured played a role in consideration and enactment of the Affordable Care Act.

The uninsured also are more likely than the insured to receive less adequate care when they are in a hospital, even for acute care, such as injuries from an automobile accident. They are more likely to go without cancer screening tests, such as mammograms, clinical breast exams, Pap tests, and colorectal screenings, and therefore suffer from delayed diagnosis and treatment. That finding helps to explain why uninsured women with breast cancer have a 30–50 percent higher risk of dying than women with private health insurance (Institute of Medicine 2002).

In addition, the uninsured tend not to receive the care recommended for chronic diseases such as diabetes, HIV infection, end-stage renal (kidney) disease, mental illness, and high blood pressure, and they have worse clinical outcomes than patients with insurance. "The fact is that the quality and length of life are distinctly different for insured and uninsured populations," the IOM report said. It added that if this group obtained coverage, the health and longevity of working-age Americans would improve (Institute of Medicine 2002).

At least some policymakers are aware of some of these risks and the inequities they present to the U.S. public. As the failure of the Clinton health policy initiative in the 1990s and continuing controversy over the Affordable Care Act show, however, reaching agreement on extending insurance coverage to the entire population is not an easy task. The debate is likely to continue for years, and the rising costs of health care may force reconsideration of current policies that leave so many citizens without health care insurance.

Prescription for health care. Dr. Jim Spears examines Sarah Ittner, a New York-based actor who does not have health coverage, at the Actors Fund's Al Hirschfeld Free Health Clinic in March 2011 in New York City. The date marked the one-year anniversary of the Patient Protection and Affordable Care Act of 2010, or Obamacare, a law designed to improve access to health care for those without medical insurance, among other goals. (*Spencer Platt/Getty Images*)

Strengths and Weaknesses of the U.S. Health Care System

No one seriously doubts that the United States has one of the finest health care systems in the world by any of the conventionally used indicators, such as the number of physicians per capita, the number of state-of-the-art hospitals and clinics, or the number of health care specialists and their expertise. The United States also has a large percentage of the world's major pharmaceutical research centers and biotechnology companies, which increases the availability of cutting-edge medical treatments.

Despite these many strengths, however, patients and physicians alike frequently complain about the U.S. health care system. As noted at the beginning of the chapter, the United States is ranked well below the level of other developed nations despite spending far more than other nations on health care per person.[20] Such findings reflect the highly unequal access of the population to critical health care services, from prenatal care to preventive screening for chronic illnesses. The poor, the elderly, minorities, and those living in rural areas generally receive less frequent and less adequate medical care than white, middle-class residents of urban and suburban areas. Because of such disparities, among others, the fifty states vary widely in the health of their populations, with Connecticut, New Hampshire, and Vermont at the top in recent rankings and Oklahoma, Mississippi, and Louisiana at the bottom.[21]

As discussed earlier, comparisons of U.S. health care costs to those in other nations force the question of what U.S. citizens are getting for their money. Just how effective are current programs, and are health care dollars being well spent? How might the programs be modified to improve their effectiveness and efficiency and to ensure that there is equitable access to health care services? Plenty of controversy surrounds each of these questions, and they remain at the center of policymakers' concerns about the future of the U.S. health care system. The

websites listed on page 263 in the box "Working with Sources: Health Care Policy Information" cover health care developments and policies and offer a wealth of information on these issues.

A Pluralistic Health Care System

Before we turn to a description and assessment of specific U.S. health care programs, we start with an overview of the health care system itself. The individual health care programs are complicated enough to confuse even the experts, but they do not represent the totality of government activities that affect the health and welfare of the U.S. public. A broad view of health care policy suggests that many other actions should be included as well. Table 8-1 lists the collection of agencies and policies at the federal, state, and local levels.

The table indicates the diversity of departments and agencies that are involved in health-related services, broadly defined, and shows that authority is highly diffused rather than concentrated and is shared among all levels of government. As we saw in the implementation of the Affordable Care Act, states have a great deal of discretion in what they choose to do under the act, as they have long had with state Medicaid programs. Moreover, as noted earlier in discussion of the hybrid U.S. health care system, health services are delivered through both the private sector and public programs. The programs most frequently in the public eye, such as Medicare and Medicaid, are only part of what governments do to promote the public's health. To put this in other terms, solutions to U.S. health problems are not to be found solely in either expanding or modifying the established Medicare, Medicaid, and veterans' health care programs. Other actions also are possible, including those that rely on preventive health care. These include personal decisions related to diet and exercise, detection of disease at its earliest stages, health education, medical research, environmental protection, and a host of public and private programs to improve mental and physical health. We will return to a discussion of such preventive health care below.

Major Government Health Care Programs

The following sections describe the major federal and state programs that deal directly with health care services. In addition to the programs' goals and provisions, the discussion tries to evaluate them in terms of the major public policy criteria we set out earlier in the text: effectiveness, efficiency, and equity.

Medicare

The federal **Medicare** program began in 1965, following authorization by that year's amendments to the Social Security Act of 1935. It was intended to help senior citizens, defined as those age sixty-five and older, to meet basic health

care needs. It now includes people under age sixty-five with permanent disabilities and those with diabetes or end-stage renal disease—for example, patients who need dialysis treatment or a kidney transplant. Medicare had over forty-nine million beneficiaries in 2013, a number certain to rise appreciably over the next two decades as the baby boom generation—those born between 1946 and 1964—reaches age sixty-five. In 2013, the three major entitlement programs—Social Security, Medicare, and Medicaid (including CHIP)—already accounted for about 43 percent of federal spending.

TABLE 8-1 Major Government Health-Related Programs

Level of Government	Agency and Function
Federal	Department of Agriculture Food safety inspection (meat and poultry) Food stamp and child nutrition programs Consumer education Department of Health and Human Services Food and Drug Administration Agency for Healthcare Research and Quality Centers for Medicare and Medicaid Services Health Resources and Services Administration (health resources for underserved populations) Indian Health Service Substance abuse programs Health education Public Health Service (including the surgeon general's office, the National Institutes of Health, and the Centers for Disease Control and Prevention) Department of Labor Occupational Safety and Health Administration (regulation of workplace safety and health) Department of Veterans Affairs Veterans Health Administration (VA hospitals and programs) Environmental Protection Agency (regulation of clean air and water, drinking water, pesticides, and toxic chemicals)
State	Medicaid and Children's Health Insurance Program (CHIP) State hospitals State mental hospitals Support of state medical schools State departments of health Health education State departments of agriculture and consumer protection State environmental protection programs
Local	City and county hospitals and clinics Public health departments and sanitation Emergency services City and county health and human services programs

Medicare Program Provisions. The Medicare program has two main parts, one standard and the other optional. Medicare Part A is the core plan, which pays partially for hospital charges, with individuals responsible for a deductible and co-payments that can be substantial. The program is paid for by Medicare trust funds, which most employees pay through a payroll deduction, much like the Social Security tax, which employers match. Part A also covers up to one hundred days in a nursing care facility following release from the hospital, but again with co-payments. Part A of Medicare covers people who are eligible for the federal Social Security system or Railroad Retirement benefits.

The optional part of the Medicare program, Part B, is supplemental insurance for coverage of health care expenses other than hospital stays. These include physician charges, diagnostic tests, and hospital outpatient services. The cost of Part B insurance is shared by individuals who choose to enroll in it (they paid $104.90 per month for it in 2014) and by the government, which covers about three-fourths of the cost from general federal revenues. Part B also has both deductibles and co-payments, and historically it did not cover routine physical examinations by a physician, but it now covers a yearly "wellness" visit that is designed to help prevent disease and maintain good health, and a variety of other preventive health services such as cardiovascular, cancer, and diabetes screenings. Many of these services were mandated by Congress under the Balanced Budget Act of 1997, and further changes have come with the Affordable Care Act. Even with its limitations, about 95 percent of eligible recipients opt for coverage under Part B of Medicare.

Medicare uses a fee schedule of "reasonable" costs that specifies what physicians, hospitals, nursing homes, and home services should charge for a given procedure, and the government pays 80 percent of that amount. Some physicians choose not to participate in the Medicare system because they believe the fee schedule is too low and their options for raising patient fees are unrealistic.

Equally important is the fact that the regular Medicare program does not cover many other medical expenses, including prescription drugs used outside of the hospital, dental care, and eyeglasses. It also pays for only the first ninety days of a hospital stay and limited nursing home care. Because of these restrictions and the deductibles and co-payment charges, Medicare historically has covered only about two-thirds of the health care costs for the elderly. Individuals must therefore pay for the rest of the costs or purchase supplementary private insurance policies to cover the gaps in Medicare. Low-income elderly also may be eligible for state Medicaid programs, which cover some of these costs. Despite the many restrictions, Medicare is a bargain for the elderly, who would have to pay much higher fees for a full private insurance policy, considering the chronic and serious health problems they are likely to face.

As we discussed earlier, the costs of health care in general, including Medicare, continue to rise, and this trend poses major challenges to the solvency of the Medicare trust fund as the population ages and the ranks of Medicare recipients swell. With the enactment of the Medicare prescription drug benefit program in 2003, a previous Medicare + Choice program was replaced with Medicare

Advantage (Part C), which consists of managed care programs that are run by private health insurance companies. In 2013, only about 28 percent of those on Medicare signed up for a Medicare Advantage plan, with the rest choosing to remain with a traditional fee-for-service Medicare plan (Part B). Medicare Part D took effect on January 1, 2006. Approved by Congress in late 2003 in response to the rapid rise in drug prices, particularly for senior citizens, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has several key elements. It is intended to provide discounts for routine prescription drugs and also to protect those who enroll against the extremely high costs that come with a serious illness. Prescription drug benefits depend on the plan that is selected.[22]

Fraud and Abuse Under Medicare. A perennial problem in all government health care programs is fraud and abuse, especially notable under Medicare. Indeed, the Government Accountability Office (GAO) has declared both Medicare and Medicaid as "high risk" programs that are "particularly vulnerable to fraud, waste, abuse, and improper payments."[23] Less-than-scrupulous health care providers may charge the government for services that were not performed or order tests and procedures that may not be necessary but for which the health care provider knows Medicare will pay. The CMS has no official estimate of fraud, but the Federal Bureau of Investigation has indicated it is 3 to 10 percent of Medicare billings; for 2011, that would translate into between $17 and $57 billion annually given the $565 billion in Medicare spending that year.

