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THE POLITICAL ECONOMY OF HEALTH IN THE UNITED STATES

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■ **Abstract** The United States pays a high price for its health system, and governments pay about half the costs. At the same time, the United States distinguishes itself by failing to provide health insurance for 15% of its population. In this article, I review research on the politics and economics of health to investigate three questions. Does this spending represent good value? Why does the United States spend so much on health? Finally, what technical and political challenges do policy makers face as they turn away from government solutions and toward market-based solutions to the challenge of balancing costs, access, and quality?

INTRODUCTION

Tax-financed health expenditures constituted nearly 60% of all health-related spending in the United States in 1999 (Woolhandler & Himmelstein 2002, p. 91). Government-sponsored public health and safety programs have led to some of the most important accomplishments of the twentieth century (Centers for Disease Control 1999), while government subsidies and policies have played a central role in the development of the U.S. health care system. Because of these investments, Americans are living longer and they are living better.

On the other hand, the health system that government has promoted is inefficient and unfair. The United States spends 50% more of its gross domestic product on health care than other OECD nations and seems to get less in return (Anderson et al. 2000). In 1960, Canada was spending 5.4% of its GDP on health and the United States was spending 5.1%. By 2000, the United States was spending >13% of its GDP on health (about $1.2 trillion) compared to Canada's 9%. Life expectancy in the United States was 2–3 years shorter, infant mortality was one third higher, and Canada had improved more quickly in both areas since 1960.

A recent report projects that private health insurance premiums will increase by >15% in 2003 (*New York Times* 2002). The Congressional Budget Office projects that federal health program spending will increase from 4% today to nearly 15% of the GDP by 2030 and will surpass Social Security as the most

expensive federal entitlement (Congressional Budget Office 2002). Despite recent reforms making health insurance more portable and expanding public program eligibility for children, the number of uninsured Americans is above 40 million (15% of the population) and rising.

Is the U.S. health care system in crisis? Health care spending in the public and private sectors continues to spiral upward with no end in sight, and with questionable benefits for the nation's overall health. Certainly, health care costs constitute something of a crisis for the governments, businesses, and consumers who pick up the tab. More spending on health means less spending on other programs, higher taxes, less profit, and less disposable income. But a focus on costs alone does not answer the central question—do we get good value for the dollars we spend? Research offers three answers to this question.

First, it is easy to demonstrate that this spending has yielded beneficial health effects (Cutler et al. 1999, Hadley 2002). For example, an additional $4000 investment in treating a heart attack extends a Medicare patient's life by an average of eight months. Five hundred dollars seems a small price to pay for an additional month of life. Cutler et al. conclude (1999, p. 69) that "although we pay more for medical care than we used to, we also get more in return." Murphy & Topel (1999) estimate the economic value of reductions in death rates since 1970 at $57 trillion, well below the cumulative health care costs of the period.

Second, these benefits have come at a high cost. The McKinney Group compared medical services in the United States and Germany and found that the U.S. system was 26.5% more productive but 65% more expensive. The Dartmouth Health Atlas Project documented variations in Medicare costs across the nation and found that the cost of treating a typical Medicare patient is three times higher in some regions (Wennberg & Gittelson 1973, Wennberg & Cooper 1999). Moreover, these higher costs usually do not translate into better outcomes for patients (Reinhardt 2000, Newhouse 2002, Wennberg et al. 2002).

Finally, the most significant benefits of medical care do not come from the most sophisticated and expensive interventions. Many health economists would question whether advances in medical care are responsible for the mortality reductions that are at the center of Murphy & Topel's economic analysis. Figure 1 graphs the percentage of the population that could be expected to survive to a particular age at four points during the last century (Anderson 2001). Clearly, the most dramatic gains occurred between 1900 and 1950, when modern medicine was still in its infancy. Public health innovations were primarily responsible for these gains. Between 1900 and 1960, the death rate from pneumonia, tuberculosis, diarrhea, enteritis, and diphtheria declined by 90% owing to improvements in sanitation and immunizations. Deaths among children <5 years of age declined from 20% of all deaths in 1900 to $<2\%$ today. In 1900, heart disease, stroke, and cancer accounted for 18% of all deaths. These diseases account for 65% of all deaths today, in part because so many more people are living longer (Centers for Disease Control 1999).

Perhaps the best evidence that spending on medical care services is not the primary driver of health differences comes from the fact that other nations have

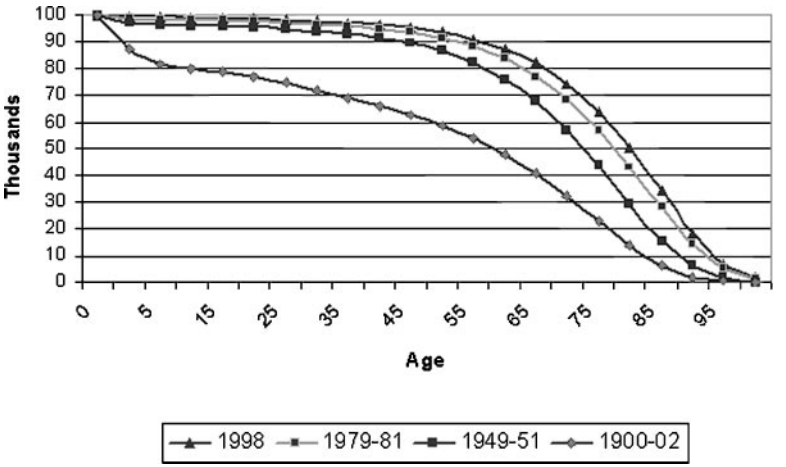

Figure 1 Survivorship rates 1900–1998.

managed to achieve similar mortality reductions with substantially smaller per capita investments. The key drivers seem to be differences in basic living conditions across societies and increased access to basic medical care, such as preventive services and antibiotics, rather than access to the latest technologies (see also Wilkinson 1986, House 2001).

