A Prescription for Health Care

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A PRESCRIPTION FOR HEALTH CARE REFORM

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The purpose of health care reform is to restructure the system of health care delivery so that everyone can have access to care and spiraling costs can be controlled. Health care should be given to those who are in need of medical assistance, but currently it is a service available only to those who can afford to pay for it, those whose employers use it as a means of compensation, or those poor enough to be eligible for Medicaid. There are currently nearly 39 million Americans who are uninsured, and millions more are underinsured. From 1989-1990 alone, 1.3 million people joined the ranks of the uninsured. "No longer is it simply the poor who must be concerned about access to health care" (Leichter, xi). Although, that is not to say access to health care is not a problem for the poor. The poor make up the largest portion of the uninsured and as a result, they use less health care and remain less healthy throughout their lives than those who have always had access to coverage.
What does it mean to be uninsured? It means that you will have to give up nearly all of your possessions and drain your life savings should you happen to develop a disease or be seriously injured. Not only do you worry about your health, you have the added distress of financial security (or insecurity) for you and your family. Over the course of the last year, we've listened to President Clinton tell us about the owner of a small business in Florida who's seen health care insurance premiums skyrocket. He could no longer afford to provide coverage for his seven employees. His insurance company explained that two of his workers had become high-risks because of their advanced age. Unfortunately, those two people were the owner's parents who had founded the store and worked there all their lives (Clinton, 3) Senator Boxer of California told us of a nineteen-year-old football player who was hit by cancer. His only chance of overcoming the disease was a bone-marrow transplant, but his health insurance didn't cover it. Dying of cancer, his family was forced to advertise their need and hold a fund-raising dinner to help them meet the costs of treatment (Mitchell, 675). Senator Mitchell reported on a retired nurse from South Dakota, living on a fixed income. The costs of her heart medication forced her to choose between eating and taking her medication (Mitchell, 675). We've heard the stories about people who can't get coverage because of a
pre-existing condition for which they need care. We've heard about the bankrupting costs of in-home care for the elderly, and the stories of families whose children's medical needs exhaust their "lifetime" insurance limits. The heart-breaking stories are infinite. Reforming America's current health care delivery system is a task that can no longer be ignored. It is an issue of equality and of justice.

It is common knowledge that human beings are born unequal in ability and wealth. People are born with mental, physical, and social capacities which may limit their opportunities. No one is able to choose the family into which they will be born, or whether disease will strike that family. Illness and accident are uncertain. We have a responsibility as a wealthy nation to provide care for those members of our society who cannot pay for expensive, but badly needed treatments. Thus, there is no other choice than to implement some type of delivery system to care for those in need, in spite of their income. People shouldn't have to deplete their life savings in the event of a health care emergency.

In June of 1991, a resident of Minnesota told his story to Ted Kennedy's Senate Labor Subcommittee investigating access to health care. He was employed as an auto sales manager, but was in the process of starting a new job when his son was diagnosed with lymphocytic
leukemia. His chances for recovery were excellent, but treatment would be costly. The man had signed up for health insurance at his new job, but his son would not be covered because of his preexisting condition. After seeking help from many social service workers and attorneys, the family was told that their best option would be to spend down their assets so that they would sink significantly below the poverty line, to declare bankruptcy, and to file for public assistance, which would allow them to receive Medicare (Kaplan, 13). The condition of our health care delivery system had forced this hard-working family to give up their jobs and everything they had earned to be able to receive medical care for their son. Our system made them better off on welfare than continuing to work at their careers. This system is clearly not beneficial to anyone involved. And this story is not unique, yet we still leave the distribution of medical services to the discretion of wealth.

In America, there are many goods and services which we provide publicly. We provide some minimal standard of nutrition for those who cannot afford to buy food. We do this because we feel responsible, as a community for taking care of our less-fortunate neighbors. Likewise, we provide public education and believe that everyone should have the opportunity to learn regardless of their personal circumstances. Without
public education, the poor would be excluded from leadership opportunities and the inequalities of wealth would persist. Our entire community benefits when its individuals gain success. Just as our entire community would benefit from secured medical care for all individual members.

