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Introduction (Special Health Law Issue)

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INTRODUCTION

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> The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste. Furthermore, these conditions are, as the following pages will show, largely unnecessary. The United States has the economic resources, the organizing ability, and the technical experience to solve the problem.[1]

Surely much has changed since the Committee on the Costs of Medical Care (CCMC) issued its controversial report in 1933. The government's role in health care has been vastly reshaped and expanded. Public and private third-party payment programs, essentially nonexistent at the time of the CCMC report, now provide some form of insurance coverage for nearly ninety percent of the population. In these regards, the CCMC recommendations proved to be remarkably prophetic. At the same time, even the most visionary members of the committee could not have anticipated the several waves of technological progress in medicine which would

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1. COMMITTEE ON THE COSTS OF MEDICAL CARE, MEDICIAL CARE FOR THE AMERICAN PEOPLE 2 (1932).

soon follow; nor would they likely recognize today's array of institutional and individual providers, from which Americans receive their health care, as the successors of the simple hospital and the office-based physician that were the primary models for delivering medical care in the 1930s. American health care has come a long way in little more than one generation.

To rephrase Joseph Califano's assessment of our present circumstances, the more things change, the more they stay the same.[2] The most remarkable consequence of the CCMC report is not that it provides a benchmark by which to judge how long we have struggled to improve health care in this country and to assess how far we have come; instead, the most remarkable consequence is that it reminds us that despite all that has transpired the "pressing problem" has changed so little. Today's report might cast a somewhat different spin on its assessment of the availability of medical care to all Americans: access to adequate care is still a problem for some—too many—Americans, but the incidence of denied access is far more exceptional today. Similar to all contemporary assessments of health care in this country, today's report would likely begin with a recounting of the ever increasing levels of economic resources that we collectively spend on health care, rather than direct its primary focus on the inequitable impact of health care costs on some individuals, as did the CCMC report. But the essence of today's problem remains the same as it has for the last fifty years: we still need to find some way to provide an adequate level of medical care for all Americans at an acceptable cost. This is the fundamental and immutable dilemma of American health policy.

Consequently, some people take issue with those assessments of our current circumstances that focus too heavily on the "cost problem," particularly those that insist health care spending in this country is approaching some critical level which, when reached, will force us to adopt some unprecedented form of resource rationing. If the Reagan years have reaffirmed any previously demonstrated lesson, it must be that our appetite for what we regard as necessary to our health, or to that of our fellow Americans, is almost beyond constraint. The Reagan administration successfully orchestrated the most significant reductions in domestic

2. Califano, *American's Health Care Revolution: Now Comes the Tough Part*, 26 HOUS. L. REV. 7, 8. (1989).

spending priorities since the Depression. Yet virtually every attempt by the administration to restructure Medicaid or Medicare, in a fashion which visibly threatened the availability of services funded by those programs, was quickly rebuffed. The central part of Reagan's conservative health policy strategy, a limitation on the tax exclusion that indirectly subsidizes employer-purchased health insurance, was repeatedly rejected by Congress.

Even in the face of annual federal budget deficits exceeding 200 billion dollars per year, Medicaid and Medicare—representing over 40 percent of the federal domestic budget—were exempted from the Gramm-Rudman automatic budget controls.[3] Indeed, by the end of his term, President Reagan was signing with feigned enthusiasm a catastrophic health bill, further extending the federal commitment to finance health care.[4]

These are hardly indications of a society engaged in a frontal, singleminded attack on a "cost problem." Rather, they are indications of our strong, deeply embedded commitment to health care. All of us should be, and many of us are, deeply concerned with the costs of that commitment, as purchasers of insurance, consumers of services, tax payers, public officials, participants in a not-always-healthy economy. To state our concern in that way, however, only highlights the fact that rising health care costs present us not with a single or focal problem but with a series of related, complex, and often conflicting problems which are only partially defined by their price tag. Surely we cannot afford to ignore a health care bill that will soon exceed 600 billion dollars annually or that has essentially doubled its share of the gross national product (GNP) in the last fifteen years.

Before we spend, as is now predicted,[5] twelve percent of our economic product on health care next year or fifteen percent annually by the end of the century, it is crucial that we first ask whether we will be getting value for our dollars, and whether we will be willing to forego those things which we will be unable to buy because of the predicted increased spending on health care. Surely if we are about to purchase services that are inefficiently provided, or of questionable quality, we could say that twelve per-

3. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (1988).