Taken as a whole, these findings suggest that the United States pays a high cost for its health system. It is more productive, but these productivity gains are offset by higher prices. It is more expensive, but these higher costs do not translate into better health outcomes or even similar levels of access.

DEVELOPMENTS AND POLITICS

Most health policy scholars place the initial blame for this situation squarely on the shoulders of private providers and the unwillingness or inability of governments to rein them in. The United States committed itself to this path early in the twentieth century (Skocpol 1997, Hacker 1998, Tuohy 1999). Starr (1984) argues that physicians drew on their claims of expertise and on public suspicion of government to define illness and to turn back repeated government efforts to "socialize" medicine. When the federal government finally did become involved, it did so in ways that explicitly avoided interfering in the practice of medicine. As a result, early developments in the U.S. health care system were oriented toward the priorities and perspectives of medical providers.

The power of the medical lobby and its allies in the insurance and hospital industries during this period is difficult to exaggerate (Morone 1990). Advances in modern medicine made access to health care increasingly important and increasingly

expensive after World War II. Presidents from Truman to Kennedy tried unsuccessfully to address these problems by tiptoeing around the medical lobby. Truman's single-payer proposal was soundly defeated. When Eisenhower proposed his version of Medicare, the American Medical Association vowed to fight it "with every resource" (*Congressional Quarterly Almanac* 1960, p. 163). When Kennedy proposed a different version, he went out of his way to argue that it was not "a program of socialized medicine" (*Congressional Quarterly Almanac* 1961, p. 870). Johnson's first attempt to pass a Medicare program failed just as Kennedy's had. Johnson ultimately succeeded, but only after he asked voters to make the 1964 election a referendum on the issue and won by a landslide (*Congressional Quarterly Almanac* 1964, p. 239).

Medicare represented a radical departure from past federal policies because it made the federal government a purchaser of health care services. Like earlier policies subsidizing the construction of hospitals and medical education, Medicare's reimbursement policies were designed to be as innocuous as possible. Providers were to be reimbursed for each service provided based on "reasonable and customary" costs. (Prepayment, in which providers receive a single payment to provide all required care, existed at the time but was never seriously considered because the independent practitioners represented by the American Medical Association staunchly opposed it.) Medicare Part A offered limited hospital benefits similar to those of private plans. Medicare Part B placed no limits on reimbursement for physician services, although both parts of the program included substantial deductibles and copayments.

The cost implications of these generous policies were probably appreciated at the time. Conservative Ways and Means Chairman Wilbur Mills (D-AR) opposed Medicare for many years, partly because he believed that program costs would rise rapidly without proper controls (Patashnik & Zelizer 2001). For the dominant political coalition, getting the federal government's foot into the door of government-sponsored health insurance was the priority (Marmor 1973, Ball 1995). Fewer than half of the elderly possessed health insurance of any kind. Partly because of the devastating costs of an illness, the poverty rate among the elderly (24%) was twice that of the nonelderly population.

By the 1970s, health care costs were rising about twice as quickly as general inflation. The increased availability of private and public insurance made health care services affordable for an increasingly large segment of the population, and the increased demand created pressure on short-term prices. What was not expected was that prices failed to moderate with increased supply. The primary culprit was soon identified. Rapid medical developments expanded the range of services available to patients, while comprehensive fee-for-service insurance gave both providers and patients little reason to ration access to those services. Newhouse (1996) and Peden & Freeland (1995, p. 235) estimate that 70% of this growth has been the result of "cost-increasing advances in medical services induced by insurance coverage." The standard variables of population increases, changing demographics, and general prices account for less than half of this growth.

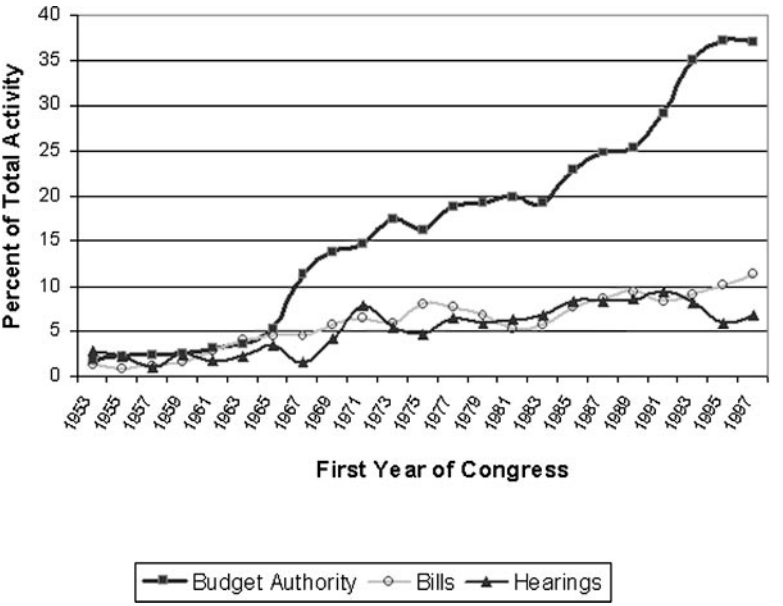

Figure 2 Federal health activity 1953–1998.

