Chapter 7
Healthcare in the United States:
Achieving Fiscal Health in the Marketplace or Delivering a Sustainable Public Good?

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ABSTRACT

Healthcare in the United States is a dynamic mix of public and marketplace solutions to the challenge of achieving the maximum public good for the greatest number of people. Indeed, in the U.S. the healthcare industry generates over $3 trillion in the economy. This creates a uniquely American paradox that is examined here. The basic structure of the U.S. public-private healthcare delivery system is explored. The dynamics of public sector involvement in healthcare delivery is reviewed, with particular emphasis on the impact of the Patient Protection and Affordable Care Act. Economic impact, employment indicators, and recent cost estimates of public revenue investment will be considered. Finally, a discussion about the future implications of healthcare for public administration in the 21st century is presented. Eight tables and figures present a visual and detailed explanation to accompany the narrative.

INTRODUCTION

Healthcare in the United States is a unique combination of marketplace innovation and ownership and substantial public financing. In the United States, healthcare is both a public and private venture with multiple funding streams, diverse accountability structures, and a market driven accretion of healthcare responsibilities and treatment options. Historically, healthcare has been both a private business and a public interest. Whether it was the typhoid epidemics of the late 19th century or the creation of the NYC Department of Sanitation to ameliorate raging cholera epidemics, the health of our population has gradually become more of a public effort. As this chapter will provide, today, that public effort is substantial. Whether it is overseeing food safety in an effort to eliminate food borne injury and illness

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or serving our nation's veterans with direct healthcare services, healthcare as a public good assumes a variety of iterations.

The following pages will provide readers with a solid background in the role of public administration in healthcare and its relevance for contemporary public administration. Fundamentally, any industry that has as large an economic footprint as the healthcare industry is bound to have extensive involvement by the public sector. This chapter will first explore the basic structure of our public-private healthcare delivery system. Next, the dynamics of public sector involvement in healthcare delivery will be considered. Economic impact, employment indicators, and recent cost estimates of public revenue investment will be examined. Finally, a discussion about the future implications of healthcare for public administration in the 21st century is presented.

BACKGROUND

Just when did the United States first determine that healthcare warranted public oversight and investment? Nearly from the beginning of our existence. In 1798 the first official effort to deliver healthcare to a segment of the US population was put in place. In this case, it was an economic interest that led President John Adams to the establishment of the Relief of Sick and Disabled Seamen Act. A tax was levied on seamen's wages to build hospitals and to support for medical care (O'Carroll, Yasnoff, Ward, Ripp, & Martin, 2003). Why did the President intervene? Because at the time sea-travel lay at the heart of economic power. Transporting goods across vast tracts of land internally via rivers and lakes or across the ocean to trade with Europe. While this unique tax was eventually abolished in 1884, the trajectory for public investment in healthcare was firmly set. Subsequent legislation established food safety programs, funding for research, vaccinations, health insurance and more. In 1862 the precursor to our current Food and Drug Administration was established as the Bureau of Chemistry. In 1878 the federal government consolidated quarantine power at the federal government, levering authority away from the states, and transferring it to the Marine Hospital Service (the predecessor of the Public Health Service).

Since the late 18th century, the U.S. healthcare system has been deeply collaborative with the public and private sectors. Over the decades, various legislation has resulted in changes to funding sources, systemic policy initiatives to eradicate disease, research to fund innovation, and building the necessary infrastructure to oversee the establishment of a complex, yet, comprehensive healthcare industry. Table 1 presents a brief overview of health-centered legislative action. Each act has resulted in more deeply cementing the indebtedness of the private healthcare industry to the public sector. Most obviously in terms of funding, but also with regard to oversight and accountability.

