INTRODUCTION

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The paradox of the United States health care system is that we spend more on health care than any other country in the world, but we do not benefit from a similar increase in the quality of care being provided.[1] Life expectancy at birth in the United States as of 1998 was seventy-three for males and eighty for females; it was as good or better in England, France, and Chile, all countries with lower total and per capita health care expenditures.[2] The infant mortality rate in the United States was seven per 1,000 in 1998; it was lower in Germany, France, and Sweden in the same year.[3] In other words, the increased investment in the health care system is not producing an increase in the effectiveness of the system, as measured by several outcome measures. This, coupled with the fact that we are again witnessing double-digit increases in annual health care expenditures in the United States, has created a crisis in health care policy formulation and implementation.

The U.S. health care system stands out in three important ways. The first significant characteristic of the U.S. health care system is that it devotes the largest share of Gross Domestic Product (GDP) to health care expenditures of any country in the Organization of Economic and Cooperative Development (OECD). In the middle of the twentieth century, less than five percent of GDP was devoted to health care. That percent had risen to nearly fourteen percent by the end of the century.

The second unique feature of the U.S. system is that it is the only developed economy without some form of universal health care. The

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1. *See*, *e.g.*, Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, HEALTH AFF., May–June 2003, at 89 (comparing United States's health care spending with that of twenty-nine other countries); Sandra Roberts, *Managing Managed Care: No Easy Answers for Regulating HMOs*, INTERGOVERNMENTAL ISSUES, Winter 1998–99, at 1 (discussing the debate over HMOs), *available at* http://www.legis.state.il.us/commission/igcc/98winter.pdf (last visited Nov. 4, 2003).

2. *See* LUCI KOZZUNI & DANIEL B. MOSKOWITZ, HEALTH CARE ALMANAC AND YEARBOOK 352 (5th ed. 2000).

3. *Id.* at 341–42.

U.S. system relies, for the most part, on private providers with a mix of private and public insurance, as well as extensive government regulatory intervention. The third and final feature of the U.S. system is that health care is not a legal right of citizenship, as it is in every other developed economy. Aside from the various kinds of smaller entitlements, for instance the entitlement for federal workers, the federal government has created legal entitlements to health insurance for only those over age sixty-five and those with very low incomes.

With rising health care costs squeezing profits and growing numbers of people without insurance pushing costs even higher, employers are beginning to highlight health care costs and health care benefits as an increasingly important issue. At the same time, employees faced with increased cost sharing, increased cost for health insurance, and the growing number of people without any kind of insurance are also pointing to health care as a "crisis."

As we think about the health care system in the United States, one crucial question is: What are the forces that are driving health care costs, utilization, patient outcomes, and system effectiveness? There are three "actors" who currently have legal standing in the U.S. health care system: patients, providers, and "third-party payers," which, as a group, is comprised of private insurers and the government. The phenomenon of third-party payers for health coverage is a driving force in shaping the health care system in the United States. As recently as 1960, fifty-five percent of health care costs were paid out-of-pocket.[4] By 1998, that number had dropped to under twenty percent. The Health Insurance Association of America (HIAA) reported that health care expenditures rose by over ten percent per year from the 1970s through the early 1980s.[5] It may not be coincidence that health care expenditures, especially in the form called fee-for-service insurance, contained very little incentive for cost control. Under this arrangement, neither the provider nor the patient is at financial risk in making health care decisions. In economic jargon, that is, the marginal cost to either of these participants in the transaction was extremely low, usually zero; however, the marginal benefit of extra health care expenditures, while diminishing, was certainly positive. Because benefits exceeded private costs, it was "rational" for the physician to order more services and tests. The result was ever increasing expenditures on health care.

In the U.S. health care delivery system, there is a fundamental tension between two problems: (1) the rising costs of health care and their impact on the overall U.S. economy; and (2) the problems of the unin-

4. *See* Greg Scandlen, Nat'l Ctr. for Policy Analysis, Policy Backgrounder No. 154: Defined Contribution Health Insurance, Oct. 26, 2000, *at* http://www.ncpa.org/bg/bg154/bg154.html (last visited Nov. 4, 2003).