In a telling commentary about a 1998 HHS investigation into abuses by community mental health centers, Donna Shalala, then secretary of the department, noted there was "extensive evidence of providers who are not qualified, patients who are not eligible, and services billed to Medicare that are not appropriate," including services "that weren't covered, weren't provided, or weren't needed."[24] More recent assessments of Medicare spending echo those concerns. The program continues to be deficient in its monitoring and enforcement of quality standards and in its oversight of spending even though it spends over $1 billion annually to combat fraud, waste, and abuse. Health care centers say that at least part of the problem lies in the government's complex billing procedures that contribute to errors. Federal agents who investigate Medicare fraud are not persuaded by such arguments. They charge that health care providers intentionally put services into a higher-paying category, or "up code" their billing, and engage in other illegal practices to increase profits. In addition, researchers at Dartmouth's medical school have estimated that as much as $1 of every $3 in the program is wasted by spending on inappropriate or unnecessary care; others have put the figure even higher.[25] Much of this kind of waste is the result not of fraudulent billing or similar abuse, but rather of the pattern of Medicare paying for procedures that provide little or no clear benefit to patients.[26]

Medicare's Future. Given the projections of an aging population, the cost of the Medicare program represents one of the most important issues in health care policy. It is a subject of regular debate in Congress, and some members, notably Rep. Paul Ryan, R-Wis., have proposed dramatic changes, such as converting

Medicare from a government-run insurance program to one where program participants are issued vouchers to purchase private health insurance on the open market. Aside from the prescription drug plan approved in 2003, there has been little agreement on how to modify Medicare to alter its benefits or improve its effectiveness and sustainability over time in light of the increasing demand for its services. There is no shortage of suggestions for how to reform the program, and these ideas are widely available.[27] However, bipartisan cooperation on health care policy, including Medicare reform, is made difficult by intense ideological disagreements over the role of government in health care and the different constituencies to which each of the major parties tries to appeal. The debate is certain to continue.

Medicaid

Medicaid is the second major program of the U.S. health care policy system. Like Medicare, it was established in 1965, as Title XIX of the Social Security Act. It is designed to assist the poor and disabled through a federal-state program of health insurance. It differs from Medicare in one critical way: Medicare serves all citizens once they reach age sixty-five, regardless of income, and is therefore a form of national health insurance for senior citizens, but Medicaid is a specialized health care program for the poor and disabled.

Medicaid Provisions and Controversies. Under Medicaid, the federal government establishes standards for hospital services, outpatient services, physician services, and laboratory testing, and it pays about half of the cost. States pay the remainder and set standards for eligibility and overall benefit levels, which have varied significantly from one state to another. If a state chooses to have a Medicaid program—and all have since 1982—it must also extend benefits to welfare recipients and to those receiving Supplemental Security Income because of blindness, another disability, or age. Medicaid provided coverage for over fifty-five million people in 2013, a number expected to increase substantially in the years ahead. About half of the Medicaid beneficiaries are children in low-income families. By default, Medicaid has become the major payer for long-term health care provided in nursing homes and similar facilities, and it accounts for about half of the nation's spending for such services. Because of the rising demand and cost for these services, some states are changing their Medicaid programs to reduce use of nursing homes and to encourage health care in the home or community. These and other innovative approaches to help keep costs down will likely become more prevalent in the years ahead.[28]

In some respects, the state Medicaid programs are more generous than Medicare. The federal government requires states to cover hospitalization, nursing home services, physician services, diagnostic and screening tests, and X-rays. States may opt to cover prescription drug and other expenses, for which the cost can be exceedingly high. States are also required to cover children under the age of eighteen if the family income falls below the poverty level.

Much like Medicare expenses, Medicaid costs continue to rise at a rapid pace. Expenditures reached $415 billion in 2012, and they will grow further under provisions of the Affordable Care Act. As noted earlier, the act changes many provisions of Medicaid. For example, adults under age sixty-five in households with income up to 138 percent of the poverty level are to become eligible for Medicaid, and state differences in eligibility will be eliminated. As a result, enrollment is expected to grow by nearly 20 million individuals, reaching a total of 75.6 million served by the program.[29]

As might be expected in such a program, the states historically have been at odds with the federal government over the imposition of additional burdens. Medicaid is one of the largest programs in most state budgets. As states and counties spend more on Medicaid and face enormous resistance to raising taxes, they must cut back on the program's optional services, reduce the rate of reimbursement for physician and other services, and curtail funding elsewhere. Education, welfare, and other programs may suffer as Medicaid costs continue to rise, as they did in the 2008–2009 economic recession.[30]

In response to concern over the rising costs of Medicaid, in late 2005 Congress approved broad changes that gave states new power to reduce their costs through imposition of premiums and higher co-payments for many of Medicaid's benefits; these include prescription drugs, physician services, and hospital services, such as use of emergency rooms for nonurgent care. Higher costs for beneficiaries are expected to reduce their demand for those services. States also were authorized to cap or eliminate coverage for many services that previous federal law guaranteed within the program. In addition, the new law made it somewhat more difficult for senior citizens to qualify for Medicaid nursing home care by transferring their assets to their children or other relatives.[31]

As part of the Balanced Budget Act of 1997, a new Title XXI was added to the Social Security Act to create the **Children's Health Insurance Program (CHIP)**, which helps to ensure that children living in poverty have medical coverage. The federal government provides funds to the states, which the states match. The states are free to set the eligibility levels, which can include families that earn up to three times the poverty level. More than six million children have been covered under CHIP in recent years, but the states have varied widely in their ability to enroll children in the program. As has been the case for Medicaid in general, many states have reduced their funding of CHIP in recent years, as they have struggled with budget constraints and competing priorities. In 2007, Congress twice passed legislation to extend and expand CHIP, especially for families that work but remain too poor to pay for health insurance and make too much to enroll in Medicaid; the bills were vetoed by President George W. Bush. In early 2009, Congress again took up similar legislation, with the cost to be financed largely by an increase in the federal tobacco tax. By the end of January, both the House and the Senate had approved the measure by large margins and with bipartisan support, and President Obama signed it on February 4, 2009.[32] The Affordable Care Act made additional changes to the program.

Issues of Medicaid Fraud and Abuse. The Medicaid program, like Medicare, is vulnerable to fraud and abuse by service providers, such as filing inaccurate claims for reimbursement. Although the money lost to fraud is less than in the Medicare program, the costs are nevertheless substantial. The service providers defend themselves by arguing that they are the victims of an excessively complicated system of eligibility requirements and reimbursement procedures. In chapter 6, we cited the example of the New York State Medicaid program. The state failed to pursue many opportunities to reduce the program's high costs and to monitor its operation carefully. The result has been billions of dollars in fraud and abuse. One former state Medicaid investigator estimated that at least 10 percent of the New York program's dollars were spent on fraudulent claims and that another 20 to 30 percent had been wasted in "abuse," or unnecessary if not criminal spending. Thus as much as 40 percent of New York's Medicaid claims could be questioned, totaling some $18 billion each year in what may well have been wasteful spending. Following the highly visible criticism of its program, New York State pledged to substantially cut fraud over the next several years, and it seems to be making some progress.[33] It should be said that the states vary widely in how they administer the Medicaid program, and New York's experience does not imply that such waste exists in other states.[34]

What should the government do to reduce the incidence of Medicaid fraud and abuse? Many of the suggestions offered earlier in the chapter on fraud and abuse in the Medicare program also apply here. For example, states may choose to hire more auditors, an effort that might easily pay for itself.[35]

Veterans' Health Care

With all the attention paid to Medicare and Medicaid, policymakers and journalists sometimes forget that one of the oldest programs of federal health care service is similar to the national insurance programs that are the rule in Canada, Great Britain, and many other developed nations, but this one is for veterans only. The **veterans' health care system** is designed to serve the needs of U.S. veterans by providing primary medical care, specialized care, and other medical and social services, such as rehabilitation. The Veterans Health Administration operates veterans' hospitals and clinics across the nation and provides extensive coverage for veterans with service-related disabilities and diseases and more limited coverage for other veterans, particularly those with no private health care insurance. It also engages in diverse medical research.

One consequence of the wars in Iraq and Afghanistan became clear by 2011. There would be a major and costly expansion of service to veterans, many of whom suffered debilitating brain injuries and other serious battle wounds that would take years of treatment and recovery. The Pentagon has estimated that more than 200,000 troops have suffered from traumatic brain injury in the wars, chiefly from roadside bombs and similar devices, with long-term effects and treatment costs unknown.[36] According to the GAO, the number of veterans who have sought mental health care increased from 900,000 in 2006 to 1.2 million in 2010. The number of veterans of the Iraq and Afghanistan wars who entered therapy increased from 35,000 in 2006

Expansion in veterans' care. The care of military veterans has attracted much new attention with the return of thousands of military personnel from Iraq and Afghanistan, many of whom suffered serious injuries in the wars. In this photo, Spc. Bob Westbrook, left, who had been on deployments to Afghanistan, receives state-of-the-art treatment and rehabilitation from the army base's Warrior Recovery Center because of a traumatic brain injury, or TBI, in Fort Carson, Colorado. (*AP Photo/Bryan Oller*)

to 139,000 in 2010, requiring the Department of Veterans Affairs (VA) to double its staffing for mental health care.[37] We do have some idea of the overall health care costs of the wars. In its tally of the long-term costs, the *New York Times* included an independent estimate that health care and disability payments for veterans of the wars over the next forty years will be nearly $590 billion.[38] Such projections are all the more reason to ensure that these health care programs are both effective in meeting veterans' needs and efficient in the use of federal health care dollars.