Between 1953 and 1998, the percentage of the federal budget devoted to health programs rose from <2% to >36% (Figure 2). Health also consumed an increasingly large share of Congress's legislative agenda, rising from <2% of all bills to nearly 12% in 1998. During the 1970s, federal policy tried to limit utilization of services through health system planning and reforms designed to realign provider incentives (Brown 1982, Ruggie 1992, Patel & Rushevsky 1995, Weissert & Weissert 1996). The Health Planning Act of 1974 required hospitals to demonstrate need for additional services in a community before they could build or expand. The HMO Act of 1973 offered subsidies to stimulate prepaid health systems in which providers profit by limiting unnecessary care rather than by providing it.

During the 1980s, the focus of attention shifted to more direct control over prices. The Prospective Payment System of the Medicare program replaced the "reasonable costs" approach with government rate setting. Diagnosis-related groups (DRGs) reimbursed Medicare providers by diagnosis, instead of for each specific service provided. The 1980s also saw employers becoming more actively involved in efforts to identify private as well as public solutions to the cost problem (Martin 1993, 2000).

Cost concerns did not completely displace concerns about access. National health insurance was on the agenda, to varying degrees, under Presidents Nixon, Ford, Carter, and Clinton. During the 1980s and 1990s, Congress passed laws expanding access and coverage. In 1988, President Reagan signed the Medicare

Catastrophic Coverage Act, only to see it repealed after objections from seniors (Himelfarb 1995, Wilkerson et al. 2002). Medicaid was strengthened. The private long-term care insurance market received a boost. New laws made it somewhat easier for people to change jobs without losing their health insurance coverage and created incentives for states to provide health insurance for all children through age 18 (Patel & Ruschevsky 1995).

These incremental efforts have been beneficial, but they have not come close to solving the access problems they were promoted as addressing. Other nations have placed much less faith in markets and have been willing to negotiate wages, ration care, and limit spending. This is a path the United States is unlikely to take for broader ideological and structural reasons. Comprehensive government reform went out the window with the decisive rejection and political repercussions of the Health Security Act in 1994.

Private and public payers have turned to market competition as the solution to rising health care costs, if for no reason other than an absence of alternatives. Such an approach conforms to a broader ideological shift away from government (Skocpol 1997). However, the assumption that competition will shake out the inefficiencies of the health care market is unproven and theoretically problematic. Left alone, markets cannot be expected to allocate health efficiently, and they will certainly not allocate it equitably. The future of the U.S. health care system will depend on the public and private sectors' abilities to restructure health markets to promote collective goals. To better appreciate the challenges these efforts will face, we need to better understand why health markets fail.

ECONOMIC MARKETS AND HEALTH

Health economists tend to focus on the limits of markets as a means for promoting the efficient allocation of health care services. According to Aaron (2002, p. 33), health markets operate on "faulty price signals" (p. 34) that lead to inefficient transactions. According to Newhouse (2002, p. 16), the "Darwinian process found in most markets does not operate as ruthlessly in medical care."

The normative appeal of competitive markets is that if an equilibrium exists, it is Pareto efficient: Any other distribution cannot make some people better off without making others worse off. The "if" of the theory is that the equilibrium prediction holds only if the market is "competitive." Producers and consumers are assumed to have good information about the prices, values, and choices available in the market. No participant is able to manipulate prices. Producers and consumers consider the total benefits and costs of a commodity in evaluating how much it is worth to them.

Arrow (1963, p. 951) brought health into the mainstream economics literature by arguing that "uncertainty as to the quality of the product is perhaps more intense here than in any other commodity."

Arrow saw professional norms in medicine as responses to consumer uncertainty about the value of medical care. The physician's knowledge "is necessarily

very much greater than that of the patient, or at least so it is believed" and "their relation is colored by this knowledge" (Arrow 1963, p. 946). Through advertising prohibitions, free care, and nonprofit hospitals, providers try to signal that the patient's health, rather than their bottom line, comes first. Through exclusive licensing practices and adherence to socially accepted "best" treatments, providers try to reassure doubtful consumers that they are receiving quality care.

Arrow's explanation stands in sharp contrast to the portrayals of other scholars, who argue that practices such as restrictive licensing were designed not to reassure patients but to limit entry in order to extract rents (Starr 1984). This debate over the motives behind private as well as public policies relating to the medical profession continues today (Arrow 2001, Robinson 2001). Both perspectives are consistent with the facts, and institutions created with one purpose in mind can serve other purposes as well.

In addition to the centrality of uncertainty, Arrow made several other important observations about medical care markets that remain relevant today. First, the normative goal of Pareto efficiency limits the range of possible outcomes to those in which no party ends up worse off than he began. Societies may have good reasons to object to this standard.

Second, some commodities are not marketable because the benefits or costs extend beyond the market participants or into the future. Immunizations, for example, serve a public as well as a private purpose in preventing the spread of illness. For an individual, the cost of an immunization may seem too high relative to its direct benefits. As a result, fewer immunizations will be purchased than is socially optimal. Genetic research benefits the firm that is developing a product, but the same research would also be expected to yield knowledge that benefits other companies and society as a whole. Once again, market incentives alone may lead to investment levels that are below what is socially optimal.

Finally, Arrow notes that Pareto efficiency is a theoretical prediction under an assumed set of conditions. If a health care market fails to meet the conditions for a competitive market, then a decision to rely on market principles to allocate health care may no longer be defendable in terms of economic theory (Arrow 1963, p. 943; Reinhardt 2001). This point is often ignored in public debates about the virtues of markets, which seem to proceed on the assumption that fairly competitive markets yield fairly efficient outcomes. How much efficiency are we willing to trade to promote equity? In fact, economic theory offers no such general reassurance that a market that meets more of these conditions will be more efficient than a market that meets fewer of them.