We provide the security of fire extinguishing, police protection, and civil defense services to protect us from things beyond our immediate individual control. These services are ideally provided communally, and do not depend on financial status. Imagine if the police department were based on a fee-for-service system, like medical help is. Would the innocent victims be allowed to be attacked because of their lack of "police insurance"? Security and safety are things we all need, so we provide it, at some basic level, for each other publicly. Some even choose to supplement their safety with things like electric security systems in their homes and cars, but everyone has access to at least some minimum level. Members of the community may not be excluded from receiving a public good like police protection. Similarly, the sick need health security, and should not be excluded from receiving it. It is an essential human need to which everyone should have access.

If we didn't provide security for each other, some basic set of goods
which make it possible to participate in society, there would theoretically be no reason for us to form societies (Walzer, 64). The concept of membership is important in the discussion of the proper distribution principles of medical care. Membership in a society is what the people of a particular community have in common. Food, safety, education, and medical care are some of the things that the people of a wealthy nation such as our own should be able to provide for each other. In his book, *Spheres of Justice*, Michael Walzer says, “Membership is important because of what the members of a community owe to one another and to no one else, or to no one else of the same degree. And the first thing they owe is the communal provision of security and welfare” (Walzer, 64). If we cannot provide such basic security as personal health care to the sick and desperate, then we are failing at our attempt at communal provision of security and welfare. Middle- and upper-class Americans have better access to health care than their poorer fellow citizens. Walzer explains why these discrepancies are so serious:

Were medical care a luxury, these discrepancies would not matter much, but as soon as medical care becomes a socially recognized need, and as soon as our community invests in its provision, they matter a great deal. For then, deprivation is a double loss- to one's health and to one's social standing. Doctors and hospitals have become such massively important features of contemporary life that to be cut off from the help
they provide is not only dangerous, but degrading (Walzer, 89).

When we fail at communal provision of these basic human needs, we deny the rights of membership to those who deserve it. Membership is important to one's dignity and thus, should not be determined by a person's income.

In describing the sort of communal provision that is appropriate in America, Walzer lays out three key principles:

1. That political community must attend to the needs of its members as they collectively understand those needs to be.
2. That the goods that are distributed must be distributed in proportion to need.
3. And that the distribution must recognize and uphold the underlying equality of membership. (Walzer, 84)

Number one. The political community must attend to the needs of its members as they collectively understand those needs. Americans can understand that there are nearly 39 million members with no health insurance. Three-fourths of the people who joined the ranks of the uninsured from 1989-1990 had incomes of more than $25,000 per year (Leichter, xi). We spend more than any other country in the world, but are not proportionally more healthy. The U.S. is seventeenth in the world in infant mortality, and it leads the westernized world in the proportion of
its population that has no way of paying for medical care (Kaplan, 15). The U.S. child immunization rate is lower than in many third-world countries, and has been falling (Viewpoints, 43). The National Medical Expenditures Survey of 1990 found that those most likely to be uninsured are between 19 and 25 years of age, and the second most likely group of uninsured are children younger than 18 years old (Kaplan, 27). Our system is inefficient and its delivery is biased. We understand the problem, we just choose to ignore it in hopes that it will fix itself.

In President Bush's inaugural address, he excused the lack of solution to this crisis by saying, "We have more will than wallet". This is merely an excuse for the government's disregard for this problem. But, Henry J. Aaron, an expert on health care economics, writes, "The United States is a nation blessed with the highest per capita income of any developed country in the world. Its national product is two and a half times larger than that of the second largest economy. It is enjoying its longest peacetime expansion. The question is not whether America has enough wallet, but whether it has the will to use its abundant wealth to solve the problems that it faces" (Aaron, 2).

