

Government and Health Care: A Brief History Concluded

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In past months I have recounted some of the long history of government involvement in health care. After a brief reflection on history in other times and places, I proceeded to discuss some elements of the history of U.S. state and federal government involvement in health care. I started with the history of regulation of the health professions in the U.S., government efforts in public health, and the history of government-run health care facilities. I then discussed the history of U.S. public investments in the sciences that guide clinical practice. I will now conclude this “brief history” by discussing public involvement in the training of health professionals and various federal efforts to expand access to health insurance.

Supporting the training of health professionals

State and local governments have been involved in the chartering and support of institutions of higher learning, including medical schools, since Colonial days. (1) Substantial federal support for health professional education dates to the 1960s. Title VII of the Public Health Service Act was enacted in 1963. Programs created under Title VII focus on increasing the number of students and faculty in primary care medicine, dentistry, public health and related health professions. (2) Title VIII was enacted in 1964 with a focus on nursing, particularly training for advanced practice nurses and improving nurse retention and patient care. In 1967 the U.S. Public Health Service created a Bureau of Health Manpower which was transferred to the newly established Health Resources Administration in 1973 and consolidated with other entities to form the Bureau of Health Resources Development. A separate Bureau of Health Manpower was established by the U.S. Department of Health, Education and Welfare but a few years later was renamed the Bureau of Health Professions and became part of the expanded Health Resources and Services Administration (HRSA) in 1982. (2)

While Congressional appropriations for these programs were initially strong, over time other federal health programs have taken a higher priority. For example, appropriations for the Title VII primary care programs have declined more than 10-fold in real dollars over the past thirty-five years. (3) Of note, appropriations for the biomedical research grants programs of the National Institutes of Health have increased almost three-fold in inflation-adjusted dollars over the same time frame. Various policy experts have speculated on the reasons for these different trajectories in appropriation. While primary care educators regularly advocate for specific programs within Title VII and VIII funding, it may not be surprising that research programs offering the promise of new treatments, or even cures, for serious illnesses can attract effective advocacy coalitions of highly committed patient representatives working with biomedical scientists and specialized clinicians focused on those conditions and so get more money.

Another source of Federal support for medical education has increased over the last 45 years, though not through the annual Congressional appropriations process. Medicare graduate medical education (GME) funding, primarily for resident physicians, has doubled in real dollars since its codification in 1985 to well over \$8 billion a year. (3) However, Federal government support for training resident physicians did not begin with the Medicare program. The GI Bill after World War II made provisions for an enhanced residency experience with a generous living allowance and a subsidy to the hospitals offering residency positions to former servicemen. Perhaps unsurprisingly the number of residency positions offered by hospitals increased six-fold from 1940 to 1960. (4)

With the establishment of Medicare in 1965, Congress acknowledged the need to support medical education as well as patient care. Originally Medicare paid hospitals on a “cost of service” basis. GME expenses represented an approved element of the calculation of “reasonable costs,” and thus Medicare paid its share of GME costs

through per patient hospital reimbursements for care of Medicare beneficiaries. Under Medicare's Prospective Payment System (PPS) adopted in 1985, Direct Medical Education (DME) payments are made through a "per resident payment" based on such factors as the hospital specific per resident payment amount, the number of full-time equivalent residents, and Medicare's share of the inpatient days for the facility. Medicare also reimburses hospitals for "Indirect" Medical Education (IME) costs related to such factors as increased use of tests and ancillary services, greater severity of illness, increased inefficiencies in teaching, greater concentration of high technology and differences in types of physicians and payments. Unlike health professions training funded through HRSA's Bureau of Health Professions, these Medicare GME (DME and IME) payments are based on a formula and not subject to annual appropriations. (4) Policy experts and advocates for teaching hospitals and academic health centers have disagreed for many years regarding the appropriate amount of GME support through Medicare, especially the size of the IME payments. Recently enacted legislation will reduce the amount paid under this formula. (5)

Government Role in Health Insurance

As noted previously, European social insurance programs developed in the late 19th and early 20th centuries. U.S. reformers first attempted health insurance legislation in the early 20th Century and the AMA House of Delegates approved a report favoring health insurance in 1917. (1) But even before the political distractions of U.S. entry into World War I, opposition from state medical societies was growing. As Starr noted, it was clear that some advocates for national health insurance saw this as an opportunity to "encourage the growth of group practice and to change the method of payment from fee-for-service to salary or capitation..." (1), directions certain to be opposed by most physicians. There was some resurgence of political interest in federal health insurance initiatives in the 1930s but no proposal achieved firm support from President Roosevelt. In November 1945, shortly after the end of World War II, President Truman called for the passage of legislation to ensure American citizens the right to medical care and avert "economic fears" related to illness. However, the AMA and the American Hospital Association opposed his approach and there was not enough Congressional support to move this far-reaching legislation. (1)

In July 1965, President Johnson signed the Social Security Amendments of 1965 which authorized a mechanism for paying for covered hospital and physician services for U.S. citizens over 65, and the Medicare program was born. The story of this legislative success has been extensively documented, and the opposition by the AMA is well known, though the support from the American Hospital Association and the Blue Cross/Blue Shield organizations less widely appreciated. (6)

Even at the time, many policy makers were concerned about the open-ended nature of this new federal obligation for health care spending, and numerous legislative revisions have been passed over the years, often in an attempt to control costs. Although physician organizations opposed the original legislation, they and other provider groups quickly became engaged in advocating for Medicare provisions supporting program payments for their professional services. (6) The perpetual and aggressive advocacy by various providers has been caricatured by Cato Institute Scholar David Hyman as follows: "Those included within Medicare compare their payment rates with those of other covered providers and ceaselessly agitate to have their services compensated more highly. Providers excluded from Medicare agitate to be included." (7)

Thus when the last comprehensive reform of the Medicare program passed in 2003 (the Medicare Modernization Act or MMA), not only the pharmaceutical manufacturers, but many health provider organizations, signed on in support, having secured various accommodations in this sweeping legislation. In addition to the signature accomplishment of providing prescription drug benefits to seniors, the MMA enhanced a variety of provider payments and expanded financial access to care for many poor children. The failure to achieve such broad based provider support for the Clinton administration's efforts to enact comprehensive health care reform has been noted to be an important reason that reform did not succeed in 1994. (8)

This article is being written just a year after the passage of the Affordable Care Act of 2010 (ACA). (5) The ACA was intended not only to reform (once again) the Medicare program (and rein in future spending) but also to achieve the long sought after goal of universal financial access to health care for most U.S. citizens. The full history of the coalition that achieved this legislative victory has yet to be written, but many professional associations, including the AMA, supported final passage of the bill. There were many vocal opponents as well, including some physician groups. Challenges to implementation of ACA have been filed in federal courts, national leaders of the political opposition have advocated for its repeal, and the new majority in the House of Representatives passed such a measure (although no such legislative action is expected in the Senate). Time will tell whether the ACA legislation will finally resolve the difficulties achieving universal health insurance in the U.S.

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