The basic structure of the United States healthcare system is one of complexity. As indicated in figure 1, there are multiple actors working to address population health. Why consider population health? Because a productive workforce is good for the economy. A health citizenry is cost effective. However, here is a question worth pondering: While paying for health care is costly, and a lack of good health is detrimental to funding sources, isn't this also simultaneously beneficial for the healthcare marketplace? This is the paradox of healthcare in the U.S. It is a commercial industry, employing millions of people, and largely dependent upon public sector financing. In other words, to a large extent, the multi-trillion dollar healthcare U.S. industry is supported heavily through public revenues. It depends upon the guarantee that populations will need healthcare at some point in their lives. That some people will be more expensive than others due to their lack of good health. That revenues will hold fairly study so that management

Table 1. Brief history of health-related legislation

Year	Legislative/Executive Act	Year	Legislative/Executive Act
2010	Affordable Care Act	**1966**	Community Health Centers/Migrant Health Centers & International Smallpox Eradication
2003	Medicare Prescription Drug Improvement and Modernization Act of 2003	**1965**	Medicare and Medicaid programs established
2002	Office of Public Health Emergency Preparedness	**1962**	Migrant Health Act
2001	Centers for Medicare & Medicaid created	**1955**	Licensing of the Salk polio vaccine
1999	CDC Initiative to combat bioterrorism	**1953**	Department of Health, Education, and Welfare
1997	State Children's Health Insurance Program (SCHIP)	**1946**	Communicable Disease Center established
1996	Health Insurance Portability and Accountability Act (HIPAA)	**1939**	Federal Security Agency established
1993	Vaccines for Children Program	**1930**	National Institute(s) of Health & Food & Drug Administration
1990	Ryan White Comprehensive AIDS Resource Emergency (CARE) Act & Nutrition Labeling and Education Act & Human Genome Project established	**1921**	Bureau of Indian Affairs Health Division
1989	Agency for Health Care Policy and Research	**1912**	Marine Hospital Service
1988	McKinney Act	**1906**	The Pure Food and Drugs Act was passed, authorizing the government to monitor the purity of foods and the safety of medicines
1985	Blood test to detect HIV was licensed	**1891**	Marine Hospital Service
1984	National Organ Transplantation Act	**1887**	Staten Island Lab Opens
1980	Department of Health and Human Services	**1878**	National Quarantine Act
1977	Eradication of smallpox worldwide & Health Care Financing Administration (HCFA)	**1871**	Supervising General
1971	National Cancer Act	**1862**	Bureau of Chemistry
1970	National Health Service Corps	**1798**	Relief of Sick and Disabled Seamen

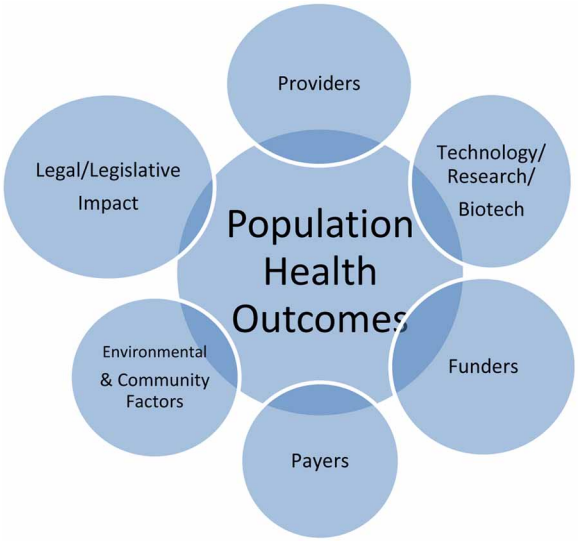
Source: Adapted from: https://www.nlm.nih.gov/exhibition/phs_history/intro.html

decisions may be made to maximize profits or surplus revenues (for those in the non-profit sectors). These revenues may be direct payments to providers, research funding for research, and subsidies to payers. The indirect supports provided to address health concerns in terms of environmental regulations and social safety-nets to address community factors are not included in the scope of this chapter, yet they do effectively impact health.

HEALTHCARE AS A PUBLIC GOOD

Health care in the United States remains a "wicked problem". There are tremendous disparities in health outcomes across the United States. Indeed, achieving the Triple Aim, as identified by the Institute for Healthcare Improvement as balancing positive population health, patient satisfaction/quality, and cost

Figure 1. U.S. healthcare system



efficiencies. The intent of the Triple Aim is to create a more sustainable healthcare environment for funder, patients and providers. Subsequently, as funders and providers have begun to consider how best to achieve this Triple Aim both public and private financing for healthcare is squeezing healthcare to do more with less. Specifically, the system must focus on health outcomes and consider both effectiveness and efficiency in measuring success.

