

# Introduction

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Major reform of American health insurance has once again risen to the top of the political agenda. For the past fifteen years, large-scale changes to the nation's \$2.2 trillion medical complex were considered infeasible—too costly, too politically controversial, and too threatening to existing stakeholders to stand any chance of enactment. But for at least the fifth time since reformers struggled to enact compulsory health plans for workers at the state level in the 1910s, the goal of guaranteeing insurance coverage for working Americans has reignited as a burning issue.<sup>1</sup>

Two concerns dominate the growing public discussion: the dwindling reach and generosity of private insurance coverage, and the rapidly escalating cost of medical care. (A third concern, the uneven quality of American medical care, is rising in prominence as well.) These twin worries frequently come together in a single phrase: “health security” — protection against the potentially ruinous costs of health care and a stable foundation of access to quality medical services. Today, many Americans and their leaders believe that health security in the United States is declining and that substantial government action is required to safeguard and improve it. Yet fierce debate continues about how urgently such action is required and what form it should take.

Much of the debate is dominated by claims and counterclaims with little or no basis in serious research. Partisans on both sides make broad assertions unsupported by the facts, abuse statistical data, and misuse foreign and historical examples. In the heat of political battle, there is understandably little attention to the findings of scholarly investigations, much less careful attempt to weigh competing interpretations of the evidence. Nonetheless, the shrill charges that dominate our public discourse should not be taken to indicate that nothing firm is known about the financing, organization, and delivery of American health care, or how they could be made better. In fact, health policy experts in a range of fields have made enormous progress in understanding how America's health system operates. And they have also carefully outlined ideas both big and small for improving how this system works.

This book is an effort to bring these findings and proposals more fully into public discussion. Sponsored by the Social Science Research Council (SSRC), the world's preeminent organization advancing research in the social sciences, this volume is premised on the notion that all of us are entitled to our own opinions about American health care, but not our own facts. The pages to come carefully examine these facts, as revealed in cutting-edge social science research. Noted experts on health coverage, the quality of care, medical bankruptcy, the history of American health insurance, and the politics of health reform draw on the best existing social science research and their own expertise to speak to the pressing issues that face our nation today.

The contributors to this volume have not checked their opinions at the door. But they have all grounded their arguments in the empirical evidence, and expressed those arguments in clear and straightforward language, without scientific jargon. In doing so, they show that we know a good deal more about how our health system functions—and sometimes malfunctions—than the grandstanding and arguing around us suggest. As President Ronald Reagan once put it, “Facts are stubborn things.” The facts about American health care should be at the center of the emerging debate over reform.

This volume grows out of a project hosted by the Social Science Research Council, “The Privatization of Risk.” The goal of the project is to consider

the extent to which the distribution, effect, and management of risks have changed over the last generation. Its particular subject is the *economic* risks facing Americans in the early twenty-first century: where they come from, whether and how they differ from those faced in the past, how people think about them, how governments and the private sector deal with them, and how they can better deal with them in the future.

This project is an effort to engage the social sciences constructively in important national policy discussions. Since the Progressive Era in the early twentieth century, social scientists have played a prominent role in the debate over economic security. Many of the early campaigners for public insurance programs (and some of their opponents) were themselves social scientists, or closely allied with the social sciences, especially the emerging economics profession. In calling for change, these social scientists believed they were bringing scientific principles to bear on pressing matters of public policy. In the years since, as economics, political science, sociology, and related disciplines have become more professional and specialized, social scientists have moved away from the front lines. But they have continued to contribute to economic policy discussions in numerous ways, studying the contours of America's distinctive welfare state, estimating the impact of specific government and private interventions, and developing proposals for change both targeted and sweeping.

The phrase "privatization of risk" traces two linked trends in the management of economic risk in the United States. The first is the contemporary celebration of the private sector as the first and best means of dealing with problems of all kinds. This enthusiasm for private-sector solutions is nothing new. Today, however, America's long-standing enthusiasm for the private sector is joined with a sometimes unbridled faith that new technologies and new attitudes have finally "solved" the problems of risk management that once bedeviled commercial insurers and private financial institutions. In this ascendant credo, not only should the private sector manage major risks; it can do it better than it ever has—and, needless to say, better than government ever could.

This brings us to the second trend: the shift of responsibility for managing economic risk from government and employers onto individuals and their families. I have elsewhere called this "the great risk shift," and I believe it is a defining economic (and political) transformation

of our times.<sup>2</sup> The individual management of the economic risks of modern capitalism, whether through private retirement accounts or individual health savings accounts or through personal investments in education and housing, has never been as widespread or as widely celebrated as it is today. Yet with this responsibility has come pressing new questions about the ability of individuals to perceive, plan for, and secure themselves against the most threatening risks to their financial welfare—including the risks posed by declining health coverage and rising medical costs.