4. *Id.*

5. Health Care Financing Administration, *National Health Expenditure 1986-2000*, 8 HEALTH CARE FIN. REV. 1 (1987).

cent of the GNP will be too much to pay. If we will be paying disproportionately higher prices for the same levels of services, surely something must be done before we pay for such inflation. If, however, we pair the prediction that we will spend twelve percent of our economic product on health care next year with an announcement that modern medicine can now provide Americans with a cure for cancer, or for the elimination of the AIDS virus, then twelve, or even fifteen percent of the GNP may suddenly sound like a bargain. In this country, health care policy involves a constant reassessment of the accessibility, the quality, and the costs of our health care; and although not entirely contradictory, it involves the balancing of complicated and conflicting social objectives in light of our resources, our technology, and our past experience. There is no single problem to focus upon, any more than there could be a single or permanent resolution.

What then are the health policy issues that are of importance to the legal community as we approach the 1990s? What follows in this volume documents the seemingly contradictory observation that much is new and much has stayed the same for over half a century. Today's advances in medical technology continue to hold out the prospects for tomorrow's "medical miracle": new, and likely more expensive, ways to treat disease and disability, to make health care more accessible and effective, to extend and enhance the quality of life. The challenge in the 1930s to find some way to distribute and finance the miracles of "modern medicine" for all Americans has its counterpart in the challenge to implement and distribute the potential advances of the current decade — organ transplants, artificial limbs, drug therapy for AIDS, Alzheimer's disease, advances in neonatal and prenatal care, and the like. At the same time, there is a new kind of technology to add to the challenge in the 1980s — one that holds out the potential to evaluate more precisely and more objectively both the quality of new technological advances as well as that of the health care services that are already widely available. Indeed, in many ways, the recent advances in our ability to collect and assess data concerning the effectiveness and efficiency of various health care services and treatment practices could have as great an impact on health care delivery in this country as any of the "medical miracles" with which our medical technology has provided us. We stand just short of the traditional border that has for so long insulated the individual physician's judgment from third-party and, in particular, non-

medical assessment and review. Crossing that border holds out the prospect for exactly the kind of reforms that so often have eluded us: containing health care costs, not by risking a reduction in quality or accessibility, but by accurately targeting reform measures to reduce unnecessary or marginally useful care, care that could be provided more inexpensively in other settings, or patterns of medical practice that have no relation to actual outcome differences. In addition, it holds out the potential for fundamental changes in the manner in which health care institutions are governed and administered, not the least of which are substantial revisions in the role, and the authority, of the individual physician. It would be difficult to understate the potential for legal and political controversy that could result.

Yet even as providers are facing more rigorous utilization and quality assessment of their medical practice, they are also facing, essentially for the first time, a more adversarial posture on the part of employers, insurors, public third-party payers, and even some consumers. Retroactive, actual-cost reimbursement has given way to prospective, cost-averaging reimbursement schemes; friendly negotiations between payers and providers have become more akin to arms-length bargaining. We no longer talk of fees and costs, but of paying for health care on the basis of "price." Even the structure of health care financing has been fundamentally altered by the attempts to integrate the financing and delivery of services and a variety of other efforts to foster competition among entities that for so long eschewed even the use of the term. As the articles that follow will illustrate, we are only beginning to sort out the legal and political problems that these new developments will create.

Nevertheless, our technological capacity, the structure of health care delivery and financing, and the specific problems that they require us to address are constantly changing, the underlying dilemma, the "pressing problem," remains what it always has been. We are trying to provide an adequate level of care to all Americans at an acceptable cost. It is intriguing to trace the potential for progress and the potential for controversy that will accompany new developments in cost containment and quality assessment. Ultimately, the impact of these developments must be measured against the same axiomatic standard: we are trying to contain costs *and* maintain the quality *and* accessibility of health care. Cost containment achieved by service reduction is certain to be rejected. Quality measures may allow us to achieve economy through effi-

ciency, but they will always be vulnerable to any perception that they have done so by reducing the adequacy of what is available; and, for that matter, they are just as likely to sharpen and increase our appetite for what is adequate and acceptable. As previously noted and reflected throughout the works to follow, developments that lead to what we perceive as denied access will continue to be politically unacceptable. Much has changed in the 1980s, but, to our credit, our underlying value system seems to be remarkably constant.