Why do we care? In 2012, the United States ranked 79th in life expectancy, 29th for infant mortality and 28th for maternal mortality, to name just a few health outcomes measured worldwide in 191 countries (WHO, 2014). This doesn't seem too bad, except that the Organisation for Economic Co-operation and Development (OECD), ranks the U.S. number one in healthcare spending per capita, and number on in pharmaceutical spending (OECD, 2014). According to the World Bank, the U.S. has the largest economy in the world, followed in a closely contested second place by China (World Bank, 2015). Clearly, for all of its economic power, these complex public challenges require innovative and flexible solutions that have so far eluded the U.S.

Further exacerbating our healthcare challenges, the U.S. also lags behind many less economically advantaged nations (Docteur & Berenson, 2014). Obesity and diabetes related deaths are higher for American Blacks (38.4/100,000 respectively) than for Whites (19.4 per 100,000 respectively) (CDC, 2015). Among poor Americans, rural communities, and racial minorities remain a critical health disparities problem (Purnell, et. al, 2016).

Public Good, Private Marketplace

Just how many businesses relate to the healthcare sector? The numbers are huge. From biotech research firms to pharmaceutical corporations, from physician practice groups to hospitals, there are thousands of businesses that depend upon a steady flow of public sector funding. For the purposes of this chapter some evidence regarding the scope of this industry is provided here. According to the American Hospital

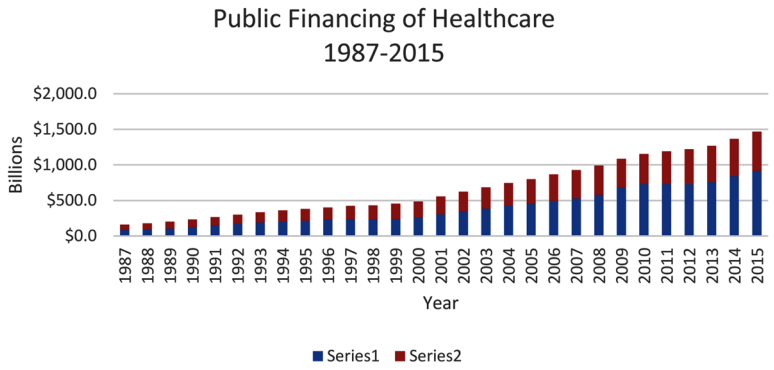
Association there are 5,564 hospitals in the United States. Of these, 983 are state and local government community hospitals, 212 are federal government hospitals, but there are 2,845 not-for-profit hospitals and 1,034 for profit hospitals currently operating (AHA, 2017). There are currently about 685,000 physicians not directly employed by hospitals (Kane & Emmons, 2013). Nearly 61% of physicians practice in small groups, of about 10 or fewer physicians and only about 18% practice solo (Brooks, 2015; Kane & Emmons, 2013). Indeed, consolidations of physician practice groups are following in the footsteps of hospitals. While hospitals merge for financial stability, sharing administrative burdens and seeking improved population health outcomes, physician practice groups are actively merging for the same reasons. They are seeking opportunity to pursue more lucrative contracts and to larger numbers of patients, along with the ability to share regulatory compliance and technology demands (Physicians Annual Survey, 2016). There are over 61,000 pharmacies (about 6,000 of which are located in hospitals) with 69% employing no more than 2 pharmacists (SK & A, 2016). Nearly 366,000 people are employed in health and medical insurance companies and they generate nearly $746 billion in premiums (NAIC, 2015).

On the other hand, the federal government has the most comprehensive structure for financing and delivering healthcare services in the U.S. through two distinct mechanisms- first, direct provision of services (think the Department of Defense TRICARE and TRICARE for Life programs (DOD TRICARE), the Veterans Health Administration (VHA) program, and the Indian Health Service (IHS) program) and through a largely privatized system of healthcare delivery (think Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP). How is healthcare privatized? Because most of the providers are not employed by federal, state, or local government. Instead, public financing is used to pay for care and services delivered by private businesses—both for-profit and not-for-profit. Public health services are comprised of several agencies that focus on healthcare. Among them are the Centers for Disease Control and Prevention (CDC), the Agency for Toxic Substances and Disease Registry (ATSDR), the Agency for Health Care Policy and Research (AUCPR), the Indian Health Service (IHS), the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA) (Smith, Eden & Corrigan, 2003). As an employer, healthcare provides employment for a substantial number of people. Full-time equivalent employment functions for people employed within public sector health and hospital related services include 395,845 people at the federal level, 526,327 at the state level and 728,929 at the local level. This represents a lot of people contributing to the economy via the healthcare marketplace.