Congress expanded the existing veterans' health programs by enacting the Veterans' Health Care Eligibility Reform Act of 1996. That legislation created an enhanced health benefits plan that emphasizes preventive and primary care, but it also offers a full range of services, including inpatient and outpatient medical, surgical, and mental health services; prescription and over-the-counter drugs and medical and surgical supplies; emergency care; comprehensive rehabilitative services; and even payment of travel expenses associated with care for eligible veterans. The VA health care benefits extend to preventive care and include periodic physical examinations, health and nutrition education, drug use education and drug monitoring, and mental health and substance abuse preventive services. Medical needs attributable to service-related injuries and disease typically are free of individual deductibles and co-payments. VA uses a priority group structure and a financial means test to set co-payment charges for other veterans (see www.va.gov). Its medical system has undergone a major transformation in recent years and is now widely considered to be a model for a national health care system. This is especially so because of its use of electronic medical records, its strong focus on preventive care measures (for example, for cancer, diabetes, and heart disease), and its high scores on health care quality indicators.[39]

Despite its many strengths, the veterans' health care system has fallen short in delivery of timely health care services, partly because of soaring demand for services as wounded soldiers returned from Iraq and Afghanistan and as aging Vietnam-era veterans sought treatment for chronic diseases. The capacity of the system to treat patients (for example, the number of hospitals, clinics, doctors, and nurses) has not kept pace with the rising needs of veterans. In 2014, evidence mounted that the wait time for a medical appointment at some veterans' hospitals had grown significantly, prompting staff members at some facilities to alter waiting list records in an effort to disguise the problem. Congressional inquiries into the scandal led to the dismissal of top health care officials at the VA and the resignation of the secretary of veterans' affairs, Eric Shinseki. Policymakers differ on the solutions needed, with some calling for improved management and efficiency at the VA and others for increased spending.[40]

At the request of senior military leaders, in 2000 Congress approved another health care program for career military personnel. It expands the military's health plan, known as **Tricare**, to include retirees with at least twenty years of service once they become eligible for Medicare. Tricare pays for most of the costs for medical treatment that are not covered by Medicare, except for $3,000 per year in out-of-pocket expenses. The plan also includes generous prescription drug coverage. One health care policy analyst, Henry Aaron of the Brookings Institution, summed up what many would conclude about this action: "It's interesting that Congress recognizes that for this one group the Medicare benefit package isn't adequate," he said. "One might well ask that if [Medicare] isn't good enough for men and women who served in the armed forces, why is it good enough for men and women who spent a lifetime paying federal payroll taxes?"[41] The answer would seem to be that Congress thought this initiative was politically attractive in an election year but feared that providing comparable benefits for the entire nation would be extremely costly and far more difficult.

Other Health Care Policy Issues

Several major health care policy issues do not directly involve government insurance programs such as Medicare, Medicaid, and the veterans' health care system, but instead affect the way private medical insurance operates and the legal rights of policyholders. Two issues merit brief mention here: the portability of insurance as individuals leave one job for another, and the rights of patients to seek legal recourse for decisions made by a managed care or other health organization. Both are somewhat less important today than they were two decades ago, as health care policy has evolved and such rights have come to be acknowledged.

Portability

Given the large number of people whose health care services are provided under employer-sponsored insurance plans, the possible loss of benefits when an employee switches jobs was a long-time concern. One employer's plan might not

be the same as another's in cost or quality. People with a preexisting medical condition, such as heart disease, hypertension, or cancer, might have found that a new employer's insurance company was unwilling to cover them at all or would charge higher premiums. To address some of these problems, in 1996 Congress approved the Health Insurance Portability and Accountability Act (HIPAA). The law guarantees that employees who change jobs have the right to insurance coverage, even if that coverage comes at a higher cost. That is, they have the right of **portability** for their insurance coverage. They can take guaranteed coverage with them if they change jobs, and they do not have to endure the waiting period that policies often impose to limit coverage of preexisting conditions. With enactment of the Affordable Care Act, portability is not as important today. Similarly, a federal act approved in the mid 1980s, the Consolidated Omnibus Budget Reconciliation Act (COBRA), was designed to allow employees to remain on an employer's health insurance policy for up to eighteen months, although the employee pays for the insurance premium, and it is no longer as important given insurance coverage under the Affordable Care Act.

Patients' Rights

Historically, one of the most common complaints about managed care health systems, such as HMOs (discussed below), was the inappropriate denial of care. Congress approved the Employee Retirement Income Security Act of 1974 (ERISA) to support **patients' rights**, particularly by allowing individuals to sue health insurance companies for such decisions, although only in federal court. ERISA says that federal regulations supersede state laws governing employee health plans and that no punitive damages may be sought beyond compensation for actual medical expenses. Once again, enactment of the Affordable Care Act set in place new expectations for insurance company coverage, and behavior builds on the heritage of ERISA but also makes it less important today.

Rising Health Care Costs

As this chapter has emphasized, one of the most difficult issues in health care policy disputes is cost. To make matters worse, the cost of providing health care services is rising inexorably even if more slowly today than a few years ago. Health care is expensive enough that individuals whose employers do not provide full coverage can easily find themselves unable to pay for private insurance or for all the medical services they need. The result can be financially devastating should a major medical emergency arise from an acute illness or an accident. Indeed, such circumstances often are a major reason for personal bankruptcy filings.[42] Even those with relatively generous health care insurance policies can find themselves facing enormous medical bills because of required deductible expenses and co-payment fees, for example, for prescription drugs and hospital stays.

Table 8-2 shows the trend in health care costs. It lists total U.S. health care expenditures for the years 1980 to 2012 (with projections out to 2022), as well as per capita expenditures, indicating that health care costs rose substantially over this period and are projected to rise much more in coming years, in part because of increases in the number of people served by Medicare and Medicaid and expected increases in those enrolled in private health insurance plans purchased through the new health insurance exchanges created by the Affordable Care Act.

As might be expected, rising costs deeply affect the leading federal health care programs. Medicare expenditures alone totaled about $580 billion in 2013, and the overall cost for federal and state spending on Medicaid was over $415 billion, for a total of about $995 billion. As noted in the chapter opening, costs have been rising more slowly in recent years than previously, and the growth may slow even more as the Affordable Care Act is more fully implemented.[43]

Rising expenditures for drugs is part of this larger picture of health care expenditures. As many television viewers have noted, pharmaceutical manufacturers have changed their marketing strategies and now advertise drugs directly to consumers, instead of only to health professionals, at a cost of about $3.5 billion each year. In sometimes deceptive advertisements, viewers are urged to ask their doctors for the new medications. The practice has been a success for the pharmaceutical companies, as the public demand for expensive new prescription drugs grew, even though many of them are only marginally more effective than cheaper, over-the-counter medications and generic versions of similar drugs, and sometimes come with significant risks of side effects.[44]

What is the future of health care costs? As shown in Table 8-2, the CMS offers projections for U.S. health care costs through 2022, and they show no change in the overall upward trend. Total health care expenditures are expected to grow at a substantially higher rate than the economy as a whole, rising from $2.6 trillion in 2010 to $5.0 trillion in 2022, per capita expenditures from $8,411 to $14,664, and expenditures as a percentage of GDP from 17.4 percent to 19.9 percent.[45] The federal government anticipates that pressure will increase on both

TABLE 8-2 National Health Expenditures, 1980–2022 (in nominal dollars)

Item	1980	1990	2000	2010	2022 (estimated)
Total national health care expenditures (in billions)	$255.8	$724.3	$1,377.2	$2,599.0	$5,009.0
Per capita health care expenditures	$1,110	$2,855	$4,878	$8,411	$14,664
Health care expenditures as percentage of GDP	8.9%	12.1%	13.4%	17.4%	19.9%

Sources: Drawn from current and historical tables prepared by the Centers for Medicare and Medicaid Services, Office of the Actuary website (www.cms.gov), January 7, 2014. Projections of health expenditures are offered for ten years out from the time of publication, or through 2022, for the most recent year of data (2012). The documents are updated annually.

public and private payers to cover accelerating health care costs, and it anticipates additional need to reconsider health care priorities in the years ahead. These projections are based on the assumption that all major provisions of the Affordable Care Act remain in effect, but even if they do not, there will still be substantial increases in overall health care spending, and there will be a continuing need to find ways to greatly improve the efficiency of the health care system.[46]

State Policy Innovations

The federal government is not the only policy actor trying to contain health care costs; the states also have a role to play, and some states have adopted innovative public policies. For example, as we pointed out in chapter 6, Oregon approved a state health plan that offered Medicaid recipients and others universal access to basic and effective health care. Based on a public-private partnership, the plan included state-run insurance pools, insurance reforms, and a federal waiver allowing for the expansion of Medicaid. The system featured rationing of services based on a ranking of medical procedures that the state and its residents believed to be cost effective. In 2002, Utah also received permission from the federal government to reduce benefits under its Medicaid program and use the savings to bring additional low-income people into the program. Oregon's program has since suffered, as the state's economy deteriorated in the 2000s and it was forced to cut back on benefits. State legislators in Utah were under similar pressure to reduce funding for its program, which was already one of the most generous in the nation.[47]

Other states have long promoted policy innovation. California, for example, developed an aggressive antismoking media campaign and raised tobacco taxes in an effort to get people to stop smoking, a preventive health care action. The goal is to reduce the number of people needing expensive medical services in the future, and thus to improve the economic efficiency of health care programs. By all accounts, the effort has been successful, and the state will likely face a declining rate of lung cancer and other serious illnesses as a result. States have also taken measures to deal with rising rates of obesity, such as limiting access to calorie-laden fast food in public schools.

Some states, as noted early in the chapter, have gone well beyond these limited measures to adopt comprehensive health care plans. Most notably, a landmark plan enacted in Massachusetts in 2006 requires all state residents to purchase health insurance coverage and imposes a financial penalty on those who do not. There is a state subsidy for low-income residents, the poorest of whom are enrolled automatically into the program. The plan also requires employers with eleven or more employees to make a "fair and reasonable" contribution toward their health insurance coverage or to pay a "fair share" contribution annually per employee. Although the plan is potentially costly, supporters point to its coverage of more than 350,000 state residents who previously did not have health insurance. They also highlight the plan's Health Care Quality and Cost Council, which sets goals for improving quality, containing costs, and reducing inequities

Public campaigns. As an illustration of the capacity of state governments to develop innovative public policies when the federal government often cannot or will not do so, some states have targeted smoking as a preventive health measure, and they have used creative ways to do so. The photo shows an e-card from the Tobacco-Free California website. The site also has ads, videos, message boards, and other information about quitting smoking and the harmful effects of tobacco. (*California Department of Public Health*)

in health care. Despite its many successes and serving as a model for what became the national policy under the Affordable Care Act, critics continue to fault the Massachusetts plan for its level of government involvement and costs.[48]

These and many other examples illustrate the pivotal role that the states can play in finding solutions to the emerging health care crisis. Where the federal government has often been unable to act because of the constraints on policymaking that we discussed in chapter 2, states have been able to try different approaches and demonstrate their merits.