ROLES OF GOVERNMENT

Many in government and the private sector believe that we are spending too much on health, period. Politically, such perceptions are important because policy makers and their publics may be less supportive of additional health-related spending if they believe that the current system is wasteful or corrupt. Reinhardt (2000,

p. 162) argues that "by its very nature the typical health care transaction lacks legitimacy . . . because health care transactions are not based on the personal cost-benefit analysis that the purchasers of ordinary commodities routinely make in the marketplace."

Much of the literature on the politics of health focuses on why governments of the past have failed to produce health policies that serve the public interest and why governments have failed to act when action was needed. These explanations run the gamut of political science perspectives. Elected officials tend to be most responsive to attentive special interests, and those who bear the direct costs of a policy change tend to be the most attentive (Feldstein 1977, Skocpol 1997, Balbach & Glantz 2000). Minority interests use institutional veto points to thwart the will of the majority (Brady & Buckley 1995, Evans 1995, Steinmo & Watts 1995). Regulatory agencies are captured and end up serving the interests of those they are supposed to regulate (Balla 1998, Huber & Shipan 2002). On the other hand, special interests often have competing agendas that limit their influence (Walker 1991, Peterson 1993, Baumgartner & Talbert 1995). Public enthusiasm is not a necessary condition for policy reform (Jacobs & Shapiro 1995). And nonincremental reforms do sometimes pass despite institutional veto points (Baumgartner & Jones 1993).

In my view, however, the complexity of the underlying issue tends to be underemphasized in this research (Peterson 1995). Governments can intervene for the right reasons and still produce the wrong policies. Reviewing a journal volume on the managed-care backlash, Peterson (1999) noted the authors' consensus that it was real and demanded a political response. But he found "relatively little agreement [among the authors] about which government initiatives are most sensible and how aggressive either state or federal policy makers ought to be in their efforts to soften managed care's hard edge" (Peterson 1999, p. 875). On one hand, there was a legitimate concern that managed care organizations would deny necessary care. On the other hand, there was a legitimate concern that policies limiting abuse would prevent managed care organizations from limiting unnecessary care.

It was not a coincidence that the Health Security Act was developed with the assistance of more than 500 experts and was over 1300 pages long. Nearly everywhere in the health care arena, efforts to reform the system in one area bump up against efforts to advance other goals. Commoner's law in reference to the environment also applies to health: "Everything is connected to everything else" (Commoner 1971, p. 163). Politics aside, creating the proper incentives has been a stumbling block of past efforts by governments and private sector payers to control costs, increase access, and improve quality simultaneously, and it remains the central challenge today.

REDUCING UNCERTAINTY

Costs (not value) have been a central motivating factor for both public and private reform efforts (Oberlander 1995). Both public and private sector payers have been frustrated by their longstanding inability to rein in health care costs. However, it is also important to recognize the challenges facing reformers on the quality side of

the equation. The value of a product is a function of both its price and its quality. An effective health care system rewards providers for the health they produce, not for the services they provide. An efficient health care system maximizes the health produced for a given level of resources.

Critics contend that government reimbursement policies have been ill designed to promote efficiency (De Parle 2002). They note that government policies have a strong status quo bias (Newhouse 2002, p. 17). Medicare payments to health maintenance organizations (HMOs) begin with average costs for the local service area. This practice, which is still in place today, assumes that there are good reasons for costs to be higher in some areas than in others despite a growing body of evidence to the contrary. Regions that have innovated to hold down costs are penalized—exactly the opposite of the policy's intended effect. Across-the-board cuts perpetuate a preexisting bias in favor of expensive, specialized treatment and reward regions with historically high rates of utilization or historically high reimbursement rates.

The same holds true for reimbursements for specific services and diagnoses.

Ambulatory procedure codes (APC) schedules provide higher reimbursements for complicated and intensive procedures, even if no evidence indicates that they are more effective. Diagnosis-related group (DRG) schedules pay a fixed rate to provide all necessary care for a given diagnosis. They too are criticized as not creating incentives that promote efficiency (Wynia et al. 2000). For example, a physician might diagnose and admit a heart attack patient to the hospital and later decide that the patient can be treated on an outpatient basis. The decision to admit places the patient in a DRG that assumes more intensive services and therefore pays more. The physician's subsequent decision to treat the patient on an outpatient basis saves the system money. However, the Department of Health and Human Services interprets such actions as fraud. The assumption is that the provider knows how best to treat the patient, and such erratic behavior indicates an effort to game the system. In this case, the provider could file an amendment to her original diagnosis, but it is probably easier to keep the patient in the hospital.

What is needed is an incentive system that rewards the benefits of the provided service by comparing inputs to outputs. Unfortunately, information about the comparative effectiveness of different treatments or the performance of different providers is the exception more than the rule. Such information is difficult to obtain because it requires an accurate diagnosis of the patient and an understanding of the effect of the intervention. How sick was the patient? If the patient was treated and died, is that evidence of poor care? If the provider did little and the patient died, is that evidence of poor care?

When Medicare first began to contract with private HMOs, the government assumed that managed-care firms would be able to operate more efficiently than traditional fee-for-service Medicare. The reimbursement rate for HMOs was set at 95% of risk-adjusted costs for an enrollee in the service area. It turned out that areas with higher reimbursement rates attracted more HMOs than did areas with lower reimbursement rates. Moreover, in areas with higher rates, HMOs were adding remarkable benefits, such as coverage for prescription drugs, at no additional cost.