As an industry, healthcare represents a substantial economic engine. In 2015, the U.S. spent $3.2 trillion dollars on healthcare, accounting for nearly 18% of the overall economy (NEH Highlights, 2015). The federal funding source, Medicare, and the federal-state funding source, Medicaid, accounted for 37% of all healthcare financing, private health insurance accounted for 33% and out of pocket expenditures accounted for 11% (NEH Highlights, 2015). Of the total spending on healthcare, private financing comprises about 50% of all healthcare dollars in the United States. This is accounted for largely by out of pocket expenses and non-public employer contributions.

So, it seems logical that perhaps the first question that should be considered here is how extensive is the funding role the public sector plays in delivering healthcare in the United States? Clearly, the funding of health care is a compelling role. As indicated in Figure 2, state and local governments are investing

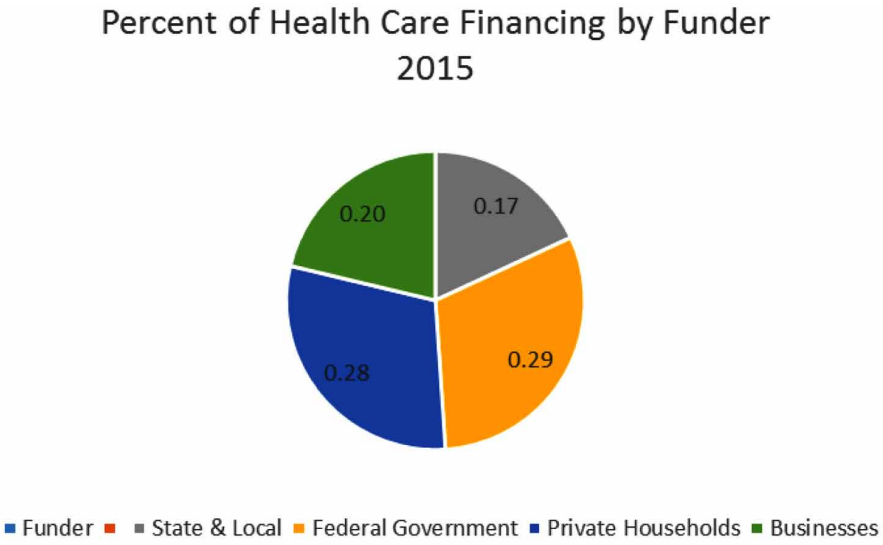
Figure 2. State and federal distribution of public financing for healthcare
Source: Adapted from National Health Expenditures, Tables 5.3 & 5.4, Centers for Medicare & Medicaid Services



significant support for health care, with Medicaid comprising no small percentage, while the federal government's contributions for health care have steadily been increasing in percent share.

It is important to remember that the health care marketplace is deeply dependent upon public funding sources. While public support has been around for more than 200 years, as Bodenheimer and Grumbach (2004) note, the early fee for service combined with the 1965 Medicaid and Medicare authorization led to stable funding for healthcare providers and the ability to project budgets accordingly. When considering any changes to the role of the public sector in delivering healthcare in the United States, it must first be recognized that the substantial stabilizing and growth in supporting healthcare organizations through payments, subsidies, research grants, and tax breaks has evolved over decades.

Figure 3. Percentages of funder financing
Source: Adapted from National Health Expenditures, Tables 5.3 & 5.4, Centers for Medicare & Medicaid Services