Regulation of Prescription Drugs

Given the already high and rapidly rising cost of prescription drugs, another way to control health care costs is to change the way the federal government and drug manufacturers develop and approve new medicines. The current process of drug development is long and expensive, forcing drug manufacturers to charge high prices to cover their cost of research and development. For example, the arthritis drug Enbrel, developed by the Immunex Corporation, can cost patients over $10,000 a year. New drugs that stave off AIDS cost even more, as do some cancer therapies, as noted earlier. In defense of their pricing policies, the drug companies note that, for every successful product, dozens of others never make it to market despite millions of dollars in development costs. Moreover, even drugs that are approved have patent protection against generic competition for only about eleven years.

Is there a way to reduce such costs without jeopardizing the public's health? Or is it more important to maintain a rigorous and demanding drug approval process regardless of the time and cost it imposes? Congress addressed the need for such balancing when it passed legislation in 2007 aimed at expanding the FDA's regulatory powers and budget, particularly for its monitoring of prescription drugs and medical devices.[49] Adding to the concerns that prompted the policy change, some news accounts in 2008 questioned the validity of new drug studies, with allegations that pharmaceutical companies often were ghostwriting medical

Steps to Analysis

Regulation of New Drug Approval

The Food and Drug Administration (FDA) requires pharmaceutical and biotechnology companies to conduct elaborate, lengthy, and costly testing of new drugs before they can be approved for patient use. The justification for this process is to ensure the safety and effectiveness of new drugs prior to marketing. Drug manufacturers have often complained that the FDA procedures are too demanding and delay the availability of new treatments, prevent some of them from reaching the market at all, and contribute to the high cost of new drug development. They also report that a new drug may take as long as ten to fifteen years to develop, with research and development costs reaching $800 million or more.

In response to some of these concerns, Congress enacted the Prescription Drug User Fee Act in 1992, which imposed tight deadlines for new drug evaluation at the agency but also required pharmaceutical companies to pay fees that would permit the agency to hire more drug reviewers, thus reducing the time needed to evaluate and approve new drugs. Reviews are now expected to be completed within ten months, half the time that was common before the act. Priority drugs may be reviewed even more quickly. Yet one consequence of the new procedures is that some drugs are approved even when questions remain about their safety, efficacy, or quality.

Has the United States struck an acceptable balance between the need for a speedy approval process and the necessity to ensure drug safety and efficacy? Is the FDA too cautious? Should the FDA use a special, expedited procedure to approve so-called breakthrough drugs that offer great promise for serious illnesses, such as cancer and heart disease? What about drugs that might be used to combat bioterrorism?

To explore these questions, consider two examples of recent FDA and company actions. In 1999, the FDA approved the pain relief drug Vioxx, a nonsteroidal anti-inflammatory medication. Vioxx was widely used, even though the majority of those taking it could have chosen instead to use safer, more effective, and cheaper drugs that had long been on the market. Then, in 2004, new information appeared on serious side effects of using the drug; those taking Vioxx for a long time faced a doubled risk of heart attack or stroke. The manufacturer, Merck, withdrew Vioxx from the market, and the FDA issued a public health advisory to warn patients to consult with their physicians about use of the drug. Merck faced at least seven thousand lawsuits over the drug, with a potential financial liability of perhaps $50 billion. In 2007, it settled the cases for nearly $5 billion. Was the FDA approval process insufficient in this case? Was its postapproval monitoring of the drug's safety inadequate?[1]

Other drugs present the opposite situation. A drug that may have broad benefits to the population faces a long testing and approval process, thereby denying treatment to those in need of it. Or a drug may be removed from the market because of safety concerns for a segment of the population, leaving others who need the drug with no medication for their disease. One example of the latter is the drug Tysabri, made by Biogen Idec. In late 2004, the company received FDA approval to market Tysabri, one of the few drugs that proved to be effective in treating multiple sclerosis (MS). In February 2005, however, the company voluntarily suspended sales of the drug after concerns arose over extremely rare (but serious) side effects. It then designed new studies to clarify the side effects before seeking FDA approval for more limited use of the drug, which came back on the market in July 2006. In the meantime, Biogen Idec reported that MS patients complained that they could no longer get the drug, or anything else that would help them, and they pleaded with the company to bring the drug back to market as quickly as possible. Should the FDA have demanded such stringent safety testing for the drug even if it meant it would not be available to those in need of it?

1. For a review of similar problems with the FDA approval process, see "Prescription for Trouble," *Consumer Reports*, January 2006, 34–39. For the Vioxx settlement as well as allegations that drug studies may not be as valid as once thought, see Stephanie Saul, "Merck Wrote Drug Studies for Doctors," *New York Times*, April 16, 2008.

research studies about their own drugs that were later published in medical journals as objective scientific evaluations.[50] The box "Steps to Analysis: Regulation of New Drug Approval" deals with these kinds of issues. It focuses on the difficult trade-offs that the FDA faces in trying to move new drug treatments to market. How carefully should it review the safety and effectiveness of new drugs prior to their approval? Is it better to err on the side of caution or to help ensure that we have early access to new medical treatments?

Managed Care Organizations

Managed care, now a fixture of modern health care services and policy, was proposed as one way to contain rising health care costs that had soared under the old system of unrestrained **fee-for-service,** in which the patient or an insurance company pays for the medical service rendered. Over the past several decades, the United States has shifted from fee-for-service to a system dominated by managed care, typically with the costs borne by **third-party payers**. By most measurements, the transition has been successful, particularly in holding down health care costs and promoting preventive health care.

Managed care organizations provide health care by forming networks of doctors, other health care providers, and hospitals associated with a given plan; monitoring their treatment activities; and limiting access to specialists and costly procedures. The best-known managed care organizations are the **health maintenance organizations (HMOs)**. Along with other managed care companies, such as **preferred provider organizations (PPOs)**, they promote health services that are the most cost effective, such as ensuring regular physicals and certain medical screening tests, limiting access to costly services and specialists, and negotiating lower fees with health care providers. PPOs differ from HMOs in that enrollees have a financial incentive to use physicians on the preferred list but may opt to see other health professionals at a higher cost. By most accounts, HMOs and PPOs save the nation billions of dollars a year in health care costs, an important achievement.

Managed care still has its critics, even if by most indications it has been a highly successful design that balances quality health care service with the concern over how to constrain costs. Recent criticism of HMOs has focused on limits placed on patients' stays in hospitals—routinely, only twenty-four hours following childbirth, for example—and denying or limiting coverage for certain procedures. HMOs counter that they are trying to ensure that limited health care dollars are spent efficiently and fairly and that patients be provided with only safe and proven treatments. They fear that expanding patients' rights might lead to the use of unnecessary and possibly dangerous procedures, resulting in higher insurance fees and injuries to patients. They also argue that laws guaranteeing patients the power to select physicians and to sue their health care plans will raise premium costs and leave more people uninsured and vulnerable to health risks.

Following patient complaints and adverse publicity in the 1990s and early 2000s, however, managed care companies changed some of their policies to become

more accommodating than in the past. The evidence suggests they are not denying care in many cases, even though the occasional horror story to that effect pops up in a movie or on television. Indeed, some states, including Connecticut, New Jersey, and New York, require managed care plans to report incidents of care denial and how they were resolved. In these states, plan administrators seem to be reluctant to second-guess physicians, but the plans still deny access to physicians outside of their networks and nonessential or experimental treatments. Economists concerned about rising health care costs think that HMOs and other plans need to be much tougher in overseeing physician decisions to minimize the use of needless and risky surgery and unnecessary and expensive diagnostic tests (Bettelheim 1999).

Reducing Health Care Costs

If managed care has not succeeded in restraining the rise in health care costs, other strategies may emerge to reach that goal. Four of these merit brief mention: (1) passing on additional costs to health care consumers; (2) setting up personal health accounts; (3) managing disease more effectively; and (4) using preventive health care.

Everyone complains about the cost of health care, but the fact is that few people ever see the full price tag because insurance plans take care of most of it.[51] Of course, even simple surgeries can cost thousands of dollars, and many prescription drugs, such as new antibiotics, can run to hundreds of dollars per month. So these relatively low burdens on individuals can escalate quickly if a major health care need arises. But under more normal circumstances, these modest costs borne by individuals suggest that one way to reduce rising demand for health care services and prescription drugs is to pass along more of the cost to them. For example, if employees had to cover more of the costs now paid by their employers' insurance policies, they might have an incentive to reduce their demand for health services that are not essential, such as visiting a hospital emergency room for a nonemergency situation, demanding exotic new drugs when less expensive alternatives exist, or requesting expensive diagnostic tests that a physician believes are unnecessary. Raising the policyholder's share of the cost with higher deductibles and higher levels of co-payments would inject "market discipline" into health care coverage.[52]

A variation on this theme is that individuals who use health services more frequently than average should pay more of the cost, for example, through higher insurance premiums. In other words, the sicker should pay more, just as those with more driving citations or accidents pay higher automobile insurance premiums and those with safe driving records get a break. Is this proposal fair? It might be if the health care consumers brought on their conditions through poor choices over which they had reasonable control. But what about individuals with inherited diseases, or accident victims, or those who simply have the misfortune of suffering from a rare (and expensive) illness? Is it ethical to pass the costs of treatment along to them and their families?

Many employers seeking ways to cope with rising premium costs are setting up personal health accounts for their workers. The employers deposit money into an account that is used to pay for each employee's health expenses that the regular insurance does not cover. The money can be used for prescription drugs, physician visits, dental work, and other health-related bills. Employees make their own decisions about how best to spend the limited funds. Once the money is gone, the employee is responsible for any additional charges that year. These plans may come with a very high deductible, which would make them essentially catastrophic insurance policies; if so, the employee is better off using the plan for a highly unusual major medical need, not routine services. Those who make poor choices, or are unlucky and suffer from a serious injury, or need continuing medical care, may be worse off under such a plan. Is this kind of plan likely to be effective as a compromise to control costs and still cover catastrophic illness or injury?

Disease management programs focus on a few chronic diseases associated with high costs. The programs promise to reduce employers' costs by bringing employee diseases under control more effectively than is likely through conventional medical treatment. Managed care organizations have led the way in developing these kinds of programs. Surveys indicate that a majority of them have implemented programs for managing conditions such as asthma, diabetes, heart disease, end-stage renal disease, cancer, and depression. Their goal is to train patients to take better care of themselves by monitoring their diseases, watching their diets, and seeking appropriate and timely medical care. Some critics are concerned that singling out employees with chronic conditions for the training programs may pose a threat to them. Even some insurance programs believe that disease management of this kind raises difficult ethical issues involving medical privacy and employee-employer relationships. But few question that such programs make many individuals healthier and also reduce health care costs. How would you weigh the ethical issues of disease management?