Each of the chapters that follow is concerned with one or more dimensions of the privatization of risk in American health care. How has health security changed in the United States? What is driving the change? What are its implications for the quality and cost of medical care received by Americans, or the health coverage they have (or, increasingly, do not have)? And what might be done to improve health security today? Although the authors are recognized experts, they have written their contributions so that they are accessible to interested nonexperts—which, ideally, should include a broad cross-section of Americans, so important is this discussion to us all.

The chapters in this volume do not present a single view on these questions. Nor are they of one mind about what should be done. What unites them is a commitment to grapple with three questions. First, what does social science research tell us about the interrelated problems that have prompted renewed attention to national health reform, most notably, those that are seen to compromise health security? Second, what does this research suggest with regard to how these problems should be addressed? Third, what does this research indicate about the prospects for changes of this sort? Not all of the contributors to this volume have addressed all three of these questions in depth, but each has thought about how his or her own research and the work of other social scientists illuminate the dimensions of contemporary problems as well as inform potential solutions to these problems.

Thus, in the first chapter, “The Transformation of American Health Insurance,” Jill Quadagno and Brandon McKelvey, of the Pepper Institute on Aging and Public Policy at Florida State University, trace the

changing ideology and institutions of American health insurance, looking at both the private and the public sectors. They focus on a revealing shift in how health insurance is understood to function: from an emphasis on shared risk, embodied in the traditional practice of “community rating,” employed by public programs and some nonprofit insurers that did not charge higher rates to less healthy subscribers, toward an emphasis on individual risk management, embodied in the contemporary private practice of “experience rating,” in which subscribers are charged according to their expected medical costs. The apotheosis of this shift, they suggest, are so-called Health Savings Accounts, tax-favored savings accounts that are coupled with a high-deductible “catastrophic” health plan, requiring that people pay most routine medical costs themselves. Although Quadagno and McKelvey are clearly worried about this new entrant into the insurance mix—they argue, based on strong evidence, that it is likely to fragment the market and drive up costs for many by encouraging healthier people to opt out of employment-based insurance—their broader point is that private health insurance is less and less a guarantee of the broad sharing of risk, leaving government and individuals to pick up the slack.

This point is driven home by Katherine Swartz in her chapter, “Uninsured in America: New Realities, New Risks.” A Harvard economist, Swartz provides an informative tour of the uneven landscape of American health coverage. She tackles the big questions that should be at the heart of today’s policy discussion: Who is most likely to be uninsured, and why? What are the key trends in coverage? And what are the options for creating broad risk-sharing in American health insurance given these trends? Swartz reminds us that the fundamental problems are relatively simple: Health insurance is too costly for middle- and working-class Americans, much less the poor, to finance reliably on their own. At the same time, because medical costs are so high, insurance is essential. The small share of Americans who end up incurring the lion’s share of national health costs in any given year must have insurance to finance these expenditures. Yet insurance coverage is dwindling, and will likely to continue to dwindle as long as costs rise and employers see declining reason to offer coverage.

Not only the uninsured are at risk because of rising costs, remind Elizabeth Warren and Deborah Thorne in their chapter, “Get Sick, Go

Broke.” So too are those who have coverage, either because they are “underinsured” or because they do not have protection for one big cost of sickness, time out of the workforce. Warren of Harvard Law School and Thorne of the Department of Sociology and Anthropology at Ohio University designed the pioneering Consumer Bankruptcy Project—a study that has used surveys, bankruptcy court records, interviews, and other evidence to look at rates and causes of bankruptcy filings over the past decade and a half. They have found that medical costs and crises are a leading (and probably increasing) cause of bankruptcy filings. Warren and Thorne discuss why medical bankruptcy is so common, affecting as many as 2.2 million Americans (filers and their dependents) in 2001; why it affects even those who have health insurance, who make up a surprising 75 percent of filers; and what can be done to reduce the problem.

Swartz, Warren, and Thorne are mainly interested in health security—whether people have insurance, whether they can afford care, and what happens when they do not or cannot. But the quality of medical care is also a crucial issue in American debates, with many critics of proposals to expand health security arguing that reform will hurt “the best medical care in the world.” In the fourth chapter of this volume, I collaborate with noted health policy experts David Meltzer and Elizabeth A. McGlynn to bring recent research to bear on this topic, asking “Just How Good *Is* American Medical Care?” As a leading quality analyst for the RAND Corporation, McGlynn has led the charge in developing new measures that reveal how big the gap is between what is known to improve health and what is done by doctors and hospitals in the United States. The cornerstone of this research is a comprehensive database of clinical guidelines for the treatment of a range of acute and chronic health conditions—in essence, a yardstick against which the appropriateness of care delivered (or not delivered) to patients can be judged.