5. *See* Health Insurance Association of America: HIAA Issue Brief, *Why Do Health Insurance Premiums Rise*, Sept. 2002, at 6, *available at* http://www.hiaa.org (last visited Nov. 4, 2003).

sured Americans (approximately forty-two million or about fifteen percent of the U.S. population). In the context of policy making and health care reform, there is a fundamental tension between these two problems: if we increase the number of Americans with health insurance, then this may induce an increase in overall health care expenditures. This may, however, not necessarily be the case: the uninsured in general have lower health care expenditures than the insured, and these lower costs might be maintained even if they are offered insurance. The reason for worry about uninsured individuals is their presumed inability to obtain medical care because of a lack of ability to pay. In some cases, this lack of ability to pay leads to delays in seeking care and increased health care expenditures later on. The financial implication of this, however, is that providing this group with health care insurance will open a new source of demand for health care services. It is also conceivable, though, that increased access to basic health care services at the appropriate time will lead to reduced health care expenditures in the long run. Of course, this would require a long-term outlook, as the immediate result of increasing access to health insurance would almost certainly increase costs as people access those basic health care services that they have been putting off.

Employers have traditionally viewed the problem of the uninsured as the responsibility of government. But, given the trends cited above, some executives and benefits specialists have come to see the forty-one to forty-four million Americans without health insurance as costing them money as hospitals and doctors raise rates to cover the cost of such care. As health care costs have spiraled upward, more and more small businesses are finding themselves in a position where they can no longer afford to offer their employees health insurance benefits. In cases where employers have not eliminated health care coverage, the higher health care costs have forced them to push more of the premium cost onto the employees. The result has been an overall reduction in employee willingness to take the health insurance benefit.[6] Thus, any success in slowing the increase in health care costs could have the added benefit of slowing the growth in uninsured. While any success in the area of reducing the number of uninsured will carry along added pressure for increased health care expenditures, there are other policies that can be employed to minimize these cost increases.

It appears that one of the most significant factors behind the rise in health care costs is medical technology. The public debate over health care expenditures has put much blame on pharmaceutical prices and increases in outpatient hospital costs. It is also clear, however, that a significant cause of the continued upward pressure on health care costs is

6. *See* Phillip Cooper & Barbara Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996*, HEALTH AFF., Nov.–Dec. 1997, at 142, 142; Henry Farber & Helen Levy, *Recent Trends in Employer-Sponsored Health Insurance: Are Bad Jobs Getting Worse?*, 19 J. HEALTH ECON. 93, 95 (2000).

the constant demand for new and better medical technology. This may prove to be an intractable pressure toward rising health care costs, as we have tried regulatory reform, voluntary restraints, managed care, and market competition, with all of these "solutions" failing to halt the incessant climb in health care expenditures.[7] Many observers fear, moreover, that consumers will never tire of their thirst for better health care and better technology.

The important policy question related to medical technology is whether this development and the resulting higher health care expenditure level are worth it. While health care consumers continue to demand these technological advancements, it could be that the marginal value of some technology does not meet the marginal cost to society. Although there is some evidence that the benefits of such technology greatly outweigh the costs,[8] much more careful empirical work is warranted in this area.

OVERVIEW

Within the context of rising health care costs, the problems of the uninsured, the growth in managed care organizations, and the increasing pressure for reform of the U.S. health care system, the University of Illinois Colleges of Law and Medicine, along with the Institute of Government and Public Affairs and the Nursing Research Institute, sponsored the first Law, Medicine, and Policy conference in March of 2001. The theme of the conference was: "Health Care Reform: Where Are We? Where Are We Going?" The following papers represent some of the revised papers from that symposium.

The first set of papers by Richard Kaplan, Robert Kaestner, and Robert Rich and Cinthia Deye examines the underlying problems and tensions in the employer-based health insurance system, as well as the problems in financing and organization of publicly funded health care programs. Richard Kaplan's paper, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, focuses on the nature of long-term care; how long-term care is provided through a variety of health care service delivery mechanisms; the financing of long-term care through Medicare (the government's health care program for older Americans); the financing of long-term care through Medicaid (the gov-

7. In a significant rebuttal to Drew E. Altman & Larry Levitt, *The Sad History of Health Care Cost Containment as Told in One Chart*, HEALTH AFF.: WEB EXCLUSIVES, Jan. 23, 2002, at w83, *at* http://www.healthaffairs.org/WebExclusives/2101Altman.pdf (last visited Nov. 4, 2003), Bodenheimer argues that one form of government regulation, Medicare and the prospective payment system, has had great success in slowing health care costs, Thomas Bodenheimer, *The Not-So-Sad History of Medicare Cost Containment as Told in One Chart,* HEALTH AFF.: WEB EXCLUSIVES, Jan. 23, 2002, at w88, *at* http://www.healthaffairs.org/WebExclusives/2101Boden.pdf (last visited Nov. 4, 2003).