The compelling logic of preventive care is addressed more fully at the end of the chapter. All agree that if people take good care of themselves throughout their lives, they are likely to be healthier and need less medical care than those who do not. Preventive care health plans usually allow regular physical examinations and diagnostic tests; education and training in diet, exercise, and stress management; and smoking cessation programs.

Quality of Care

The issue of quality in medical care is easy to understand. At a minimum, every patient should expect to receive professional and competent care that is consistent with good medical practice. The physician or other health care professional should be well trained, up-to-date on new research and treatments, and able to spend sufficient time with a patient to properly diagnose and treat medical conditions that arise. These expectations are particularly reasonable in the United

States, given the vast amounts of money invested by government, insurance companies, and individuals in one of the best medical care systems in the world.

The evidence suggests, however, that quality care is not as routinely available as many would like to believe. Patients complain about poor-quality care, and even the American Medical Association concedes that errors in diagnosis and treatment occur at a significant rate.[53] In addition, studies indicate that many physicians rely excessively on costly medical technology and drugs, in part to increase revenues for physician offices and hospitals and in part as "defensive medicine," to guard against liability in malpractice claims. Indeed, a 1991 study put the cost of defensive medicine in the United States at $25 billion per year.[54] Another study in 2002 by the Juran Institute, a group representing large employers, found that $390 billion a year was wasted on outmoded and inefficient medical procedures. The authors argued that poor quality in health care at that time cost the average employer some $1,700 to $2,000 for each covered employee each year. More recently, studies by Dartmouth's medical school questioned the effectiveness of aggressive medical care found in some regions of the country. Patients receiving such care were at increased risk of infections and medical errors, and they didn't benefit appreciably compared to those who received less aggressive care.[55]

If, as patients in HMOs sometimes complain, doctors spend less time with them and access to specialists is limited, are these problems evidence of lower-quality care? They might be, if physicians and other health care professionals are too busy to properly diagnose and treat their patients. It is true that, to cope with rising patient demand and to compensate for lower rates of reimbursement, medical professionals must see more patients per day than they did in the past. Still, it is difficult to measure the quality of medical care.[56] The issue is not likely to go away because the amount of care and patients' perceptions of its quality are closely tied to the factors that escalate health care costs, such as seeing physicians more frequently, gaining access to specialists, benefiting from new medical technology and treatments, and using the latest prescription drugs.

Medical Errors

One element of the concern about the quality of medical care is more concrete and disturbing—the incidence of medical errors. A widely circulated and influential report released in 1999 by the IOM, which is part of the National Academy of Sciences, estimated that between forty-four thousand and ninety-eight thousand patients die each year as a result of medical errors made in hospitals. The errors include operations on the wrong patient or the wrong side of a patient, incorrect drug prescriptions or administration of the wrong dosages, malfunctioning mechanical equipment, and nursing and other staff errors. The study did *not* include medical errors in other health care settings, such as physician offices, clinics, pharmacies, nursing homes, and urgent care facilities, which presumably would add considerably to the overall numbers. Nor did it include the estimated 1.7 million infections acquired in the nation's hospitals each year, which the CDC

Working with Sources

Ethical Issues In Health Care

Some of the most contentious issues in health care involve ethical rather than economic issues. One of the prominent debates in recent years concerned provisions of the Affordable Care Act that related to insurance coverage for contraceptive services. The act requires group health insurance plans to offer Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity (not for men), and to do so without a co-pay or deductible. The law exempted health plans that are sponsored by certain religious organizations or nonprofit organizations with religious objections to contraception, such as churches. In addition, the federal government provided some accommodation for eligible organizations that voiced religious objections to such coverage, with the insurance companies rather than the religious organization paying for the contraceptive coverage.

Some organizations and businesses objected to the new mandated coverage even with this accommodation, saying that the requirement to provide cost-free contraceptive coverage violated their religious freedom. That is, they did not want to provide such coverage for their employees. Among the dozen or so businesses objecting to the new law was the arts and crafts store Hobby Lobby, with some twenty-one thousand employees. In November 2013, the U.S. Supreme Court agreed to hear two cases brought by such secular, for-profit corporations, whose owners sought an exemption under the law based on their religious beliefs, and in late June 2014, the Court ruled 5 to 4 in favor of the corporations.

To examine some of the arguments for and against the Affordable Care Act's contraceptive coverage mandates, go to the federal government's website for preventive health care services for women at www.healthcare.gov/what-are-my-preventive-care-benefits/#part=2 to see a review of the services that are covered under the act. For an overview of Planned Parenthood's perspective on the act's contraceptive coverage rules, see www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-statement-final-birth-control-rule-new-report-impact-41554.htm. For the perspective of religious organizations on the new contraceptive coverage rules, go to the website for the United States Conference of Catholic Bishops at www.usccb.org/issues-and-action/human-life-and-dignity/health-care and follow the Contraception link to the Health and Human Services contraceptive services rule.

- What do you see as the main points of contention?
- Is one view more persuasive than another?
- Do you think the ethical issues involved in either support for or opposition to the rules are stated clearly enough?

claims lead to some one hundred thousand deaths every year. The CDC findings have led many hospitals to adopt new procedures to try to cut infection rates, with some measure of success.[57]

To put the IOM study into perspective, using the lower number of forty-four thousand deaths per year would make medical errors in hospitals the eighth-leading cause of death in the United States, higher than motor vehicle accidents, breast cancer, and AIDS.[58] Aside from the dire consequences for the patients, including injuries as well as death, medical errors are expensive. The IOM study estimated that they cost the nation $37.6 billion each year, about $17 billion of which is associated with preventable errors.

The IOM called for a new federal law to require hospitals to report mistakes that cause serious injury or death to patients, just as they are supposed to report disciplinary actions against doctors. Initially, federal health officials were unwilling to back such a proposal without further study.[59] In 2005, however, Congress approved, and President Bush signed legislation that establishes procedures for voluntary and confidential reporting of medical errors to independent organizations that are to submit the information to a national database. After analysis, recommendations for improving patient safety are likely to follow. It is not clear that such a reporting system will reduce the number of errors, but it has the potential to do so. Further evidence of government commitment to deal with the problem came in late 2008, when the federal Medicare program announced that it would no longer pay for medical errors—what it called "reasonably preventable" conditions on a list it made available to hospitals. Four state Medicaid programs, and some of the nation's largest health insurance companies, also announced that they would not pay for what they called "never events"—that is, medical errors that should never occur.[60] As noted earlier, the Affordable Care Act is likely to be yet another force for reducing medical errors.

Focused Discussion: Should There Be Greater Emphasis on Preventive Health Care?

Throughout the chapter, we have highlighted many of the weaknesses of the U.S. health care system, particularly its high costs and the forecasts for increasing costs as the baby boom generation ages. Much of the debate over health care policy actions, from government programs such as Medicare and Medicaid to employer-provided health insurance plans, focuses on how to pay for expensive health care services. One of the most promising ways to constrain health care costs and also to keep people healthy would be to give greater emphasis to **preventive health care**, or the promotion of health and prevention of disease in individuals. This would include routine screening for serious diseases such as diabetes, heart disease, and high blood pressure; better treatment of chronic illnesses; improved health care education; and more attention to the role of diet, exercise, smoking, and other lifestyle choices that can affect individuals' health. Put otherwise, ill health and premature death are not merely functions of genetics or exposure to disease-causing microbes or environmental pollutants over which individuals have little control. They also reflect choices people make in their daily lives.

For this focused discussion we turn to selected efforts of this kind, particularly those involving smoking and diet. We evaluate them in terms of the criteria we have emphasized in the chapter and throughout the book: effectiveness, economic efficiency, and equity and other ethical issues. That is, we want to see how effective preventive health care measures might be in improving health; what

they might save in costs to the nation; and how we can appraise the wisdom of such policy actions in terms of ethical issues, including possible infringement on individuals' right to behave as they choose without government regulations or pressures to change their lifestyles.

Effectiveness

One way to appreciate the importance of preventive health care is to consider the leading causes of death in the United States. Heart disease and cancer are dominant, followed by chronic respiratory diseases such as emphysema and cerebrovascular diseases or stroke. Among the leading contributing factors in all of these cases are smoking, diet, lack of exercise, stress, and exposure to environmental pollutants. Moreover, even where the causes can be found elsewhere (such as in genetic predisposition to certain diseases), early detection and treatment can both save lives and lower the costs of treatment. For chronic diseases such as diabetes and high blood pressure, regular monitoring of those conditions and use of appropriate medical treatments could improve the quality of patients' lives, reduce premature death rates, and save money, all at the same time.

Take the issue of smoking. It is widely recognized to be the single most preventable cause of premature death in the United States, accounting for more than 480,000 deaths annually, according to the CDC, and another 16 million suffer from a disease attributable to smoking. Secondhand smoke takes an additional health toll, accounting for an estimated 42,000 deaths a year. Roughly half of those who smoke die prematurely from cancer, heart disease, emphysema, and other smoking-related diseases, and the CDC estimates that on average smokers die ten years earlier than nonsmokers.[61] If there is good news related to smoking it can be found in the number of Americans who have quit. An estimated 48 million people have stopped smoking, while about 42 million people continue to smoke. Of those eighteen years of age or older, smokers account for about 18 percent, the lowest level since the mid 1960s. The U.S. surgeon general's reports indicate that smoking cessation at any age conveys health benefits; for example, quitting even at age sixty-five can reduce the risk of dying from some diseases by as much as 50 percent.[62] The recent marketing of e-cigarettes that deliver nicotine without the harmful ingredients may help some to quit smoking, and they are rising sharply in popularity; their sales doubled from 2012 to 2013. Yet experts continue to debate their safety, and some are concerned that, at least for some users, e-cigarettes may prolong their habit of smoking.[63]

Or consider the role of diet and insufficient exercise to prevent excessive weight gain. The surgeon general has observed that, left unabated, "overweight and obesity may soon cause as much preventable disease and death as cigarette smoking."[64] Recent studies by the CDC indicate that nearly 36 percent of U.S. adults age twenty or older, more than 78 million people, are obese, as are about 17 percent (12.5 million) of children and adolescents. Another 34 percent of the adult population is overweight, and the number of young people who are overweight has tripled since 1980. After increasing for years, the prevalence of obesity

