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Officials of the federal executive branch have behaved as if they are hierarchically superior to their colleagues in state government. Powerful interest groups have helped to reduce the power of the states. Most large employers have been delighted to escape state rules, mandates, and taxes. Labor unions decided in the 1930s that their members were better off with national regulation. Advocates for the rights of minorities pool their influence against restrictive state and local law and behavior. Because of the success of these interest groups, almost every college and university textbook on American politics for two generations has taught that an inevitable trend in the twentieth century has been the diminution of the role of states in our federal system. As textbooks go, so goes the next generation of journalists, business leaders, and practical politicians.

But the states endure. They tax, they spend, and they subsidize capital spending for education, health, welfare, infrastructure, and economic development. States are major employers and purchasers. States and local communities are the places where most political careers begin and end. Effective federalism has been a casualty of American progress and prosperity in the twentieth century. We internationalized the world and nationalized our economy. We persuaded ourselves that Americans were becoming less diverse and then behaved as if people who tried to protect the diversity that remained were bigoted or silly. At best we demeaned the states as “laboratories of democracy” (places in which national solutions were tested) or spoke euphemistically about “cooperative federalism” (making states pay for policies from Washington).

The states endure, however, because they are useful. Hawaii, as this book makes plain, is a leader among states, not a model for the nation. Hawaii is a leader, because, among other reasons, its elected officials persuaded Congress to stop preempting health care reform by granting Hawaii a waiver from the Employee Retirement Income Security Act (ERISA). As a result, the history of health policy in Hawaii in the past two decades is the best example we have of what can happen when a federal government that cannot muster the political will to solve a problem gets out of the way.

**Slouching Toward Integrated Health Care**

*by James C. Robinson*

Reforming the Health Care Market: An Interpretative Economic History

*by David F. Drake*

(Washington: Georgetown University Press, 1994), 240 pp., $16.95 paper, $42.50 cloth

Reforming the Health Care Market is an enigmatic Rorschach test for the health services researcher-an “interpretative economic history” that chronicles eight decades of organizational dysfunction, denounces anticompetitive collusion between physicians and hospitals, compares health systems data among industrialized nations, chides the Clinton Health Security Act, sneers at managed competition, and argues that a retreat from comprehensive to catastrophic health insurance will realign incentives and tame the health care beast. Written over the course of two decades by David Drake, a senior hospital executive with many other responsibilities, this book reflects the frustration of a protagonist who sees at close range how the rhetoric of cooperation and community service can prevent the rationalization of the system. I choose to see in this blotch of ink and insight a theme that interests me: the organizational development of the health care delivery system.

Drake stands in the long and illustrious line of health care observers and reformers for whom the ideal delivery system is one based on vertically integrated organizations that combine financing and hospital and physician services. Beginning in this country...
with the Progressive urgency to bring scientific methods of organization to the iatrogenic democracy of nineteenth-century medicine, through the Committee on the Costs of Medical Care's (CCMC's) espousal of hospital-based group practice, to accountable health partnerships and integrated systems of care. The teleological tone is pervasive. Don't all hospitals, physicians, and insurers forestall the attempt by the CCMC and progressive specialists to build hospital-based group practices. Hospital-based specialists overinvest in technology and divert the nation from primary care (the generalists reappear in these sections as prevention-oriented primary care physicians). Hospital managers lack the entrepreneurial spirit to compete and prefer the comfortable life of cooperation with their medical staffs, other hospitals, and insurers. Blue Cross misses its historic opportunity to translate prepayment into the foundation of integrated systems of care and settles for noncompeting regional monopolies. Discipline within this unholy alliance is enforced by the American Medical Association (AMA), villain extraordinaire ("No cartel in any other industry has ever found a stronger or more open enforcer").

The second explanation, and the one that the author concludes is the most important, concerns the blunting of consumer cost-consciousness through first-dollar insurance. The cost inflation of the postwar years was financed by a national binge of moral hazard, as consumers demanded increasingly comprehensive coverage to escape the burden of paying medical bills and then used more services under the theory that it was somebody else's money. The federal Medicare program finished off any chance for efficiency by cementing in the AMA's free-choice-of-provider framework.

In the concluding chapter Drake develops the theme of overinsurance and the cost-unconscious consumer into a full-blown proposal for delivery system reform via insurance reform. If first-dollar coverage is the problem, then catastrophic health insurance is the answer. Drake picks up where Martin Feldstein left off, advocating that federal health insurance be limited to coverage of extraordinary expenses, thereby freeing the competitive market to deal with the actuarially predictable and hence commercially insurable noncatastrophic cases.

Ordinarily, I would not see it as my role...
to dispute a health care reform proposal, especially one that has some merit. However, just in case the Clinton crash and bum raises the visibility of these sorts of unmanaged competition proposals, two brief comments are in order. First, the catastrophic insurance approach itself, which in Drake's hands resembles a vertical merger between Medicare and Lloyds of London to create a subsidized public-sector reinsurer of the managed care industry, portends a bailout for the least efficient plans that generate most of the economic catastrophes in health care. Patients enrolled in tightly managed health maintenance organizations (HMOs) are less likely to generate the tens of thousands of dollars in charges reimbursable by the catastrophic insurance policies.