Former U.S. Congresswoman, Barbara Jordan once said, "Things which matter cost money, and we've got to spend money if we do not want
to have generations of parasites rather than generations of citizens" (Zahniser, 4). Her sentiments are especially true with regard to health care reform. A 1989 study found strong evidence that lack of private health insurance increased AFDC participation. The researchers predicted that the AFDC caseload would drop 16% if all working female heads had insurance coverage equivalent to Medicaid (Bane and Ellwood, 105). And a 1990 study by Ellwood and Kathleen Adams found that people with high expected medical costs are less likely to leave welfare (Bane and Ellwood, 105).

It has also been popular to argue that this increased percentage of GNP devoted to health care ultimately undermines the competitiveness of U.S. products abroad. The international consequences of rising health care costs have been studied. In 1960, the U.S. spent only 5% of GNP on medical care. By 1990, medical services accounted for 12.2% of GNP, and the expenditures are expected to rise to more than 15% of GNP by the year 2000 (Kaplan, 18). At first glance, the correlation between percentage of GNP and decreasing competitiveness of U.S. goods abroad seems to make sense: Higher health care costs mean higher costs of labor. Higher labor costs mean higher costs of production. Higher costs of production mean higher prices for consumers. Finally, higher consumer prices make it
difficult for these American companies to compete with foreign products produced at lower costs (Aaron, 95). However, Henry Aaron explains why this is not true. First, companies with rising health insurance costs will offset the added cost of the insurance by smaller increases in wages or other fringe benefits. Companies are interested in the total cost of worker compensation, not just in a single component of compensation (Aaron, 95). Second, a change in health insurance costs can affect the competitiveness of the U.S. only if it changes the difference between domestic investment and saving, or if it changes the government deficit (Aaron, 95).

So, Aaron and many of his colleagues believe that the percentage of GNP that we are spending on health care will not have much of an effect on the competitiveness of U.S. products, but it could distort the balance of trade. Although some have argued that our expenditures on health care will mean the economic ruin of America, Aaron believes there is little danger of this actually happening. However, for the enormous amount of money we are spending in this industry, the inequities of health care distribution are inexcusable. Soon, we will be spending one-fifth of our GNP on health care and we will still have people who don’t have access to the care that they need.
Number two. *That the goods that are distributed must be distributed in proportion to need.* Health care in America is currently a commodity. It is not distributed according to need, rather on one's ability to afford insurance coverage. But, any talk of providing universal access instills in some a fear of rationing. The truth is we are rationing already. The only difference between the U.S. and other countries that ration medical care, like Britain, is that we ration health care by not providing it to entire classes of people (Kaplan, 16). "The United Kingdom gives priority to equity. The United States gives priority to excellence. American society, while proclaiming the finest health care in the world, offers excellence for the fortunate at the expense of access for all" (Kissick, 121).

Children and the working poor make up the majority of the uninsured (Kaplan, 27). The working poor is the group of people who work full time, but their jobs don't offer adequate health insurance coverage. A 1987 survey showed that 47.5% of individuals or families with incomes below the federal poverty level had no health insurance whatsoever (Kaplan, 27). "The national average for Medicaid eligibility is set at less than 50% of the federal poverty level. With the current federal poverty level at about $12,000 per year, this means that a family of three with a yearly income of $6,000 is too rich to be considered eligible for Medicaid support"
(Kaplan, 27). This is the type of regulation which either traps people on welfare or hinders the struggle for self-sufficiency for the working poor. The National Medical Expenditures Survey conducted in 1987 found that among ethnic groups, 18.6% of whites, compared with 29.8% of blacks, and 41.4% of Hispanics were uninsured during that year (Kaplan, 26). When broken down by industry, the 1990 Census revealed that construction workers and workers in the agriculture industry, those who are most likely to be injured on the job or exposed to harsh chemicals, are rarely insured by their employers. In contrast, public administrators, those who make and influence public policies were almost universally insured (Kaplan, 27).

While there are too many Americans who are unable to see a doctor, conversely, the overutilization of medical services is one of the major causes of the skyrocketing costs of health care. Health care is a finite resource, and the right to care exercised by one person can diminish the availability of care for another (Kissick, 120). U.S. patients have relatively short hospital stays compared to patients in other countries. But, once admitted, the U.S. patient on the average will be subject to much more intensive treatment than anywhere else in the world (Aaron, 82).