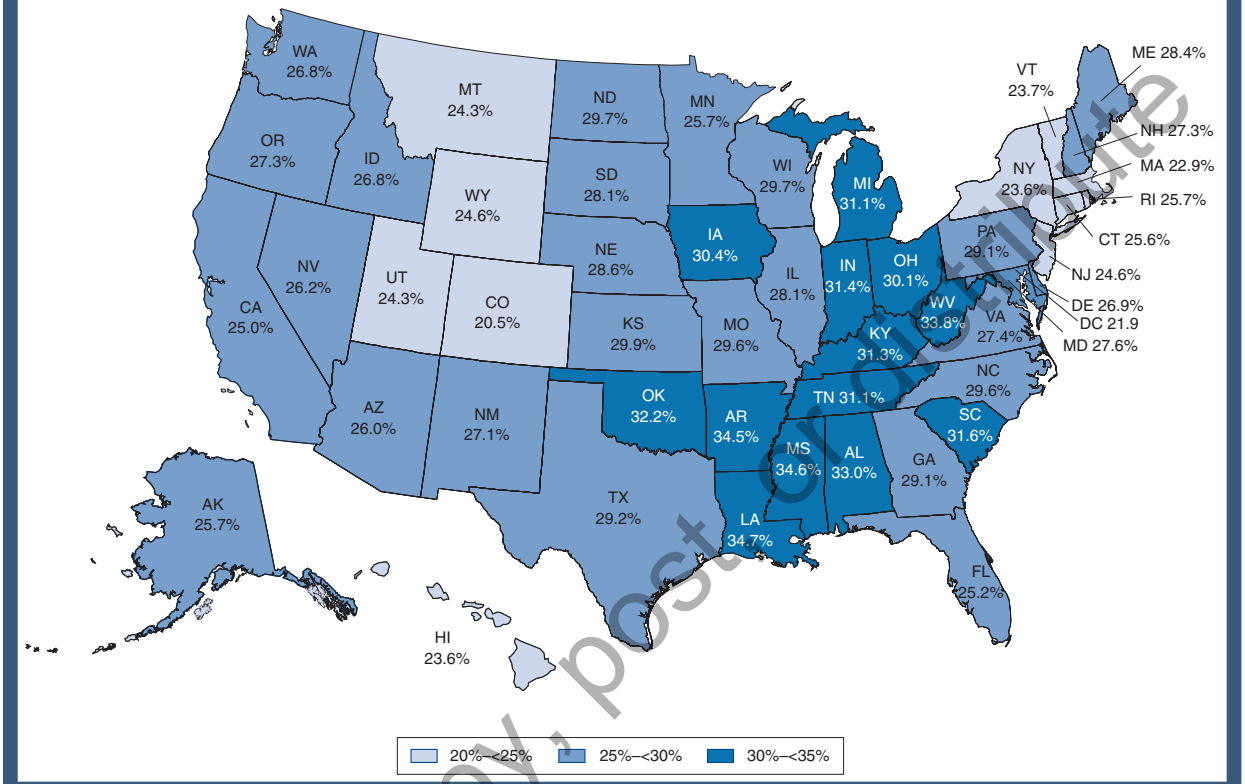
declined slightly from 2003 to 2010, as did the prevalence of extreme obesity, and a report released in February 2014 found an astonishing drop over the past decade in the obesity rate for very young children (ages two to five). The finding was important because children who are overweight between the ages of three and five are five times as likely as others to be either overweight or obese when they reach adulthood.[65]

As might be expected, the rates of obesity and overweight vary substantially from state to state, with some states such as Colorado, New York, and Vermont having comparatively low obesity rates (25 percent or less) and others such as Arkansas, Mississippi, and West Virginia having relatively high rates (more than 33 percent). (See Figure 8-1.).[66] Being overweight, which for some is beyond their control because of genetic and other factors, increases the risk of many health problems. Among them are hypertension, high cholesterol levels, type 2 diabetes, coronary heart disease, and stroke. Taken together, these are so important that a 2005 study projected an eventual decline in U.S. life expectancy because of obesity trends and their associated health problems.[67]

The American diet is a strong contributing factor in obesity for both children and adults, with increasing reliance on prepared foods high in calories, fat, and cholesterol. Some critics single out the $800 billion food industry for much of the blame, saying it undermines good nutrition by strongly promoting sales of unhealthy food (Nestle 2002). Not surprisingly, the food industry rejects the charge, and it has fought hard in Congress and state legislatures to protect itself against any legal liability for the nation's collective weight gain.[68] Some analysts have favored the imposition of taxes on unhealthy food, such as sugary soft drinks, much as we have taxed and regulated cigarettes to discourage their use, and the idea has gained some traction in recent years.[69] It should be said as well that some studies indicate that once obese or overweight, many people find it extraordinarily difficult to lose the extra pounds and keep them off, thus suggesting the logic of early intervention in obesity prevention programs.[70]

By most accounts, Americans also fall well short of the recommended levels of physical exercise and fitness, and they drink too much alcohol. Both habits contribute to poor health. Recent studies show that at least a portion of the national weight gain can be attributed to declining physical activity at work, as more jobs become sedentary or require only very light activity—for example, being seated at a desk and using a computer for much of the workday.[71] About one in ten adults reports consuming alcohol excessively, with higher percentages among younger adults. Despite these habits, life expectancy in the United States reached an all-time high of 78.7 years in 2011—which, however, placed it only number twenty-six among the thirty-six Organisation for Economic Co-operation and Development (OECD) nations, behind Canada and Germany but close to the Czech Republic and Poland. Life expectancy is slightly higher for women and somewhat lower for men, and there are large and growing disparities between rich and poor citizens, which parallels growth in U.S. income inequality over the past several decades.[72] It is reasonable to assume that average life expectancy would be even higher if people took better care of themselves throughout their lives, and also higher if more people had regular access to health care services.

Figure 8-1 State Obesity Rates, 2012



Source: Centers for Disease Control and Prevention, "Overweight and Obesity: Adult Obesity Facts," www.cdc.gov/obesity/data/adult.html, accessed June 27, 2014.

Economic Efficiency Issues

Consistent with the information provided in the previous section, many advocates of preventive health care defend such initiatives as providing economic benefits. That is, spending money on preventive health care would pay substantial dividends, both financially and in improved health and well-being. For example, a 2009 article in *Health Affairs* put the cost of obesity at $147 billion per year in 2008, up from $78 billion in 1998, and another study in 2012 estimated that obesity accounted for $190 billion in U.S. health care costs at that time. These studies indicate the potential savings if the nation found effective and acceptable ways to reduce our collective waistlines.[73] In addition, some studies make clear that health care for obese and overweight individuals can cost considerably more (about 37 percent more on average) than for those of normal weight.[74] As one example, type 2 diabetes, strongly associated with being overweight, currently ranks number one in

direct health care costs, at more than $218 billion a year in the United States; this number is projected to rise to $500 billion a year by 2020, when half of Americans are expected to have diabetes or prediabetes.[75] Excessive weight also has been linked to more than a hundred thousand cancer deaths per year.[76] Studies like the ones cited here have helped to convince the federal government to spend more on antiobesity therapies and to increase support for research on obesity.

Experience at the state level tells much the same story. The state of West Virginia, for example, found that the cost of obesity for its state employees more than doubled since 1995; it is now about one-fifth of the health plan's cost. An even more striking study comes from California. In 2005, a report put the cost of obesity to businesses and the state itself at $22 billion per year in lost productivity, increased medical costs, and higher insurance payments. The report was the first to link such weight problems to increases in employer costs. The study concluded that a 5 percent increase in physical activity could save businesses and the state $6 billion each year; a 10 percent increase could save nearly $13 billion.[77] Numbers like these suggest that both state governments and businesses would be wise to give serious thought to programs that promise to reduce weight gain. Analysts have long made similar arguments about the costs of smoking, which are estimated to result in about $150 billion in health-related economic losses each year.

Equity and Other Ethical Issues

As suggested in the discussion above, taking action on preventive health care should be evaluated not only on the grounds of effectiveness and efficiency but also in terms of ethics. One of the concerns is equity, or fair treatment for all groups in the population, and another is whether governments (or employers) are justified in taking actions that may impinge on individual rights.

Consider the case of smoking. Do the statistics presented above make for a strong case for further government intervention to reduce smoking and therefore smoking-related disease? For example, should government further raise the price of cigarettes to discourage their use? Studies show that increasing the price of cigarettes can substantially decrease the number of young people who become smokers, and that restrictions on smoking in workplaces and public places can decrease smoking by young adults (Tauras 2005). But does this mean that it is right for government to restrict smoking, particularly among adults who choose to smoke? Should state and local governments become more aggressive in restricting smoking in public places? Would it be right for employers to refuse to hire employees who smoke, or to fire those who do, based on the impact on their health and the cost to the employer? In all of these illustrations, it is easy to see that smokers might well feel they are being treated unfairly as a group even if they acknowledge the possible health care costs of their habit.

Lifestyle choices and wellness activities also are part of the equity question when it comes to provision of generous prescription drug coverage or other health care insurance benefits. Some would argue that heavily subsidized coverage of drugs and other medical expenses discourages individuals from making sensible lifestyle

decisions regarding diet, weight, exercise, and smoking. Individuals may believe that medical science will be able to treat any resulting illness with no cost to them, so they have little incentive to take responsibility for such choices. However, if they were responsible for more of the eventual cost, they might make different choices.[78]

Given the arguments here for effectiveness, efficiency, equity, and other ethical issues, would you favor a major shift on the part of government, employers, and insurance companies toward emphasizing preventive health care? What reasons do you find most persuasive? What reasons might lead you to challenge such a recommendation?

Conclusions

This chapter traces the evolution of government health care policies and examines the leading programs. It emphasizes issues of cost, access, and quality, and the diverse ways government activities affect the public's health and well-being. The present array of health care programs, from Medicare and Medicaid to innovative state preventive health measures and provisions of the new Affordable Care Act, may seem complex and confusing to many, and it strikes health care professionals the same way. Students of public policy, using the criteria discussed in the text, can evaluate all of these programs against standards of effectiveness in delivering quality health care services, efficiency of present expenditures in terms of the benefits received, and equity in access to and payments for those services. Many analysts, policymakers, health care professionals, and patients alike find strengths and weaknesses in this system in terms of all three criteria. The strengths merit the praise they have received, but the weaknesses need to be addressed as well.