Second, last-dollar insurance is not what Drake really wants anyway, if his real goal is integration and rationality. He repeatedly blurs the sins of first-dollar insurance into those of free-choice-of-provider insurance. It is the latter that really impedes the development of competing integrated systems. Catastrophic medical insurance in its classic form does nothing directly to undermine the collusive cooperation of the medical guild; it simply eliminates insurance coverage for preventive and ambulatory care by imposing a large deductible. Today's price-competitive health plans and delivery systems rely largely on provider incentives and organization rather than consumer cost sharing at the point of service to achieve their efficiencies. Consumer cost-consciousness is an essential prerequisite for market competition, but it is most important when choosing from among health plans at the time of open enrollment rather than when shopping among physicians at the time of illness.

If we follow the logic of Reforming the Health Care Market, now should be the historic moment for vertical integration in health care. The AMA cartel has broken down because of excess capacity and the unleashed antitrust attorneys. The cost-unconscious consumer is increasingly a matter of mere provider nostalgia, as large employers implement managed competition and small employers shift the burden to their employees or forsake the health insurance market altogether. And we do observe a dramatic organizational ferment: Hospitals are buying medical groups; medical groups are buying individual practice associations; commercial insurers are building staff-model HMOs; and staff-model HMOs are adding quasi-indemnity point-of-service options. Everybody's doing it.

Maybe Drake is right. Maybe when the smoke clears, every community in America will be served by one, two, or three fully vertically integrated systems of care. But the muse of history possesses many devious means to trick us. On the very eve of its triumph, vertical integration is threatened by a resurgence of the market alternative. Everywhere we look in the economy outside of health care we see downsizing, rightsizing, outsourcing, subcontracting, franchising, partnering, and just about everything except textbook vertical integration. The organizational sociologists call them “network” and “alliance” forms. The institutional economists refer to “relational contracting.” The Japanese have their keiretsu. Business Week has its “virtual corporation.” Some interpret the emerging phenomena as holding an intermediate position between arm's-length “spot” contracting and hierarchical authority, between atomistic competition and vertical integration. The Hegelians might refer to it as a “category crisis.” All we can say for sure is that this period of organizational innovation is simultaneously a period of innovation in the forms of market contractual relations that permit coordination while eschewing bureaucratization.

Today's dominant health policy voices argue that integrated systems of care are the efficient solution to the health care dilemma and will outcompete their rivals if given a fair chance. The case is incontrovertible that well-intentioned and not-so-well-intentioned institutions, regulations, and payment mechanisms have impeded innovation in health care and that some of these impediments are crumbling. But the historians of the future may not interpret the twentieth century as the long road to vertical integration. Loosely coupled organizations and long-term market relationships offer important performance advantages in the ele-
tronics, finance, and hotel industries. Is health care really that different? Or, in the words of the dead poet: “And what rough beast, its hour come round at last, / Slouches towards Bethlehem to be born?”

Making America Safe From ‘Foreign Germs’

by Dorothy Nelkin

Silent Travelers: Germs, Genes, and the “Immigrant Menace”
by Alan M. Kraut

Debates over U.S. immigration policy have intensified in recent years, and questions of health and the anticipated cost of public assistance are critical issues. We hear claims that diseases such as acquired immunodeficiency syndrome (AIDS) and tuberculosis (TB) are brought to this country by outsider groups. We hear arguments that recent immigrants have “low cognitive ability,” are therefore not competent to thrive in American society, and constitute a threat to our interests. And we see proposals to bar immigrants from Medicaid and other public assistance programs. These are all themes with a long tradition in the history and practice of U.S. immigration policy.

In Silent Travelers, Alan Kraut reviews the complex and critical relationship between immigration and public health in the United States with insight and foresight. He believes that “[t]he double helix of health and fear remains encoded in American society and culture, reappearing in patterns fresh but familiar.” In this light, he identifies four themes that marked the early history of immigration and, indeed, persist today.

First is “medicalized nativism”—the use of beliefs about disease to justify prevailing prejudices against foreigners and to exclude them. Second is the role of scientific medicine in reinforcing the association of immigrants and disease, as both nativists and assimilationists have called forth the latest scientific theories to support their social agendas. Third is the institutional struggle, as problems of immigrant health have challenged the ability to weigh individual rights against social welfare. Fourth is the clash between immigrants and public health officials, as cultural beliefs and traditional practices concerning hygiene, disease prevention, and therapy have conflicted with American medical practices.

Kraut begins his research in the eighteenth and early nineteenth centuries, when the devastating epidemics in Europe led to the stigmatization of whole nations of foreign-born as carriers of contagious disease. Just as AIDS was associated with Haitians in the 1980s, so yellow fever (the “Palatine fever”) was associated with Germans in the eighteenth century, cholera with the Irish in the nineteenth century, typhoid and smallpox with the Chinese, and TB (the “tailors’ disease”) with Jews. Nativists played on fears of disease, stereotyping foreigners as unclean, vulnerable, unhealthy, and a risk to the American population.

These beliefs developed as the significant increase in immigration beginning in the 1880s brought unprecedented public health problems. The procedures for inspecting and processing immigrants were formalized to “make America safe from foreign germs.” They were facilitated by improvements in medical diagnostic techniques such as x-rays and the Wassermann test. And they were shaped by the prevailing beliefs of the eugen-