Was this evidence of increased efficiency? Or was it evidence of something else? The evidence indicated that HMOs profited not by being more efficient but by attracting healthier Medicare enrollees (De Parle 2002). Medicare HMOs appeared successful in holding down costs because their enrollees used fewer services. Medicare has subsequently altered adjustments for enrollment mix and has reduced payments to HMOs—so much so that HMOs are scaling back benefits or raising premiums, and even fleeing from the Medicare program altogether.

Medical savings accounts (MSAs) have also been promoted as a means for making health care markets operate more efficiently by making consumers more price sensitive (Pauly & Goodman 1995). This argument for MSAs assumes that consumers are able to compare the value of alternative health care services, an assumption that seems to be contradicted by both Arrow's observation that information is what providers sell in a health care system, and by research at RAND (Newhouse 2002, p. 17). The results of the RAND Health Insurance experiment indicate that increased cost sharing led consumers to reduce their number of visits to physicians but had little impact on their use of the most expensive services (Newhouse 1996). Lower costs do not imply increased efficiency if, for example, additional cost sharing deters consumers from seeking out cost-effective preventive services (Hsaio 2001).

Society as a whole benefits from knowing whether a particular approach to health is beneficial or cost-effective, or whether a particular hospital provides quality care. Unfortunately, markets cannot always be counted on to provide the necessary data. Information is often costly to obtain, and the benefits are distributed. Consumers may have good reasons to resist sharing their medical information for the greater good. Providers may resist collecting data, especially high-quality data, because it is time consuming or because it is threatening (Newhouse 2002, p. 20). Recent research suggests that medical mistakes are a leading cause of death in the United States (Kohn et al. 2000). Better information may serve to reduce such mistakes, but it is also damaging to the providers responsible. "Better transparency and speedier communication in U.S. health care actually [have] more powerful enemies than friends" (Reinhardt 2001, p. 987). More generally, information about the effectiveness of treatments is proprietary.

And information, if it is available, may not be used. Consumers (and providers) may not be well equipped to balance the tradeoffs that are often inherent in medical care choices. Providers may believe that proper medical care cannot be guided by statistical patterns, or they may operate according to norms and financial incentives that provide little reason to deny access to treatments that have only marginal benefits. Fully insured consumers may have little incentive to question the decisions of providers, unless they perceive that the interests of the provider are at odds with their own. The moral hazard predicts that consumers who appreciate that generic drugs are largely equivalent to brand-name drugs and are considerably cheaper will nonetheless choose the brand-name drug. Legislators from Florida who complain about rising health care costs will resist reductions in Medicare reimbursements to their state, even if the evidence demonstrates that average costs in Florida are twice as high as another state's with no improvement in health. Corporations may oppose

reforms that would promote greater information sharing because they fear that the end result would be increased state or federal regulation of their health plans.

VALUES BESIDES EFFICIENCY

Information is valued for its ability to reduce waste and harm. But information cannot tell us what our goals are, or how we should trade off among competing objectives. Information can tell us whether angioplasty is more economical than bypass surgery, but it cannot tell us whether we are spending too much on treating heart disease. Information cannot answer the "who counts?" and "what's fair?" questions that are central to health policy debates.

Even in a competitive market, a society may legitimately choose to intervene to promote fairness or to address problems of undersupply and oversupply of public goods. The public may want to control how their medical records are shared. The public may want to subsidize immunizations or weight-loss programs when private insurers are unwilling to provide them. The public may want to tax tobacco products because the market price of cigarettes does not include the future costs of smoking for the individual and society. And of course markets will not allocate health care and health equitably.

Equity concerns have been most visible in reform efforts promoting health insurance coverage for the uninsured. The case can be made that income security, rather than health security, has been the central motivation behind such efforts. Medicare was promoted primarily as a program to protect seniors and their families from financial ruin. In 1994, President Clinton's Health Security Act was a response to public concerns about the tenuous state of the economy. People were worried about losing their jobs and their employment-based health insurance.

Health equity probably requires that policy move in a different direction. Fuchs (1994, p. 109) finds "little evidence either in this country or abroad to suggest that providing universal coverage or changing the delivery system will have significant favorable effects on health, either in the aggregate or for particular socioeconomic groups." Access to health insurance coverage does appear to be related to better health outcomes (Hadley 2002), but other factors are more important in explaining health differences across populations. Income disparities, not health care spending differences, are the best predictors of differences in health status across developed nations. As House puts it (2001, p. 530), conditions of poverty (discrimination and poor housing, sanitation, education, and recreation) are not "promotive of health."

Public health initiatives that extend beyond health care services are controversial, not because they are less effective but because they would primarily benefit the "undeserving" poor (Ingram & Schneider 1993). Medicaid has received much less political support over the years than Medicare, even though two thirds of Medicaid spending supports the elderly and disabled. Improved public housing is good public policy for improving the health of children, but it will be much more controversial than providing those same children with access to health insurance. Needle-exchange programs may be a very effective and inexpensive method for

preventing the spread of HIV/AIDS to children, but they are opposed as supporting the chosen habits of "deviants" (Donovan 1998).

HEALTH AND THE POLITICS OF INDIVIDUAL RESPONSIBILITY

Stone (1989) argues that whether a problem such as the uninsured deserves a government response depends on which causal story ends up dominating the debate. The original logic for health insurance was that illness occurred rarely and was beyond the control of the individual. In this story, the uninsured are victims of circumstances beyond their control. President Clinton reflected on Kerry Kennedy, a small businessman who had "poured his heart and soul, his sweat and blood" into his business but could no longer afford health insurance for his workers because his mother and father, who had started the business, "had become high risks because of their advanced age" (Clinton 1993, p. 1558). Tobacco reform efforts claim to be protecting the health of children, who are victims of unwanted advances by Joe Camel.