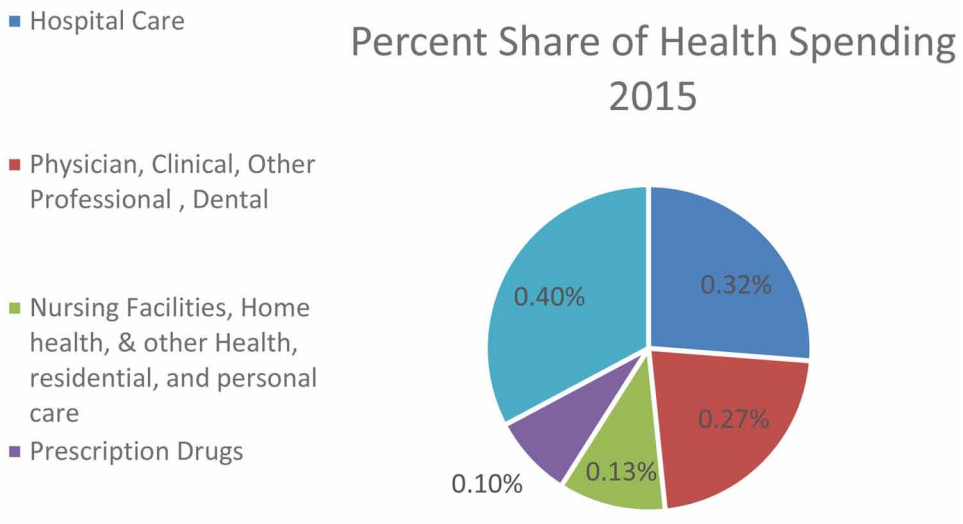
Who is paying the healthcare bill? As indicated in Figure 3, in 2015, state and local governments accounted for about 17% and the federal government accounted for about 29%, with private households and businesses picking up the remaining 28% and 20% respectively (NHE, 2015).

Ultimately, the role of public administration in achieving the Triple Aim (population health, patient satisfaction, and cost efficiencies) is constrained by the public interest in maintaining and supporting a health economy. What may be most beneficial to affordability, efficiency, and effectiveness is certainly in direct opposition to sustaining a viable healthcare marketplace. Today's public administration plays several roles in the healthcare marketplace: provider, purchaser of services, initiatives and research funder, regulator, and policy implementer. How do these diverse roles reconcile with the conflicting goals of marketplace moderator and guardian of public goods and services?

Marketplace synergies have placed a premium on the healthcare industry. The dynamic system of public and private investments has led to a complex, yet, evolving system of care. The stabilizing force of more than a trillion dollars of public revenue investment has led to the creation of a healthcare industrial complex that rivals the world in its achievements. The U.S. continues to lead the world in medical technology, medical training, research, and sophistication of its complex and multivariable system. Figure 4 identifies the distribution of healthcare funding across the different businesses, keeping in mind that these business represent for-profit, not-for-profit and public sector. Examples of for profit business included in the categories provided in figure 4 include prescription drugs and physicians while examples of not-for-profit include most hospitals and some nursing homes.

In fact, capacity building in general for local health organizations has been dependent in no small part on how the public sector incentivizes collaboration with community based (marketplace) resources (Campbell and Conway, 2005). The Institutes of Medicine have noted that the scope and success of any health care system to affect community health relies upon multiple actors building public and private partnerships (2002).

Figure 4. Distribution of healthcare spending by category
Source: Adapted from National Health Expenditures, Highlights, 2015



THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA): A PERIOD OF UNCERTAINTY

The 2010 enactment of the first comprehensive effort to assure health insurance access to millions of Americans relied heavily upon the private insurance marketplace. With incentives and subsidies, and a large expansion of Medicaid, coupled with regulations and restrictions, health insurance was extended to nearly 20 million Americans (Kaiser, 2016). However, in an effort to stabilize this massive overhaul of the healthcare delivery system, the PPACA needed to create some protections for the insurance marketplace. The PPACA provided for three methods for mitigating the adverse impact on the insurance market of the entrance of millions of Americans into the market. These methods included risk adjustment (transfers funds from a healthier pool to cover high-cost enrollees), reinsurance (allowing some reimbursement to insurers to offset high-cost patients); and risk corridors, to enable insurers to trade between overestimated areas and underestimated areas (Levitt, 2015). Both the reinsurance and risk corridor programs are time limited but currently, the risk adjustment program remains permanent.

While the Patient Protection and Affordable Care Act (PPACA) has greatly expanded access to health care, it is estimated that 7% of the U.S. total population, 23 million Americans, will continue to remain uninsured in 2019. This figure assumes no restrictions or rollbacks on the access to care delivered by the affordable care act.