Rising costs alone suggest the imperative of change. As we have shown, the costs threaten to bankrupt the Medicare system as the baby boom generation ages. Employers and individuals face similar hurdles in meeting the anticipated increases in insurance policy premiums and almost certainly higher deductibles and co-payments. Health care policy therefore would profit greatly from critical assessments that point to better ways of providing affordable and high-quality health care to the U.S. public in the future. The questions posed throughout the chapter encourage such assessments, from how best to reform Medicare and Medicaid to the effectiveness of many state efforts to constrain costs to the promotion of health education, wellness training, and other preventive health care measures. Fortunately for the student of public policy, information to help design more appropriate health care policies and institutions is widely available on the Internet through government and independent sites.

DISCUSSION QUESTIONS

1. Consider the data provided in this chapter on the rising cost of health care services. What are the most effective ways to control these costs? Try to think of several alternative ways to do so, and then compare them in terms of the criteria of effectiveness, efficiency, and equity.
2. In light of the chapter's discussion of the consequences of being uninsured, what else should governments do to meet the needs of Americans without health care insurance beyond what the Affordable Care Act does?
3. Should employers continue to carry the burden of providing health care benefits to employees, or should the government institute a form of national health insurance instead? What difference might this make for the ability of U.S. companies, such as automobile manufacturers, to compete internationally when most other developed countries provide national health insurance?
4. Was Congress right to approve the new Patient Protection and Affordable Care Act in 2010 despite unanimous opposition by Republicans and considerable doubt about it among the American public? What provisions in the act ought to be kept, and which would you favor repealing or replacing with something else, and why?
5. What kinds of public policies might be designed to give individuals more incentives to remain healthy and reduce demand for costly health care services?

KEYWORDS

Affordable Care Act 265
Children's Health Insurance Program (CHIP) 275
fee-for-service 284
health maintenance organization (HMO) 284
managed care 284
Medicaid 274
Medicare 270
merit good 267
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MAJOR LEGISLATION

Balanced Budget Act of 1997

Children's Health Insurance Program Reauthorization Act of 2009

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Employee Retirement Income Security Act of 1974 (ERISA)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Health Security Act

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Patient Protection and Affordable Care Act of 2010

Social Security Act Amendments of 1965

Veterans' Health Care Eligibility Reform Act of 1996

SUGGESTED READINGS

Thomas S. Bodenheimer and **Kevin Grumbach,** *Understanding Health Policy*, 6th ed. (New York: McGraw-Hill, 2012). A broad introduction to the field of health care policy.

CQ Researcher, *Health Care Issues: Selections from* CQ Researcher (Washington, D.C.: CQ Press, 2011). Selections dealing with a diversity of health policy issues, including health care reform.

Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton, N.J.: Princeton University Press, 1997). A review of the failure of Clinton's national health care plan of 1993.

Lawrence R. Jacobs and **Theda Skocpol,** *Health Care Reform and American Politics: What Everyone Needs to Know*, revised and updated edition (New York: Oxford University Press, 2012). A history and assessment of the politics of the Affordable Care Act of 2010.

Theodore R. Marmor, *The Politics of Medicare*, 2nd ed. (Hawthorne, N.Y.: Aldine de Gruyter, 2000). An insightful assessment of Medicare's history and success.

Kant Patel and **Mark E. Rushefsky,** *Health Care Politics and Policy in America*, 3rd ed. (Armonk, N.Y.: M. E. Sharpe, 2006). A major text in health care policy that covers the full spectrum of issues.

SUGGESTED WEBSITES

www.citizen.org/hrg. Public Citizen's Health Research Group, with extensive links to policy issues and citizen activism.

www.cms.gov. Centers for Medicare and Medicaid Services within the Department of Health and Human Services, with extensive links to federal and state health care programs.

www.hhs.gov/healthcare/rights/index.html. The federal government's portal for health care information, particularly related to the Affordable Care Act.

www.kff.org. Kaiser Family Foundation, respected by both liberals and conservatives for its reliable health care studies and reports. Written for the general public.

www.rwjf.org/en/topics/rwjf-topic-areas/health-policy.html. Robert Wood Johnson Foundation's health policy page. Research and policy analysis on health care issues, with a progressive leaning.

NOTES

1. The cost estimates come from the federal Centers for Medicare and Medicaid Services, Office of the Actuary, and are based on the National Health Expenditure Accounts, with detailed reports available at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf. See also Annie Lowrey, "In Hopeful Sign, Health Spending Is Flattening Out," *New York Times*, April 28, 2012.
2. Ceci Connolly, "'We're Not Getting What We Pay For': Experts Say U.S. Health Care Is Inefficient, Wasteful, and Sometimes Dangerous," *Washington Post National Weekly Edition*, December 8–14, 2008; Elizabeth Rosenthal, "The 2.7 Trillion Medical Bill," *New York Times*, June 1, 2013; and Annie Lowrey, "Study of U.S. Health

Care System Finds Both Waste and Opportunity to Improve," *New York Times*, September 11, 2012.

3. See Reed Abelson, "While the U.S. Spends Heavily on Health Care, a Study Faults the Quality," *New York Times*, July 17, 2008; Connolly, "'We're Not Getting What We Pay For'"; and Rosenthal, "The $2.7 Trillion Medical Bill." The Commonwealth Fund study can be found at the group's website: www.commonwealthfund.org. For an interesting account of how the U.S. health care system compares to that of other nations, see T. R. Reid, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care* (New York: Penguin Books, 2010).
4. Kevin Sack, "Research Finds Wide Disparities in Health Care by Race and Region," *New York Times* online edition, June 5, 2008.
5. The data come from the website for the Kaiser Family Foundation: www.kff.org. The foundation staff regularly survey employers nationwide on the costs of health insurance for employees and report the results. See "Employer Health Benefits 2013 Annual Survey" at the website.
6. For a description of the much-touted Massachusetts plan, see Marilyn Werber Serafini, "The Mass.-ter Plan," *National Journal*, June 10, 2006, 22–27.
7. See, for example, Reed Abelson, Gardiner Harris, and Robert Pear, "Whatever Court Rules, Major Changes in Health Are Likely to Last," *New York Times*, November 14, 2011. See also Lawrence R. Jacobs and Theda Skocpol, *Health Care Reform and American Politics: What Everyone Needs to Know* (New York: Oxford University Press, 2010); and a compilation by the staff of the *Washington Post*, *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All* (New York: Public Affairs/Perseus Books, 2010).
8. See Adam Liptak, "Supreme Court Upholds Health Care Law, 5–4, in Victory for Obama," *New York Times*, June 28, 2012.
9. For a detailed summary of the act, see Marian Jarlenski and Richard Rubin, "Health Care Overhauls's Key Parts," *CQ Weekly*, April 12, 2010, 914–922.
10. See, for example, Sharon Begley, "The *Best* Medicine," *Scientific American*, July 2011, 50–55; and Jocelyn Kaiser, "Health Bill Backs Evidence-Based Medicine, New Drug Studies," *Science* 327 (March 26, 2010).
11. See Robert Pear, "New Health Initiatives Put Spotlight on Prevention," *New York Times*, April 5, 2010.
12. See a special report, "Questioning the Cost of the Health Care Overhaul," *New York Times*, April 3, 2010.
13. See, for example, "In Florida, Opposition by the State and Snags in Signing Up on the Web," *New York Times*, October 10, 2013. See also Emily Ethridge, "Medicaid Expansion a Tough Call for GOP," *CQ Weekly*, June 17, 2013, 1037–1038.
14. Marilyn Werber Serafini, "Grading Reform," *National Journal*, March 27, 2010, 30–36. On enrollment in the new plans, see Robert Pear, "Administration Details Late Surge in Health Enrollments, *New York Times*, May 1, 2014.
15. For a revealing picture of health care around the world that includes a review of the British system, see the PBS *Frontline* documentary "Sick Around the World," available with discussion, interviews, and analysis at www.pbs.org/wgbh/pages/frontline/sickaroundtheworld.
16. The data come from the annual Employer Health Benefits Survey conducted by the Kaiser Family Foundation, available at its website: www.kff.org.
17. Ibid.
18. The numbers come from the Kaiser Family Foundation website (http://kff.org/statedata/) and represent the uninsured from ages zero to sixty-four for 2011–2012. The data are regularly updated.
19. Stan Dorn, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality" (Washington, D.C.: Urban Institute, 2008), available at www.urban.org/publications/411588.html.
20. World Health Organization, *World Health Statistics 2013*, available at the WHO website:

www.who.int/gho/publications/world_health_statistics/en/index.html.

21. Taken from "America's Health Rankings," 2011, available at www.americashealthrankings.org. The data are presented on an interactive map of the United States, allowing quick access to individual state health care data.
22. For a clear discussion of all these provisions, see Mary Agnes Carey, "Provisions of the Medicare Bill," *CQ Weekly*, January 24, 2004, 238–243. It is interesting that Congress chose to devise such a complex drug plan when the federal government already has one that is widely considered a model. This is housed within the veterans' health care program. See Robert Pear and Walt Bogdanich, "Some Successful Models Ignored as Congress Works on Drug Bill," *New York Times*, September 4, 2003.
23. Government Accountability Office, "Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments" (Washington, D.C.: GAO-11–409T, March 9, 2011); and a follow-up study, "Medicare Fraud: Progress Made, but More Action Needed to Address Medicare Fraud, Waste, and Abuse" (Washington, D.C.: GAO-14–560T, April 30, 2014).
24. Robert Pear, "Cost of Rampant Mental Health Care Fraud Soars in Medicare," *New York Times*, September 30, 1998.
25. Gilbert M. Gaul, "Medicare's Chronic Condition," *Washington Post National Weekly Edition*, August 1–7, 2005, 6–9.
26. See, for example, "Rita F. Redberg, "Squandering Medicare's Money," *New York Times*, May 25, 2011.
27. For one short list of how to reform Medicare, see "Working with Medicare," *New York Times*, December 18, 2011. As noted earlier, the Affordable Care Act includes many provisions aimed at improving care under both Medicare and Medicaid and controlling rising costs.
28. A comprehensive review of Medicaid and its future can be found in Rebecca Adams, "Medicaid on the Edge: Balancing Cost and Coverage," *CQ Weekly*, May 22, 2004, 1223–1238. See also Joanne Kenen, "Medicaid's Home for Aging Millions," *CQ Weekly*, May 16, 2011, 1046–1048; Sandhya Somashekhar and Karen Tumulty, "With New Year, Medicaid Takes on a Broader Health-Care Role," *Washington Post*, December 31, 2013; and Sabrina Tavernise, "Law's Expanded Medicaid Coverage Brings a Surge in Sign-Ups," *New York Times*, January 20, 2014. A summary of the provisions of the Affordable Care Act dealing with Medicaid can be found at www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html.
29. The data come from the CMS report "National Health Expenditure Projections 2012–2022," 2012, available at www.cms.gov.
30. See, for example, Kevin Sack and Katie Zezima, "Growing Need for Medicaid Strains States," *New York Times*, January 22, 2009.
31. Robert Pear, "Budget Accord Could Mean Payments by Medicaid Recipients," *New York Times*, December 20, 2005.
32. Alex Wayne, "Congress Defies Bush on SCHIP," *CQ Weekly* online edition, October 1, 2007; and Robert Pear, "Health Bill for Children Is Passed by Senate," *New York Times*, January 30, 2009.
33. Clifford J. Levy and Michael Luo, "New York Medicaid Fraud May Reach into Billions," *New York Times*, July 18, 2005.
34. Gaul, "Medicare's Chronic Condition." See also Robert Pear, "Oversight of Nursing Homes Is Criticized," *New York Times*, April 22, 2007, an account that suggests lax supervision, even of nursing homes that have been cited repeatedly for mistreatment of patients.
35. See, for example, Michael Luo and Clifford J. Levy, "As Medicaid Balloons, Watchdog Force Shrinks," *New York Times*, July 19, 2005.
36. Greg Miller, "Engineering a New Line of Attack on a Signature War Injury," *Science* 335 (January 6, 2012).
37. GAO, "VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access" (Washington, D.C.: GAO-12–12, Oct 13, 2011).