On the other side is the argument that health is largely a matter of individual responsibility and choice. Shortly after Clinton gave his speech, Senate minority leader Robert Dole (R-KS) questioned Administration claims of a health crisis by suggesting that many of the uninsured could purchase health insurance but elected not to. [A Kaiser Family Foundation (2000, p. 12) survey of the uninsured found that 19% of uninsured adults felt that they did not need insurance, and 3% cited this as their primary reason for not purchasing it.] Similar arguments about individual responsibility are presented in objection to policy initiatives designed to mitigate the consequences of risky behaviors, such as sexually transmitted diseases, lung cancer, and the growing problem of obesity (Shiltz 1987, Rosin 1998, Kessler 2001).

THE MYTH OF RATIONING

The complaint that government-based reforms will lead to rationing has been a powerful weapon in the arsenal of opponents of health care reform. This claim is undoubtedly true, if only because *any* system for allocating health care services rations. The Health Security Act proposed an alternative rationing scheme to the one that was already in place. The current system places the burden on the 15% of the population that is uninsured. The Health Security Act would have redistributed that burden over the 85% of the population who already had coverage.

The assumption that government-funded health care is less efficient is also far from evident. There are reasons to expect that consumers collectively would get more out of a government-based health care system. Private health insurance has substantially higher administrative costs than the Medicare program, largely because of marketing costs. And, as discussed, much of the health care spending in the United States is wasteful in the sense that more service use does not always translate to better health outcomes. A government-based system might better control

utilization and prices and, as a result, costs. Canada regulates utilization, salaries, and how much the nation spends on health. Although these actions would clearly constitute rationing for those who can currently afford the best in care under the U.S. system, the end result might be increased access and improved population health.

A universal health care system would cost more, but it would not necessarily be less efficient. A government reform that expanded coverage for poorer individuals would be expected to increase utilization and perhaps even raise average costs if wealthier individuals tend to be healthier. But judging whether these higher costs indicate inefficiency requires a comparison of the added costs to the added benefits. Those benefits would include improved health, improved economic productivity, and increased protection from financial hardship.

CONCLUSIONS

The holy grail of health care reform is a proposal that promotes quality and increases access while controlling costs (Reinhardt 2000). Public perceptions that such a reform must exist have been a central stumbling block of health care reform efforts. These three objectives are dynamically related. Most people who lack health insurance cannot afford it. Health insurance costs are high because consumers and providers have weak incentives to limit access to services when those costs are broadly distributed. The existence of dramatic geographic variations in utilization rates without evidence of improved health outcomes suggests that costs could be dramatically lowered, given sufficient political will. This, in turn, would lower overall costs and make health insurance more affordable. More people would purchase insurance. Costs would be distributed even more broadly, reducing premiums once again.

Most Americans believe that we are spending too much on health, but they are also reluctant to embrace the solutions that have been proposed. Polls suggest that Americans (collectively speaking) want it all. They would like to see everyone covered. At the same time, the vast majority of Americans express satisfaction with their own care and have resisted reforms that would limit their own health care choices in order to control costs or provide coverage for others (Brodie & Blendon 1995). The fictional Harry and Louise captured the sentiments of a nation when they rejected the Health Security Act as flawed, while failing to provide any hint of the "better way" they preferred (West et al. 1996).

Policy makers have followed the public's lead. They have tried to address the problem of rising costs while avoiding accusations of rationing (at least for the most politically active constituencies). When policy makers have addressed rationing, they have attempted to make it more difficult for providers to limit access to services, instead of easier. When policy makers have enacted reforms designed to promote greater attention to quality, they have worried too much about short-term political consequences and not enough about long-term benefits. And for the most part, these efforts have had little impact on the problems they were designed to address.

Some suggest that many of these challenges will be resolved as technological advances lower the costs of promoting and preserving health, and warn against reforms that might suppress the innovation that will cause this to happen. Physician Lewis Thomas (1983) argued that the current medical care system emphasizes what he calls expensive "halfway" technologies, such as organ transplants and dialysis, whose purpose is to treat diseases that cannot be cured or managed. The future of medicine, according to Thomas, rests with "decisive technologies" that attack the fundamental underlying causes of illnesses at the molecular level. For example, HIV interventions have become more effective over time, but they remain prohibitively expensive and do little to reduce the spread of the disease. The vaccine that will prevent HIV/AIDS, saving millions of lives and billions of dollars in the process, remains elusive because researchers do not fully understand the biological processes underlying the disease. There are reasons to think that technical evolution may address many of the concerns that seem so problematic today (Gelijns et al. 2001). The past century, indeed the past decade, has witnessed dramatic advances in health and our scientific understanding of the human body. Perhaps technology will soon solve the cost and equity problems that resist simple solutions today.

Belkin (1997) calls such thinking the "technocratic wish," because it appeals to science and objectivity to resolve contentious political issues. As discussed, we also need to consider whether the innovations that we would like to see are the things that markets of the future are likely to produce. The answer to this question is far from obvious, even if our understanding of disease and interventions expands much more rapidly than past patterns would lead us to expect. There will be tremendous advances in our understanding of disease and how to treat it, but the benefits of those advances will be tempered by the same factors that shape health care decisions today. Market actors will always have limited incentives to share information, to promote quality, and to supply public goods. Governments will always have an important role in reshaping market incentives to promote the public interest or in supplying what markets cannot supply. Despite the best wishes of the technocrats, politics cannot be avoided. The challenge of politics, on the other hand, is to persuade governments to focus on the right question: How can health, as opposed to health care services, be allocated efficiently and equitably?