Unfortunately, all is not stable in the insurance marketplace under the PPACA. Several insurance companies have determined that losses in healthcare premiums have not been offset by the number of new, healthier, subscribers. Among those major insurers exiting the insurance marketplace, Humana announced it was going to stop selling plans on the insurance marketplace exchange. Aetna dropped 11 states from its roster. UnitedHealth is limiting itself to delivering premiums in a handful of states, down from 34 states in 2016 (Livingston, 2016). However, it is important to point that these are three of the largest health insurance companies in the United States, each with a health market value and net sales. These companies are presented in descending order, each posting enormous market shares and net sales, in Table 2.

IMPLICATIONS FOR PUBLIC ADMINISTRATORS

What, or who, determines public value? Who determines what good is a public good? It may be argued, this determination is made when it is the will of the people or where there is an inherent and compelling public interest. In 1948, the UN Declaration of Human Rights put forth in Article 25 the right for all

Table 2. Health insurance fiscal standing

Insurer	Market Value (in Billions)	Net Sales (in Billions)
UnitedHealth	112.7	130.5
Aetna	38.8	58
Humana	27.2	48.5

Source: Adapted from Forbes.com

people to have medical care. It took nearly 40 years for the U.S. to ratify this declaration. In 1976, the United Nation's International Covenant on Economic, Social and Cultural Rights Article 12 recognized, "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". As of this writing, the United States had not ratified this covenant.

In 1969, Galtung coined the phrase "structural violence", to explain widespread systemic violence, for example, disparities among life expectancy for affluent communities vs poor communities. Should the U.S. efforts to reduce healthcare inequities within its on environs be considered progress toward alleviating one edifice of structural violence? One might argue in the affirmative. Conversely, as Wolff (2012) posits, how do we negotiate a universal right to health when resources are limited? Inevitably, the attempt to reduce health disparities must eventually lead to some measures of resource allocations and restrictions. While the public sponsorship of some level of universal healthcare is necessary to combat these disparities, a new problem for public administrators is created. How to build an equitable system of healthcare that delivers the most good for the greatest number of people. In our current global environment in which very little lies beyond our ability to witness, resource allocation should not be limited by government boundaries.

As population growth has slowed, but continued to slowly rise in the U.S., so spending on health care has slowed but continued to grow. Consider the trends noted in Figure 5. First, investment in healthcare, such as research and development in the government or not-for-profit centers has held fairly steady. Meanwhile, health consumption expenditures includes spending for all medical care rendered during the year (this includes all public health spending) and national health expenditures are the aggregate of the health consumption expenditures plus investment (CMS, 2015).