"Doctors admit that they waste anywhere from $15 billion to $100 billion
each year on unnecessary procedures" (Castro, 31). The rates at which medical procedures are performed vary widely among countries. Of nine common surgeries, the U.S. physicians performed more than the average for all but two (Aaron, 82). Some doctors may use excessive testing for insurance reasons, or to protect against malpractice law suits, but other doctors are clearly motivated by the fee-for-service system. The fee-for-service system is how health care providers are generally paid. They are reimbursed for every procedure they perform or test they run, adding their profit to the bill. Some doctors have financial interests in labs or radiology facilities. "A study in Florida found that those owned by physicians did twice as many tests per patient as did labs owned by non-physicians. Another study found that doctors with financial interests in radiology facilities referred patients four times more often than did physicians who had not invested in such facilities" (Rasel, 41).

Physicians in America face what Robert Kaplan calls the Hippocratic Predicament, referring to the oath taken when medical students graduate. "On the one hand, physicians have taken a solemn oath to do everything in their power to help individual patients. Further, they have pledged not to consider social standing as a factor in treatment decisions. Yet the American system has evolved such that there is discrimination on the
basis of income and social standing. Further, resources are limited to the extent that we are unable to provide basic services for all people” (Kaplan, 40). So, care is not being given to many who need it and too much care is being given to people who are not benefitting from it. It is quite obvious that health care in America is not distributed in proportion to need.

Number three. And that the distribution must recognize and uphold the underlying equality of membership. If membership is to be distributed among equals, it is unjust to exclude our equals from receiving needed medical care. So, when we exclude the poor and sick from receiving medical care (which is fundamental to one’s security and well-being), we are denying them membership. And to deny membership is to deny equality. “The assurance of dignity for every member of the society requires a right to a decent existence-- to some minimum standard of nutrition, health care, and other essentials of life” (Okun, 17). Therefore, all are to receive care, the assurance of dignity, when they are in need, because of their equal membership in our community.

The three principles described by Walzer are meant to apply to any community where the members are, or ought to be each other’s equals (Walzer, 84). These principles about equality and membership are basic
guidelines for constructing a policy for public health care. “Thinking about health care priorities involves thinking about the ends of medicine itself in a way that is communally oriented and not simply individualistic, and in a way that sees medical knowledge and technology as a public resource of common value and not simply as an instrument for the realization of individual self-interest” (Leichter, 199,200). Anyone in need of treatment should be able to receive the benefits of medical technology and knowledge that our country has to offer its citizens. “So long as communal funds are spent, as they currently are, to finance research, build hospitals, pay the fees of doctors in private practice, the services that these expenditures underwrite must be equally available to all citizens” (Walzer, 90). We must also decide to what extent services will be provided.

The concept of providing access to everyone who needs it is objected to by few; even the most conservative faction can recognize that health care is a basic human need. At some point, we must set priorities. To what extent should coverage be provided and how do we define what an equitable minimum standard of care is? “America’s insistence on absolutes in health care has inhibited its ability to guarantee access to basic health services for every individual. Access, quality, and cost
containment cannot be achieved in absolute terms. Access to basic health services for all Americans, like access to elementary and secondary education, can be provided only as a relative right” (Kissick, 121). There can be a minimum standard of care, but the rich can always buy more, and the poor will always be excluded from something. “Define benefit broadly enough and give a social carte blanche to individual perceptions of need and want in a society as risk averse and as health conscious as ours, and one more incremental utilization of health care services can always be justified. And it will always be demanded by someone.” (Leichter, 198). Arthur Okun believes it is difficult to define a minimum standard because of costs. He says,

Any entitlement is more likely to be established as a right when it has relatively low resource costs, when economizing and comparative advantage, and the other verities of the marketplace are relatively unimportant compared with the significance of broad sharing and common access...Although the right to survival now seems to be generally accepted, it has not been explicitly written into our statute books. It has been kept fuzzy because its fulfillment could be very expensive. Uncertainty holds down the resource cost” (Okun, 16-18).

