INTRODUCTION

FIFTEEN YEARS LATER: ANOTHER LOOK AT HEALTH CARE IN AMERICA

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“It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going directly the other way – in short, the period was so far like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only.”

Fifteen years ago the Stanford Law and Policy Review published a symposium issue on the American health care system. I wrote the introduction, which opened with that famous beginning to A Tale of Two Cities. I argued that it was both the best and the worst of times for the American health care system, with exciting and life-extending innovations climbing almost as fast as the cost of health care or the numbers of Americans left uninsured.

Whether or not 1991 was the best and the worst of times for the health care system, it was clearly a time of great excitement. The insatiable increases in health care costs coupled with a sharp recession had increased interest in major reform. That fall Harris Wofford would win a stunning upset victory in a special election for one of Pennsylvania’s seats in the United States Senate, running largely on the issue of health care. The next year the young governor of Arkansas would use that same issue to wrest the presidency from George H. W. Bush.

The 1991 symposium reflected that excitement. Its articles forthrightly tackled some of the biggest questions in health care, focusing broadly on fundamental, system-wide reform. The question was how to proceed,

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1. Charles Dickens, A Tale of Two Cities (New York, Vintage, 1989) (originally published in 1859). It is interesting, in light of the timing of the two Stanford Law and Policy Review symposia, fifteen years apart, that this quotation does not refer, as most people believe, to the time of the French Revolution. The book is quite explicit that the year in question was 1775, a little more than 15 years before the events in revolutionary Paris that make up most of the book.
whether to proceed.

Within three years this health reform fever had broken. Bill Clinton had been elected and he and his wife Hillary had tried, and failed, to extend health coverage to all Americans through a combination of required employment-based coverage and an expanded social safety net. The Republican Party took control of the House of Representatives for the first time in fifty years, in part as a result of that failure. Major health reform was dead and the age of incrementalism was upon us, an age when only small steps were attempted and many of those unsuccessfully.

This 2006 symposium reflects these new political realities. Each of the seven articles featured in this issue addresses a discrete challenge faced by the American health care system; none proposes a fundamental overhaul of the system.

The first article is the closest to an exception. In it, Philip Lee, Thomas Oliver, A.E. Benjamin, and Dorothy Lee analyze the causes of the unmistakable American exceptionalism in health care in terms of the sometimes conflicting strains of the American character, particularly individualism and equality. The authors see a struggle between visions of medicine as a market good and medicine as a public good and call for leadership to better balance “the importance we attach to individualism with the economic and social benefits of greater equality.”

The next two articles deal with the health care financing system, but only about two of its component parts, Medicaid and funding long term care. Governor Jeb Bush lays out his administration’s plan for reforming Florida’s Medicaid program. Medicaid, the joint state-federal program for health care for (some of) the poor, is serving record numbers of Americans—over 50 million—and threatening the budgets of many states. Governor Bush wants “to reinvent Medicaid to create a competitive health care market driven by educated consumers who are empowered to make purchasing decisions for themselves.” Medicaid recipients will be given access to a “premium” with which they will buy their own comprehensive care plans; they will also have access to catastrophic and preventive care plans. One might question whether the Medicaid population—all poor, some institutionalized, many elderly, or developmentally disabled, or children—offers the best opportunity for informed consumer control, but the experiment may be worthwhile.

Christopher Jennings and Christopher Dawe tackle another piece of the health care puzzle, financing long-term care. They point to the crisis that seems

3. The first author, Dr. Philip Lee, is certainly well placed for that assessment, as he has played a substantial role in the last forty years of American health policy. He served as Assistant Secretary for Health in the Department of Health, Education, and Welfare under President Lyndon Johnson and, 30 years later, in the same position in what was then the Department of Health and Human Services under President Bill Clinton.
inevitable when the Baby Boomers hit the nursing homes. In 2002, the last year for which they had data, a year in a nursing home cost $52,000, almost none of it covered by private insurance or Medicare, but instead paid for first out of pocket and then by Medicaid. (Forty percent of Medicaid expenditures are for long-term care.) They seek to invigorate the thus-far unsuccessful market for private long-term care insurance by creating a large new federal benefit, available only to those who have purchased such private insurance. The idea is a novel one in an area that has seemed devoid of many ideas, or much hope. It deserves careful attention, including particularly an analysis of its fiscal and political feasibility.

The third section of this symposium comprises three articles dealing with different ethical questions. Representative Louise Slaughter argues the merits of her bill banning genetic discrimination in health care and employment. As one who has supported her legislation in print, although for complicated reasons, I share her indignation at the fact that a bill that passed the Senate ninety-eight to zero and has been explicitly endorsed by the White House cannot even get committee hearings in the House of Representatives. Nonetheless, though important, this issue is not likely to affect many people.

Professor Robert Vischer then writes on the complex issues raised by the recent moves to include pharmacists and contraception in “conscience clauses,” legislation that allows some health care personnel to refuse to provide some kinds of health care services based on conscientious objections. Vischer argues for what he sees as a new approach, focusing on neither a right of conscience nor a right to health care services, but on a “moral marketplace,” where a hundred consciences bloom, based on the decisions of pharmacy owners, whether local individuals or massive corporations. Vischer’s analysis does not discuss the particular realities of the services involved or the urban, suburban, and rural markets where they would be demanded, but it may provide another useful approach to this genuinely difficult issue.