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LITERATURE CITED

Aaron HJ. 2002. A funny thing happened on the way to managed competition. *J. Health Polit. Policy Law* 27:31–36

Anderson RN. 2001. United States life tables. *Natl. Vital Stat. Rep.* 48(18):1–39

Anderson GF, Hurst J, Hussey PS, Jee-Hughes M. 2000. Health spending and outcomes: trends in OECD countries, 1960–1998. *Health Aff.* 19:150–57

Arrow KJ. 1963. Uncertainty and the welfare

economics of medical care. *Am. Econ. Rev.* 53:941–73

Arrow KJ. 2001. Reflections on the reflections. *J. Health Polit. Policy Law* 26:1197–1203

Balbach E, Glantz S. 2000. The implementation of California's tobacco tax initiative: the critical role of outsider strategies in protecting Proposition 99. *J. Health Polit. Policy Law* 25:689–715

Ball RM. 1995. What Medicare's architects had in mind. *Health Aff.* 14:62–72

Balla SJ. 1998. Administrative procedures and the policy process. *Am. Polit. Sci. Rev.* 92: 663–73

Baumgartner FR, Jones BD. 1993. *Agendas and Instability in American Politics*. Chicago: Univ. Chicago Press

Baumgartner FR, Talbert JC. 1995. From setting a national agenda on health care to making decisions in Congress. *J. Health Polit. Policy Law* 20:437–45

Belkin GS. 1997. The technocratic wish: making sense and finding power in the "managed" medical marketplace. *J. Health Polit. Policy Law* 22:509–32

Brady DW, Buckley KM. 1995. Health care reform in the 103rd Congress: a predictable failure. *J. Health Polit. Policy Law* 2:447–57

Brodie M, Blendon R. 1995. The public's contribution to congressional gridlock on health care reform. *J. Health Polit. Policy Law* 20: 403–10

Brown L. 1982. *The Political Structure of the Federal Health Planning Program*. Washington, DC: Brookings Inst.

Centers for Disease Control. 1999. Achievements in public health 1900–1999: infectious diseases. *Morbid. Mortal. Wkly. Rep.* 48:621–29

Clinton WJ. 1993. Address to a joint session of the Congress on health care reform. *Public Papers of the President*, 2:1556–65. Washington, DC: Gov. Print. Off.

Commoner B. 1971. The closing circle: nature, man and technology. In *Thinking About the Environment*, ed. MA Cahn, R O'Brien, pp. 161–66. New York: Sharpe

Congressional Budget Office. 2002. *The Budget and Economic Outlook* (ch. 6). http://www.cbo.gov/showdoc.cfm?index=3735&sequence=0

Congressional Quarterly Almanac. 1960, 1961, 1964. Washington, DC: Congr. Q. Press

Cutler D, McClellan M, Newhouse J. 1999. The costs and benefits of intensive treatment for cardiovascular disease. In *Measuring the Prices of Medical Treatments*, ed. JE Triplett, pp. 34–71. Washington, DC: Brookings Inst. Press

De Parle NA. 2002. As good as it gets? The future of Medicare+Choice. *J. Health Polit. Policy Law* 27:495–512

Donovan MC. 1998. *Taking Aim: Target Populations and the War on Drugs and AIDS*. Washington, DC: Georgetown Univ. Press

Evans LM. 1995. Committees and health jurisdictions in Congress. In *Intensive Care: How Congress Shapes Health Policy*, ed. TE Mann, NJ Ornstein, pp. 25–52. Washington, DC: AEI/Brookings

Feldstein PJ. 1977. *Health Associations and the Demand for Legislation*. Cambridge, MA: Ballinger

Fuchs VR. 1994. The Clinton plan: a researcher examines reform. *Health Aff.* 13:102–14

Gelijns AC, Zivin JG, Nelson RR. 2001. Uncertainty and technological change in medicine. *J. Health Polit. Policy Law* 26:913–24

Hacker JS. 1998. The historical logic of national health insurance: structure and sequence in the development of British, Canadian and US medical policy. *Stud. Am. Polit. Dev.* 12:57–130

Hadley J. 2002. *Sicker and Poorer: Health Insurance, Health, and the Consequences for Work, Income, and Education of a Large Uninsured Population*. Washington, DC: Kaiser Comm. Medicaid and the Uninsured

Himelfarb R. 1995. *Catastrophic Politics: the Rise and Fall of the Medicare Catastrophic Coverage Act of 1988*. Philadelphia: Penn. State Univ. Press

House JS. 2001. Relating social inequalities in health and income. *J. Health Polit. Policy Law* 26:523–32

Hsaio WC. 2001. Behind the ideology and theory: What is the evidence for medical savings accounts? *J. Health Polit. Policy Law* 26:733–37

Huber JD, Shipan CR. 2002. *Deliberate Discretion: the Institutional Foundations of Bureaucratic Autonomy*. Cambridge, UK: Cambridge Univ. Press

Ingram H, Schneider A. 1993. The social construction of target populations: implications for politics and policy. *Am. Polit. Sci. Rev.* 87:334–47

Jacobs LM, Shapiro RS. 1995. Don't blame the public for failed health care reform. *J. Health Polit. Policy Law* 20:411–23

Kaiser Family Foundation. 2000. *National Survey of the Uninsured*. San Francisco: Kaiser Family Fdn.