So, Okun believes that our fuzzy definition of rights is our largest obstacle in the fight to attain universal access. As soon as our rights in the realm of health care are defined, we could be faced with a very expensive tab. We need to decide what universal access entails, we need
to set the priorities of distribution in a socially responsible manner, and we must consider costs. But a cost-benefit analysis cannot solve this problem. "Cost-effectiveness is often championed as a solution to the problem of the iron triangle [Kissick refers to the 'iron triangle of health care' as the relationship between access, quality, and cost-containment. To achieve more of one aspect, we have to compromise the other two]. It seems to deliver appropriate quality at the lowest unit cost. But the addition of universal access returns one to the question of trade-offs. Although it may be politically unattractive, a health care strategy must balance cost with quality and access to yield the greatest good for the greatest number" (Kissick, 4). In other words, we must define what basic coverage is and make sure that everyone gets it. But realistically, we will all pay for the reform. Health care for all will not come without a cost.

We must ensure that all members of society gain the right to a decent existence by financing a program to provide a standard system of health care coverage. When defining our priorities for common access, and for coverage limits, we must consider both the common value of medical knowledge and access to care, as well as the economic implication of setting such priorities.
PART TWO: WHY HEALTH CARE COSTS SO MUCH

American health care is some of the best in the world, but it is also the most expensive. It's costs are due to many aspects of this unique industry. It is difficult to think of the health care market in the same way as the market for say, M&Ms. First of all, "consumers" in the health care market aren't really what we usually think of when we use the term "consumer". Usually, "consumer" refers to a person who knows how much they are willing to spend for a particular product. The average "consumer" usually has some knowledge about the product she is considering, and also she has some knowledge about other options, or substitutions to the given product. Take M&Ms again. You usually know that a package of M&Ms will cost about $.65. You probably don't value M&Ms enough to pay $50.00 for that same package. Also, you have a good working knowledge of the product: plain and peanut. You also know that if M&Ms were $50.00, you could get just as much satisfaction from a KitKat or a Snickers bar. This type of market and consumer doesn't exist in the realm of health care.

In the American health care industry, the consumer is hard to define.
The patient may receive a particular service, but it is most likely her doctor who made the decision to purchase that service, and her insurance company which will typically pay for the procedure. In order to have an ideally efficient market system economists have defined some ideal conditions under which it must operate. First, buyers must have good information about the product, and its price (Implications, 12). This allows the consumer to decide how much he/she values that product, a decision which is necessary prior to the purchase of a good in a free market. Secondly, market efficiency requires a large number of sellers whose competition with each other reflects true resource costs (Implications, 12). The market for health care, however, does not operate under these conditions, thus it is not a discretionary good.

Consumers in the health care market are, for all practical purposes, patients. They generally do not know about the consequences of different medical treatments, nor are they able to determine whether they even need medical care at all (Browning, 180). Also, it is difficult for patients to find information about the costs of procedures. Patients' lack of knowledge about quality and price make it difficult for them to judge the value of a given medical service, as they would if they were paying for it themselves. Also, it is difficult for someone outside of the medical
profession to independently and accurately assess the appropriateness or urgency of a given procedure. Since patients usually know very little about price and treatments, their decisions about purchasing care are made by someone other than themselves, namely their physician. When the physician, not the buyer, decides both how much and what type of care will be purchased, and also gains financial rewards from the sale of that care, it is known as physician-induced demand, or physician sovereignty. The power of a physician to decide what level of care will be given to a patient stems from the following circumstances:

First, a small minority of very sick patients account for most health care expenditures. Seriously ill patients cannot review the appropriateness of care. Second, and more generally, patients frequently do not know what diagnostic procedures or therapeutic measures are necessary: that is one reason they go to doctors. (Aaron, 15)

Patients, especially those with health insurance, usually trust their doctor's decisions and rarely have any incentive or desire to shop for alternatives for financial purposes.