8. *See generally* Penny Mohr et al., Project Hope, Ctr. for Health Affairs, Final Report: The Impact of Medical Technology on Future Health Care Costs, Feb. 28, 2001 (on file with the University of Illinois Law Review).

ernment's health care program for poor people of any age); the role of private long-term care insurance in financing long-term care, including nursing home care; and presents a "comprehensive approach to financing long-term care" by restructuring the United States's approach to "recognize the fundamental difference between medically oriented services and more residential and social setting for such care."

Robert Kaestner's paper, *Publicly Provided Health Insurance for the Nonelderly Poor: Can We Save Money Safely?*, focuses on the question of how we, as a society, can reduce spending on health insurance provided through Medicaid and the State Children's Health Insurance Program. The paper focuses on the non-elderly poor even though this group only accounts for about thirty percent of all Medicaid payments. Kaestner argues that it is possible to significantly reduce spending on health insurance for this target group without adversely affecting the health of families or increasing financial risk. He recommends specific mechanisms for achieving these goals.

Robert Rich and Cinthia Deye's paper, *The State Children's Health Insurance Program: An Administrative Experiment in Federalism,* examines a very different aspect of providing health care to children eligible for an innovative program designed to provide health insurance to poor children and their mothers. This paper describes the State Children's Health Insurance Program (SCHIP) as an administrative experiment in federalism. SCHIP provides the states with more policy-making discretion than any previous intergovernmental program. The paper examines the advantages and disadvantages of the "basic choice" available to states in implementing this program. The paper concludes by discussing the "future of federalism in health care and the extent to which the model promulgated by Title XXI (SCHIP) can serve as a model to be replicated by other programs and other policy areas." The authors find that the administrative experiment in federalism has been successful.

The second set of papers by William White, Paul Hattis, Michael Cantor, and Charles Rice examines different strategies and aspects of health care reform. William White's paper, *Market Forces, Competitive Strategies, and Health Care Regulations,* considers what can be learned from looking at the interaction between market forces and regulation in health care from an historical perspective. The analysis focuses on competitive reforms of private insurance since 1975. White concludes that private insurance markets have responded to the challenges of rising costs and consumer and provider pressures in a variety of ways, including changes in marketing strategies and benefit design, as well as renewed efforts to manage patient care by focusing on high-cost patients. White examines each of these strategies.

While White focuses on managed competition and regulatory strategies, Paul Hattis's paper, *Overcoming Barriers to Physician Volunteerism: Summary of State Laws Providing Reduced Malpractice Liability*

Expenses for Clinician Volunteers, looks at a very different aspect of health care reform. In the absence of universal entitlement to health insurance in the United States, "organized efforts involving volunteers, state legislatures, and even Congress have passed laws which in some way reduce the liability concerns of clinician volunteers in the non-emergency context." As of July 1, 2002, forty-three states plus the District of Columbia have passed some law in this regard. The paper provides an overview of these state approaches and examines what their future viability may be.

Michael Cantor's paper, *Making Tough Choices*, focuses on the strengths and weaknesses of the current health care delivery system in providing care for the chronically ill and dying. The paper looks at how Americans die; the implications of these findings for the types of health care services that are needed; the financing system for these services; and the lack of financing for important types of care for "frail, dying, and older individuals." The paper analyzes barriers to good care for the chronically ill, including financing, lack of knowledge of options, and the lack of a coordinated system of care. "It concludes with a vision of what palliative care should be like" and a brief set of recommendations for policy makers.

Charles Rice's paper, *Rationing Revisited*, examines the question of health care reform from a broader perspective. Rice starts by first noting some of the major trends in health care spending, and then poses the question: "What can be done?" He examines implicit and explicit strategies for rationing, and examines the "Oregon experiment" as one "explicit" strategy.

The final paper in this symposium, by Theodore Marmor and Jonathan Oberlander, *Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future*, represents the culmination of our discussion of health care reform. Marmor and Oberlander note that, from an historical perspective, there have been very few opportunities for health care reform in the United States. After the defeat of the Clinton health care reform proposals, the prospects for comprehensive health care reform were pronounced "dead" for the foreseeable future. Then, in the late 1990s, there was a resurrection of health care reform as an item on the national agenda. The paper evaluates reform in the early twenty-first century, analyzes various policy options, and elaborates a set of principles, goals, and strategies. Marmor and Oberlander argue that the best hope for reform may be the "federalist option," which relies on federal-state partnerships. This strategy offers the great strength of political flexibility; however, dramatic, transformative shifts in American health care policy are less likely than marginal adjustments and incremental reforms.

Taken as a whole, these papers provide both conceptual and practical insight into the organization, financing, and delivery of health care

services in the United States. They examine the prospects for reform from legal, economic, political, and clinical perspectives. For those interested in different dimensions of reform, they should provide useful insights that will contribute to the ongoing debate over how the American health care system should be reformed.