Kessler DA. 2001. *Question of Intent: a Great American Battle with a Deadly Industry*. New York: Public Aff.

Kohn LT, Corrigan JM, Donaldson MS, ed. 2000. *To Err is Human: Building a Safer Health System.* Washington, DC: Natl. Acad.

Marmor TR. 1973. *The Politics of Medicare*. Chicago: Aldine

Martin CJ. 1993. Together again: business, government and the quest for cost control. *J. Health Polit. Policy Law* 18:359–93

Martin CJ. 2000. *Stuck in Neutral: Business and the Politics of Human Capital Investment Policy.* Princeton, NJ: Princeton Univ. Press

Morone JA. 1990. *The Democratic Wish: Popular Participation and the Limits of American Government.* New York: Basic Books

Murphy KM, Topel R. 1999. *The Economic Value of Medical Research*. Chicago: Univ. Chicago Press

New York Times. 2002. Cost of health benefits are seen rising by 15%. *New York Times* Oct. 15, 2002, p. C6

Newhouse JP. 1996. *Free For All? Lessons from the Rand Health Insurance Experiment.* Cambridge, MA: Harvard Univ. Press

Newhouse JP. 2002. Why is there a quality chasm? *Health Aff.* 21:13–25

Oberlander J. 1995. *Medicare and the American state: the politics of federal health insurance*. PhD thesis, Dep. Polit. Sci., Yale Univ.

Patashnik EM, Zelizer J. 2001. Paying for Medicare: benefits, budgets, and Wilbur Mills' policy legacy. *J. Health Polit. Policy Law* 26:7–36

Patel K, Rushevsky ME. 1995. *Health Care Policy and Politics in America.* New York: Sharpe

Pauly MV, Goodman JC. 1995. Tax credits for health insurance and medical savings accounts. *Health Aff.* 14:125–39

Peden EA, Freeland MS. 1995. A historical analysis of medical spending growth, 1960–93. *Health Aff.* 14:235–47

Peterson MA. 1993. From iron triangles to policy networks. *J. Health Polit. Policy Law* 18: 395–438

Peterson MA. 1995. How health policy information is used in Congress. In *Intensive Care: How Congress Shapes Health Policy*, ed. TE Mann, NJ Ornstein, pp. 79–126

Peterson MA. 1999. Introduction: politics, misperception, or apropos? *J. Health Polit. Policy Law* 24:873–86

Reinhardt UE. 2000. International perspectives on health care reform. In *Social Security and Medicare: Individual Versus Collective Risk and Responsibility*, ed. S Burke, E Kingson, UE Reinhardt, pp. 161–82. Washington, DC: Brookings Inst.

Reinhardt UE. 2001. Can efficiency in health care be left to the market? *J. Health Polit. Policy Law* 26:967–92

Robinson JC. 2001. The end of asymmetric information. *J. Health Polit. Policy Law* 26: 1045–53

Rosin H. 1998. The fat tax. *New Republic* May 18, pp. 18–19

Ruggie M. 1992. The paradox of liberal intervention: health policy and the American welfare state. *Am. J. Sociol.* 97:919–44

Shiltz R. 1987. *And the Band Played On: Politics, People, and the AIDS Epidemic.* New York: St Martin's

Skocpol T. 1997. *Boomerang: Health Care Reform and the Turn Against Government.* New York: Norton

Starr P. 1984. *The Social Transformation of American Medicine*. New York: Basic Books

Steinmo S, Watts J. 1995. It's the institutions stupid. Why comprehensive national health insurance always fails in America. *J. Health Polit. Policy Law* 20:329–72

Stone DA. 1989. Causal stories and the formation of policy agendas. *Polit. Sci. Q.* 104:281–300

Thomas L. 1983. *The Youngest Science: Notes of a Medicine-Watcher.* New York: Viking

Tuohy CH. 1999. *Accidental Logics*. Oxford, UK: Oxford Univ. Press

Walker J. 1991. *Mobilizing Interest Groups in America*. Ann Arbor: Univ. Mich. Press

Weissert CA, Weissert WG. 1996. *Governing Health: the Politics of Health Policy*. Baltimore, MD: Johns Hopkins Univ. Press

Wennberg JE, Cooper MM. 1999. Practice variation and the quality of surgical care for common conditions. In *The Dartmouth Atlas of Health Care for 1999*, ed. Cent. Eval. Clin. Sci. Staff. Am. Hosp. Assoc.

Wennberg JE, Fisher ES, Skinner JS. 2002. Geography and the debate over Medicare reform. *Health Aff.* 21:96–114

Wennberg JE, Gittelson A. 1973. Small area variation in health care delivery. *Science* 182:1102–8

West DM, Heith D, Goodwin C. 1996. Harry and Louise go to Washington: political advertising and health care reform. *J. Health Polit. Policy Law* 21:35–68

Wilkerson JD, Feeley TJ, Scheiereck NS, Sue C. 2002. Using bills and hearings to trace attention in Congress: policy windows in health care legislating. In *Policy Dynamics*, ed. BF Baumgartner, BD Jones. Chicago: Univ. Chicago Press

Wilkinson RG. 1986. Socioeconomic differences in mortality: interpreting the data on their size and trends. In *Class and Health: Research and Longitudinal Data*, pp. 1–20. London: Tavistock

Woolhandler S, Himmelstein DU. 2002. Paying for national health insurance—and not getting it. *Health Aff.* 21:88–98

Wynia MK, Cummins DS, VanGeest JB, Wilson IB. 2000. Physician manipulation of reimbursement rules for patients: between a rock and a hard place. *JAMA* 283:1858–65

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