In this chapter we walk through the findings of this research: American adults receive only half of recommended care, children slightly less, and patients are more likely to be undertreated than overtreated. We then look at the United States in cross-national perspective, concluding that while American health care looks relatively good in comparative relief, it is hardly as exceptional as commonly believed. Despite the American system’s very high price tag, for example, the United States has fewer

doctors, hospital beds, and nurses per person than the norm among rich nations. Though less healthy overall than citizens of other rich nations, Americans visit doctors and hospitals less frequently and have shorter hospital stays. And the United States lags behind other rich nations in the use of information technology, such as electronic prescription systems, to improve quality and lower costs. Perhaps most surprising, the best care in the United States is actually delivered by the government: through the Veterans Health Administration, which, thanks in part to the innovative use of information technology, provides more than two-thirds of recommended care (vs. the 44–55 percent seen in the U.S. system overall). The big message is that quality does not naturally follow from greater spending or coverage; it needs to be cultivated with targeted efforts using information technology, practice guidelines, and other strategies for bringing into greater harmony what is known to work and what is actually done.

The cumulative effect of these chapters is to suggest that long-standing problems in American health care are growing worse even though there are known ways to make the situation better. The issue, it seems, is not irresolvable gaps in our knowledge or administrative capacities, but rather political and ideological disagreement about the proper direction of change. Given this evident dissensus, how likely is major action by our elected leaders to address declining health security? This is the question that I address in chapter 5, “The New Push for American Health Security.” The goal of the chapter is to situate current political struggles in historical and cross-national relief. This requires knowing why the United States is the only affluent nation without health insurance for all its citizens, and what the answer to that question means for the prospects for reform today. It turns out that the main barrier to reform today is the failure of reform in the past, which has left the United States with a patchwork quilt of public and private coverage that divides the public and political elites and makes many Americans worried about the effect of change on *their* pieces of the quilt. In recent years, however, fundamental political and economic trends have collided to make large-scale reform a real possibility. The unanswered question is whether those favoring reform can learn from the “lessons of the past” and build a political and policy strategy that surmounts the barriers to reform that still loom large, without giving up on the basic aim of universal health security.

These contributions stand on their own. But they share a common conviction: that careful scholarship can and should speak to society directly and clearly on questions about which nonscholars truly care. The past and future of American health security could not be a more appropriate topic for such a discussion.

Every book rests on the contributions, advice, and assistance of many. That is all the more true of edited volumes. Each of the contributors to this book deserves a deep thanks. So too do the many colleagues, research assistants, administrative associates, spouses, friends, and children who directly or indirectly aided in the effort. Among them, Victoria Bilski deserves special gratitude for her diligent work transforming the essays that make up this volume into coherent and polished chapters.

Not only is this book inherently a collective effort, but in addition, it took a good deal of shared work to both envision it and bring it into its current printed form. All credit ultimately goes back to Craig Calhoun, president of the SSRC, who commissioned the “Privatization of Risk” project and envisioned the edited series that came out of it. Generous financial support for the project came from the John D. and Catherine T. MacArthur Foundation, as well as the SSRC itself.

To shepherd the volume to its completion, heartfelt thanks go to Paul Price at the SSRC and all of the hardworking editors and staff at Columbia University Press. They learned that it can be very difficult to contribute to current public debates, at least when that means turning a manuscript into a book in the amount of time that it takes most academic books to come back from reviewers. May the speed and quality of their efforts be a harbinger of the success of the debate that this book aims to influence.

## NOTES

- 1 Previous debates took place during the 1930s, late 1940s, 1970s, and, of course, the early 1990s. I do not in this tally include the 1960s debate over Medicare, a program explicitly limited to the aged (though passed alongside the Medicaid program for the poor and later extended to the disabled). I say “at least the fifth” because there were arguably two major debates over reform in the 1970s—one

of which centered around President Nixon's proposal to mandate that employers provide coverage, the other of which occurred later in the decade and featured competing proposals by President Carter and Senator Kennedy, among others.

- 2 Jacob S. Hacker, *The Great Risk Shift: The New Economic Insecurity and the Decline of the American Dream*, rev. and exp. ed. (New York: Oxford University Press, 2008; originally published 2006).