Figure 5. U.S. population growth
Source: Created from U.S. Census Bureau Data

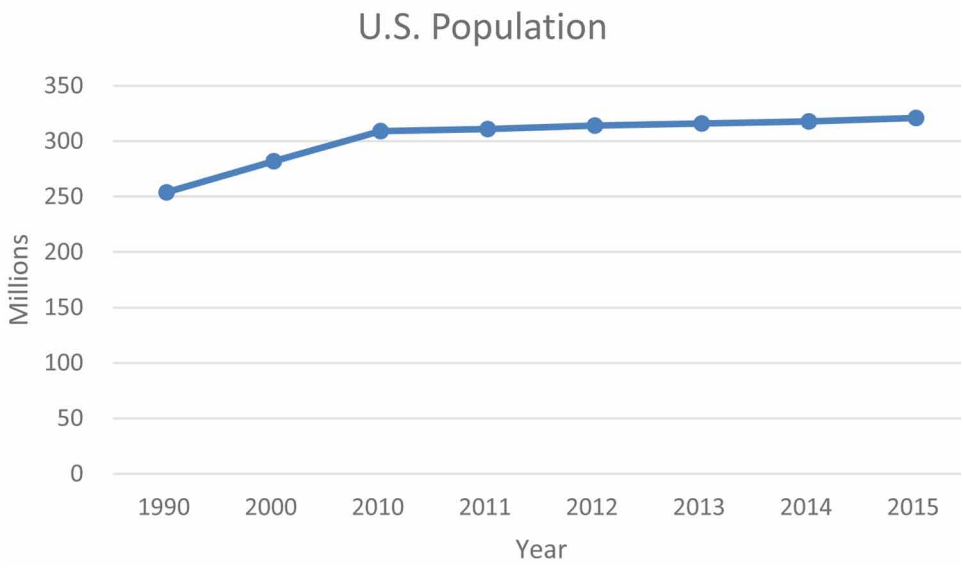
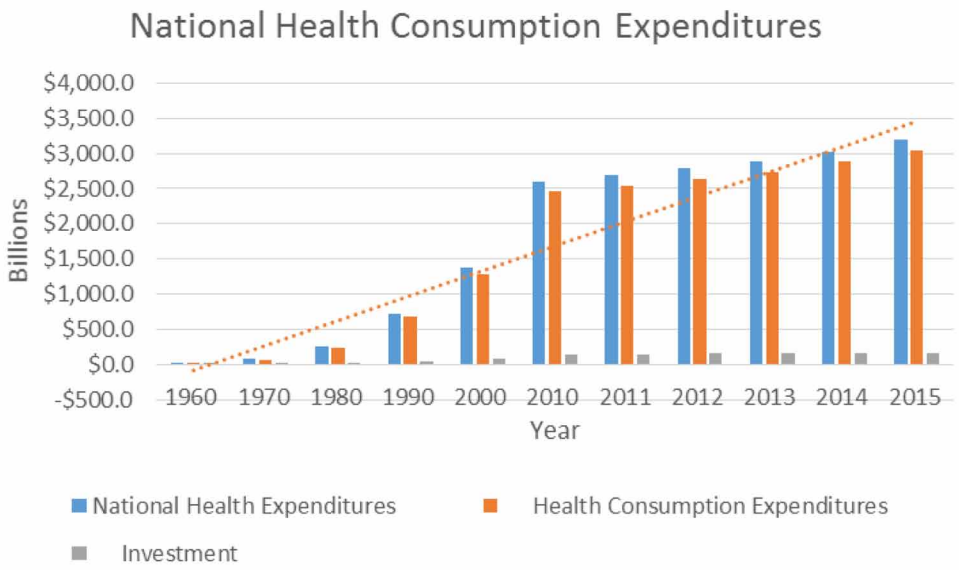


Figure 6. Trend line for u.s. health consumption expenditures
Source: Adapted from National Health Expenditures, Table 01, Centers for Medicare & Medicaid Services



One of the biggest questions that public administrators across all levels of government must wrestle with is the question of sustainability. While supporting the marketplace with significant stabilizing funding, the burden facing tax payers is enormous. As governments are under pressure to meet increasing demands for services coupled with demands for lower taxes, public administrators must systematically decide where the best investment of public goods and services will achieve the highest possible outcomes in healthcare at the most affordable price. The question is, can this be achieved while continuing to support healthcare as a profit yielding industry?

CONCLUSION

This chapter has explored some of the fundamentals of how the U.S. healthcare system is firmly supported by an active investment of public financing in the private healthcare marketplace. The bulk of this investment takes the form of capital outlay for infrastructure, direct payments for healthcare services, and research and development. While the public price is steep, the U.S. healthcare industry, subsidized heavily in its current iteration, serves as an enormous employer and innovator. How best should changes be made that will deliver cost efficiencies with minimal degradation of the marketplace? Is it even possible or is a fundamental restructuring necessary to accommodate the population health goals established under the Triple Aim? These are questions to be wrestled with not only at the federal level, but across states and local governments and within board rooms. If the U.S. is to join with most economically advanced countries of the world and develop some form of universal healthcare, it will in all likelihood depend upon a serious examination of just how much private industry can be supported by public tax dollars. However, the public private system that has been in place in the U.S. for over 200 years has advanced

global health, eradicated disease, invented innumerable technological achievements and expanded life expectancy. Without the injection of stable and substantial revenues from the public sector, would these same successes have occurred? A glance around the world at our neighbors suggests that perhaps not.

DISCUSSION QUESTIONS

1. Analyze the healthcare system paradox referenced by the author and determine the implications it presents for public administrators as we move through the next 20 years.
2. What intergovernmental and cross-sectoral tensions and challenges have emerged as the result of historical and contemporary healthcare legislation?
3. Consider the term, "structural violence". Explore whether or not adequate progress has been made to reduce its impact. Next, expand your exploration beyond the U.S. borders. Does your opinion change regarding your original answer?

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