In the third ethics article, Professor Sandra Carnahan examines the ethical implications of what is sometimes called “concierge medicine,” a personalized and privileged kind of medical care increasingly being offered to those who will pay (much) extra for it. Carnahan nicely describes the effects on the doctor-patient relationship for patients whose doctors move to such a system, leaving them the choice of finding hundreds more unreimbursed dollars for their health coverage or finding a new doctor. She also points out the potential consequences for the overall health care system of doctors shedding eighty to ninety percent of their existing patients, patients who will need to find care

from someone. She makes some interesting suggestions for interventions to limit concierge care; a policy debate that will become more important if concierge medicine ever becomes a significant trend.

The symposium ends with one article on an aspect of the Food and Drug Administration. Professors Lars and Barbara Noah, two of the very few legal academics writing on the FDA, examine the FDA’s authority over dietary supplements. In my view, dietary supplements are the patent medicines of our time, shamelessly promoted to improve every human structure and function with only the barest excuse for proof that they are either safe or effective. The Congress that passed the Dietary Supplement Health and Education Act in 1994 intended to impose a nearly impotent regulatory scheme to prevent the FDA from implementing one with teeth. The Professors Noah, however, find within the “adulteration” provisions of the Act the potential for more powerful FDA oversight of this $20 billion a year business.

Seven substantial articles on seven significant topics, and yet, to me, the contrast with the 1991 symposium is both striking and unsettling. In 1991, the symposium focused on the main issue, the unsustainable path of the overall health care financing system. In 1991, health care accounted for about twelve percent of the American gross domestic product. Its cost had been growing by about ten percent a year. And about thirty-five million Americans had no health coverage at all. In 2006, health care will account for about sixteen percent of the American gross domestic product. Its cost has been growing by about ten percent a year for the last several years. And, on each day during this year, about forty-five million Americans will have no health coverage. The United States continues to spend far more of its GDP on health care than other country—about a third more than its nearest competition—while remaining the only rich country in the world that does not provide health care to all its people. The first is a cause of alarm; the second for shame.

In 1991 I wrote of three hard truths and one bleak scenario. The hard truths were that significant reform could only come from the federal government, that passing meaningful federal reform would be difficult, and that any program is only as good as its implementation. The bleak scenario was that

6. The 1991 introduction noted that Massachusetts and Oregon had recently announced programs for universal coverage that had not gone into effect and predicted that they probably never would. The prediction was correct. Earlier this year Massachusetts passed another universal coverage bill, one that I believe will also run into problems with the preemption provisions of the federal Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1144, and will never go into effect. (There is some question about just what bill will eventually be passed in Massachusetts, as the Republican governor vetoed several provisions of the bill, vetoes the Democratic legislature has vowed to override.) Pam Belluck and Katie Zezima, Massachusetts Legislation on Insurance Becomes Law, NEW YORK TIMES A13 (April 13, 2006).
Sometime in the next decade, responding to ever louder cries of pain from the middle class about diminishing access and from business about increasing costs, the federal government will institute a major reform of the health care financing system. It will either adopt a Canadian-style single payer system of national health insurance, or, more likely, will require employers to cover their workers and dependents while building a social safety net for the rest. The President and Congress will fight over who is to get credit for this breakthrough, the crisis will be “solved,” and the system will soon be in worse shape than ever.7

I was wrong, though not, I think, by much. It is not widely remembered how close the Clintons came to getting comprehensive health reform; in the fall of 1993 the Senate Republicans were looking for common ground. Newt Gingrich and the House Republicans decided to take a hard line and were rewarded with victory, both on health reform and in the 1994 Congressional elections. The Clinton plan’s ignominious demise (not with a bang, but with a whimper) both demoralized proponents of major reform and convinced the practical among them that only incremental changes were currently possible. And the late 1990s saw the combination of an excellent economy and an unprecedented pause in health care cost increases, both taking the urgency out of reform.

But we are not in the late 1990s any longer. Unsustainable trends have returned to the health care system with increasingly serious effects on patients, providers, and employers—just ask General Motors. There is a virtue in trying to take small and achievable steps, but there are also times that require ambitious plans, hopes, and dreams. I ended my 1991 introduction by saying

It is clear that the present system cannot continue in its present path for much longer; the center cannot hold. Whatever our stake in the health care system—as doctor, payer, patient, or citizen—we must prepare to meet the challenge of rebuilding America’s health care system for the next century. This symposium is one small but useful step toward doing so.8

This symposium and its constituent articles are useful steps in improving several individual aspects of our health care system, but they do not address the issues of overarching reform of that system to improve quality, increase access, and control costs. Such reform is hard to write about and is even harder to effect. But we know we cannot continue on the present course, so we know that change must come. Now is the time to take those crucial next steps and confront directly the huge problem of health care reform for this (and our) century.9

8. Id. at 22.
9. Having predicted fifteen years ago that there would be major, albeit probably unsuccessful, reform within a decade, I should perhaps be more cautious about whether the time is right. But I take comfort from the fact that time is on my side – if I keep predicting major reform, sooner or later I have to be right (I believe that sentiment is a paraphrase of a comment made by the great Reggie Jackson about premature predictions of his retirement
while he was playing for the then California Angels in the early 1980s, but I have not been able to find a source for the comment I think I remember. On the other hand, I am unwilling to take his good line without giving him at least some tentative credit.)