38. See Shan Carter and Amanda Cox, "One 9/11 Talley: 3.3 Trillion," *New York Times*, September 8, 2011. For another view of the costs of veterans' health care resulting from the wars, see David Herszenhorn, "Estimates of Iraq War Cost Were Not Close to Ballpark," *New York Times,* March 19, 2008. For a much fuller treatment of the subject, see "VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement" (Washington, D.C.: Government Accountability Office, January 2009).
39. Gilbert M. Gaul, "Back in the Pink: The VA Health Care System Outperforms Medicare and Most Private Plans," *Washington Post National Weekly Edition*, August 29–September 4, 2005.
40. See Michael E. Shear and Richard A. Oppel Jr., "V.A. Chief Resigns in Face of Furor over Delayed Care," *New York Times*, May 30, 2014.
41. Elizabeth Becker, "Congress Approves Plan to Insure Military Retirees," *New York Times*, October 13, 2000.
42. David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "MarketWatch: Illness and Injury as Contributors to Bankruptcy," *Health Affairs* online edition, February 2, 2005, available at http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1.
43. The cost data come from the Kaiser Family Foundation and are available at its website: www.kff.org. More detailed reports are available from the CMS at www.cms.gov.
44. Robert Pear, "Investigators Find Repeated Deception in Ads for Drugs," *New York Times*, December 4, 2002. The article summarizes findings from a GAO report. See also Elisabeth Rosenthal, "A Push to Sell Testosterone Gels Troubles Doctors," *New York Times,* October 15, 2013.
45. Extensive data on these trends can be found at the CMS website: www.cms.gov. The CMS actuary staff also offer a detailed discussion of the economic models, assumptions, and calculations that lie behind these kinds of cost projections.
46. For an overview of reform ideas for controlling health care spending, see Marilyn Werber Serafini, "Bending the Curve," *National Journal*, October 3, 2009, 22–28; and Ezekiel J. Emanuel, "Saving by the Bundle," *New York Times*, November 16, 2011.
47. See Carol Anderson, "Squeeze Play," in *Outlook: Health Care*, a special supplement to *CQ Weekly*, June 2005, 24–26; and Lisa Rosetta, "Medicaid Programs May Be on Chopping Block: Cuts Pondered, Poor Utahns Could Find It Difficult to Qualify for Coverage," *Salt Lake Tribune*, January 12, 2009.
48. The plan and its implementation are described in a May 2012 report by the Kaiser Family Foundation, "Massachusetts Health Care Reform: Six Years Later," available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8311.pdf. See also Kevin Sack, "With Health Care for Nearly All, Massachusetts Now Faces Costs," *New York Times*, March 16, 2009; and Marilyn Werber Serafini, "The Lessons of Massachusetts," *National Journa*l, July 18, 2009, 20–27.
49. Drew Armstrong, "FDA Bill Clears after Intense Negotiations," *CQ Weekly* online edition, September 24, 2007.
50. See Stephanie Saul, "Merck Wrote Drug Studies for Doctors," *New York Times*, April 16, 2008.
51. Steven R. Machlin and Marc W. Zodet, "Family Health Care Expenses, by Size of Family, 2002," Statistical Brief 63, Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, January 2005.
52. Cited in "The Unraveling of Health Insurance," *Consumer Reports*, July 2002, 48–53. See also Charles Morris, "The Economics of Health Care," *Commonweal* 132 (online edition, April 8, 2005), for insightful analysis of the need to find more creative ways to limit overuse and misallocation of health care resources.
53. See, for example, "Misdiagnosis Is More Common Than Drug Errors or Wrong-Site Surgery," *Washington Post*, May 6, 2013.
54. See Richard E. Anderson, "The High Cost of Defensive Medicine," available at www.the

doctors.com/TDC/PressRoom/IntheMedia/CON_ID_000697.

55. Milt Freudenheim, "Study Finds Inefficiency in Health Care," *New York Times*, June 11, 2002. The Dartmouth study is reported in "Too Much Treatment? Aggressive Medical Care Can Lead to More Pain, with No Gain," *Consumer Reports*, July 2008, 40–44.
56. For research on health care quality and discussions of national commitment to quality health care, see the website for the Agency for Healthcare Research and Quality: www.ahcpr.gov/qual/measurix.htm.
57. Kevin Sack, "Swabs in Hand, Hospital Cuts Deadly Infections," *New York Times*, July 27, 2007.
58. See Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academies Press, Institute of Medicine, 2000). A summary is available online at http://books.nap.edu/books/0309068371/html/index.html. The high numbers of deaths reported in these studies represent an extrapolation from several state-level studies, including analysis of deaths in hospitals in Colorado, New York, and Utah. Some critics charge that the estimates are too high, and others believe they may be too low.
59. Robert Pear, "U.S. Health Officials Reject Plan to Report Medical Mistakes," *New York Times*, January 24, 2000.
60. Kevin Sack, "Medicare Rules Say, 'Do No Harm,'" *New York Times*, October 1, 2008. See also Tina Rosenberg, "To Make Hospitals Less Deadly, a Dose of Data," *New York Times*, December 4, 2013.
61. The figures come from the CDC, which reports regularly on smoking-related deaths and economic losses, and are available at the CDC website: www.cdc.gov/tobacco.
62. These statistics are taken from the surgeon general's extensive report of 2004, and are available at the CDC website: www.cdc.gov/tobacco.
63. Sabrina Tavernise, "A Hot Debate Over E-Cigarettes as a Path to Tobacco, or From It," *New York Times*, February 23, 2014; and Matt Richtel, "Selling a Poison by the Barrel: Liquid Nicotine for E-Cigarettes," *New York Times*, March 23, 2014.
64. Quoted in a review of Marion Nestle's *Food Politics: How the Food Industry Influences Nutrition and Health* (Berkeley: University of California Press, 2002), by Ben Geman, *National Journal*, June 22, 2002, 1899.
65. The new study is summarized in Sabrina Tavernise, "Obesity Rate for Young Children Plummets 43% in a Decade," *New York Times*, February 25, 2014. The CDC regularly reports on the prevalence of obesity and overweight among Americans on its website: www.cdc.gov/obesity. Use the search engine at the page to find information on these conditions. A significant proportion of Americans, about 69 percent, can be classified as obese or overweight. Obesity is defined as having a body mass index (BMI) of 30 or greater, and being overweight is defined as having a BMI of 25 or higher. On some explanation for the recent decline in obesity rates, see Sabrina Tavernise, "Obesity in Young Is Seen as Falling in Several Cities," *New York Times*, December 10, 2012.
66. Reed Abelson, "F Is for Americans Getting Fatter," July 7, 2011.
67. Charles C. Mann, "Provocative Study Says Obesity May Reduce U.S. Life Expectancy," *Science* 307 (March 18, 2005): 1716–1717. See also Susan Levine and Rob Stein, "Obesity's Toll on a Generation: Experts Predict an Epidemic of Earlier Deaths and Higher Health Costs," *Washington Post National Weekly Edition*, May 26–June 1, 2008, 6–9.
68. Melanie Warner, "The Food Industry Empire Strikes Back," *New York Times*, July 7, 2005.
69. For a comprehensive recent review of the idea, see Mark Bittman, "Bad Food? Tax It," *New York Times*, Sunday Review Section, July 24, 2011. In 2009, Congress approved new powers for the federal government to regulate cigarettes and other forms of tobacco, financed by new fees imposed on the tobacco industry, in the latest

efforts to reduce tobacco use. See Duff Wilson, "Senate Approves Tight Regulation over Cigarettes," *New York Times*, June 12, 2009.

70. Tara Parker-Pope, "The Fat Trap," *New York Times Magazine*, December 28, 2011. See also David H. Freedman, "How to Fix the Obesity Crisis," *Scientific American*, February 2011.
71. Tara Parker-Pope, "Less Active at Work, Americans Have Packed on Pounds," *New York Times*, May 25, 2011.
72. The National Center for Health Statistics in the CDC releases these figures each year. The OECD numbers come from Sarah Kliff, "The U.S. Ranks 26th for Life Expectancy, Right Behind Slovenia," *Washington Post*, November 21, 2013. See also Sabrina Tavernise, "For Americans Under 50, Stark Findings on Health," *New York Times*, January 9, 2013.
73. Neil Munro, "The End of Obesity," *National Journal*, February 6, 2010, 36–42. The 2012 study is J. Cawley and C. Meyerhoefer, "The Medical Care Costs of Obesity: An Instrumental Variables Approach," *Journal of Health Economics* 31, no. 1 (2012): 219–230.
74. The cost estimates come from the journal *Health Affairs* and are reported on its website: www.healthaffairs.org. See also Levine and Stein, "Obesity's Toll on a Generation."
75. Mark Bittman, "How to Save a Trillion Dollars," *New York Times*, April 12, 2011.
76. Munro, "The End of Obesity."
77. David M. Drucker, "A Fat and Lazy State: Obesity Costly for California," *LA Daily News*, April 13, 2005.
78. Morris, "The Economics of Health Care."