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The Amazing Noncollapsing U.S. Health Care System — Is Reform Finally at Hand?

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Amid the myriad social transformations, corporate reorganizations, and policy innovations that have shaken the U.S. health care system, one great, puzzling constant endures. For roughly 40 years, health care professionals, policymakers, politicians, and the public have concurred that the system is careening toward collapse because it is indefensible and unsustainable, a study in crisis and chaos. This forecast appeared soon after Medicare and Medicaid were enacted and has never retreated. Such disquieting continuity amid change raises an intriguing question: If the consensus is so incontestable, why has the system not already collapsed? Perhaps pondering this question can yield insights into the system as the 2008 elections approach.

The diagnosis of imminent collapse rests on three symptoms. First, without affordable universal coverage, the system leaves 47 million Americans uninsured. Second, health care costs are extraordinarily high: the United States spends about 16% of its annual gross domestic product (GDP), or $6,400 per capita, on health care, whereas France, for example, covers virtually its entire population reasonably well at 11% of GDP and half the per capita spending. Third, the U.S. system is in fact a nonsystem, an incoherent pastiche that has long repulsed reforms sought by private and public stakeholders. Yet this diagnosis misses as much as it reveals.

The sources of collapsing coverage are easily sketched. High insurance costs wreak havoc on the private, voluntary, employer-based system, especially in the small-group and individual markets. As costs increase, purchasers drop or limit coverage or charge workers more for it, leading more workers to do without it. Public coverage fills some but not all of the gap. A system in which the number of the uninsured rises by a million each year must surely be toppling.

The problem with this analysis is that the U.S. health care system consists not of two sectors (private and public) but three, one of which, the safety net, rarely gets proper attention and is poorly understood. The safety net encompasses public and voluntary hospitals, community health centers, public health clinics, free clinics, and services donated by private physicians. Configurations of safety-net providers vary markedly among communities, as does their financing, a shifting patchwork of funds from Medicaid, the State Children's Health Insurance Program (SCHIP), the federal disproportionate share program, tax levies, foundation grants, state appropriations, commercial payers,

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and other sources. These institutions often live on the financial edge, but with 11th-hour infusions, they mostly manage to stay afloat. This fact is of paramount importance, for these providers also extend a safety net for the political legitimacy of the health care system as a whole. That Americans who lack coverage can "still get care," as President Bush recently declared, drains moral urgency from the health care reform enterprise.

This self-congratulatory proposition is half true: many of the uninsured can make an appointment or drop in for care at a safety-net venue. Should they become seriously ill, however, and need referrals to specialists, inpatient care, high-tech procedures, or a regimen of prescription drugs, access becomes unpredictable and spotty, an ugly exercise in rationing. Yet this reality seems to sit too many layers down for the American public to appreciate it. Hence the reception to (for example) the Clinton health care reform plan of 1993–1994: why let the government muck up the system for 100% of the population merely to bring it to the 15% who can get health care without it? The problem is not so much deficiencies in the U.S. value system as it is a myopic reading of facts that keeps important values out of political play. The social mythology surrounding the safety net lends the system an eerie stability — which does not augur well for reforms requiring redistribution of resources from the haves to the have-nots.

U.S. health care costs have been in "crisis" for roughly 40 years, and they remain high for several reasons, including administrative overhead, high payments to providers, and the practice of defensive medicine. The key variable, however, seems to be a heavy reliance on specialized services and technology. Managed care was supposed to contain these "excesses," but its unhappy fate shows that the country's medical "style" is less a problem to be solved than an entrenched American cultural construct.

The Flexnerian seeds of scientific medicine began to flower 60 or so years ago when the expanding National Institutes of Health began aggressively charting medicine's endless frontier. The top health policy priority of other Western nations — securing the citizenry's access to care — was in the United States entrusted to private and voluntary arrangements backed up by charity care and the safety net. Federal health policy was primarily about encouraging, producing, and disseminating medical breakthroughs to cure disease. As research grants became central to the missions, budgets, and faculty of teaching hospitals, medical schools, and universities ("academic medical centers"), innovation and specialization became integral to medical education and to U.S. definitions of high-quality care.

To be sure, this configuration is not inviolate: advocates for public health, prevention, and primary care decry the system's inverted priorities; some argue that public policies should more accurately reflect the influence of social determinants on health outcomes; chroniclers of transformation and reorganization highlight the impact of managed care. None of these critics have much dented the medical–cultural nexus, however, and the less rapidly rising health costs of the 1990s triggered a strong backlash against managed care. Nothing in today's strategic portfolio holds much promise of disrupting these formidable medical–cultural continuities, so reformers cannot plausibly promise substantial new efficiencies and savings.

Finally, critics have long contended that the U.S. health care system cannot intelligently address problems of coverage and cost because it is really a nonsystem, a fragmented assemblage of private, voluntary, and public powers that resists any semblance of the planning that a $2 trillion annual enterprise demands. The indictment rings true: the system's stubborn localism ("health is a community affair"), voluntarism (employer-based coverage), privatism (an insurance industry free to reject bad risks or price them out of the market), and federalism (wide variation among states in Medicaid eligibility and services) defy coherent ordering.

For about 20 years, however, pundits have opined that the endless shifting of costs and the disconnect between the independent minds and interdependent fates of powerful groups have grown sufficiently frustrating that they may now accept public policies obliging them to trade some autonomy for security. Reform is indeed on the agenda of all the major relevant groups, but the crucial question is how much political capital they are prepared to spend to make it happen. Despite deep differences in the interests of its members, the axis of opposition that has throttled reform in the past — business, insurance, and providers — still concurs on three points: that reform should not make big government much bigger; that the costs of reform ought not to fall on them; and that other items on their agendas take precedence. Lacking a plausible strategy for defeating these interests, reformers may have to work around them. Doing so may admit major expansions of Med-

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icaid and SCHIP but will not turn the patchwork into a true system.

So, though deeply dysfunctional by most standards, the U.S. health care system remains disturbingly stable. That no one really likes it does not translate into the inevitability of real change. Because the system is unlikely to collapse from within, reformers' best hopes lie with shifts in public sentiment and the election of activist and reform-minded political leaders. Such shifts can happen, as they did with lasting consequences in 1932 and 1964. But big bangs do not guarantee comprehensive health care reforms. Franklin Roosevelt declined to include national health insurance in his package of New Deal programs. Lyndon Johnson won enactment of Medicare and Medicaid but declined to fight for universal coverage. Since 1968, U.S. social politics have proceeded largely to the right of center, and the health care reform ideas whose time seemed to have come in 1993 crashed dramatically.

Underestimating the system's resilience risks leading reform astray yet again, but what exactly should be done is far from clear. No one knows how to infuse moral urgency into the push for universal coverage, make the system's medical style markedly less expensive, and thrust reform to the top of the agenda for powerful interest groups. Careful reconnoitering of historical terrain yields no formulas for success but may at least reduce the prospects of déjà vu.

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Golden Gate to Health Care for All? San Francisco's New Universal-Access Program

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Impatient with the lack of progress at federal and state levels in reducing the number of uninsured Americans, many counties across the United States are seeking their own solutions to the health care crisis. Unfortunately, local efforts to achieve universal coverage often encounter substantial obstacles, including the high cost of insurance plans, the loss of federal and state revenues that benefit the uninsured, and limited authority to mandate insurance coverage.

To broaden access while avoiding these problems, the government of the City and County of San Francisco launched Healthy San Francisco (HSF) in April 2007. Building on the success of an earlier effort to provide health insurance for nearly all the city's children, HSF is a novel initiative designed to make comprehensive health care available to San Francisco's 73,000 uninsured residents (13% of adults under the age of 65 years).[1]

Currently in the form of a phased start-up, HSF is not an insurance program but rather a restructuring of the county's health care safety net. Administered by the San Francisco Department of Health, where I am director of health, HSF's universal-access model features key elements of managed care, such as "medical homes," defined participation and point-of-service fees, and customer service. It provides inpatient and outpatient care, tertiary subspecialty care, prescription coverage, laboratory services, durable medical equipment coverage, and treatment for mental illnesses and substance abuse. (Cosmetic procedures, dental services, fertility treatments, organ transplantation, vision care, and long-term care are excluded.)

All uninsured residents between 18 and 65 years of age are eligible to enroll in HSF regardless of income, employment status, immigration status, or preexisting conditions. During an online application process, clients' eligibility for federal and state programs such as Medicaid is first determined. Those who are eligible can enroll in the appropriate program; those who are not are enrolled in HSF and choose a primary care home from among 14 county and 8 private nonprofit clinics. (As enrollment grows, we hope to broaden the network of providers.) Participants are given an identification card, a handbook explaining how to obtain services, a list of standard point-of-service charges, and access to multilingual customer assistance. Participation is free for residents whose incomes fall below the federal poverty level. Others pay quarterly participation and point-of-service fees (see Tables 1 and 2), with total fees for those at or below 500% of the

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