Because most people pay for health care through some form of third-party payment, they have few incentives to look for cost-efficient options. Third-party payment is when another party other than the patient or the physician pays for health care. Third-party payments are usually in
the forms of insurance companies or government sponsored programs such as, Medicare and Medicaid. Insured consumers pay only relatively small or nonexistent copayments, and the total costs are spread out among an insurance company’s policy holders (Implications, 2). Because the out-of-pocket costs are so modest, patients and doctors have little incentive to economize on the use of medical resources (Browning, 183). People generally do not shop around for many reasons: because they have an established relationship with a doctor, because they are sick, or because meaningful price information is hard to come by (Enthoven). But the biggest reason most consumers don’t look for lower-priced services is because someone else pays for most or all of the cost anyway. The third-party payment system is like giving provider and patients a credit card for which someone else pays the bill. This causes consumers to view health care as a “good deal” which increases their demand for health care and also causes prices to rise. The third-party insurance system creates incentives for consumers to consume health care for which the costs exceed the benefits.

Insured consumers tend to feel that health care is a good buy because they pay a relatively small portion of the cost. When we debate the overutilization of services by consumers, we should remember that
consumers in this market are sick people who are seeking help. After all, patients know very little about medical services, and it is the providers who make the decisions about what care is to be purchased. When a sick patient sees a doctor, that doctor is inclined to prescribe a treatment that may or may not be necessary. For instance, health care is usually provided through a fee-for-service system. This is when the health care provider is reimbursed for every procedure and for every test they perform, adding their profit to the bill. This creates incentive for providers to increase the amount of care given, in excess of that which may be appropriate (Cutler, 15). Through the fee-for-service system, providers can charge different purchasers different prices for the same service. Less favored insurers and uninsured individuals who lack market power to negotiate or insist on lower prices (like governments do) ultimately face higher prices. This may provide insight to why doctors have such large incomes. The Congressional Budget Office reports that American physicians earned 50% more than physicians in Canada, 55% more than physicians in Germany, and three times as much as those in the U.K. in 1986 (Trends, 8). Under a system like this, no doctor would opt for a salary, when he/she can dictate both the price of his/her services, and how much of it will be sold. There are few financial incentives to merely suggest rest, stress
reduction, or to promote prevention. Also, physicians cannot always be fully informed of all the new treatments and discoveries in this age of constant information and rapid change. Therefore, physician preference, rather than science, may often determine what procedure is used for a given disease or injury (Implications, 14). The Congressional Budget Office reported the findings of several studies on this theory:

For example, a study on the practice of medicine found that 40 percent of men in Portland, Maine, had prostrate surgery by age 85, compared with only 12 percent of men in Bangor, Maine. Similarly, heart surgery rates in Des Moines, Iowa, were nearly twice those in Iowa City... In another study, Using a sample of 1,302 Medicare patients who had carotid endarterectomies, found that 1/3 of the operations were inappropriate according to doctors who reviewed the patients records after the operations. For these patients, the expected benefit of the surgery was not sufficient to offset the risk of complications. (Implications, 14)

So, providers play a substantial role in the increasing demand for health care. But should they be forced to shoulder more of the responsibility for the abuse of the third-party payer system, and the increasing costs of care in America? The providers are not trained to control costs, they are interested in using any measures available to help their patients. “Many doctors do earn a large sum of money, but this has nothing to do with the nation’s high medical bills. For every dollar that Medicare spends on physician fees, it spends $3 on bureaucratic salaries
and $98 on hospital and nursing home charges” (Wohl, 178).

The growth of improved technology and the increase in its use has accounted for most of the increase in the bill for health care costs. The third-party payment system encourages the proliferation of more development in technology.

As long as health insurance pays for new technology on a fee-for-service basis, the private sector is encouraged to develop any innovation regardless of cost, that is likely to increase the quality of care. These technologies, in turn, raise the overall costs of health care. And as these costs go up, consumers often want more insurance coverage to protect them from the increased costs of health care and to gain access to the new technologies. (Implications, 22)

The third-party payment system provides a ready market among consumers and providers for any type of technological development regardless of its effect on the cost of care (Aaron, 48-49).

This effect makes the industry of developing and selling medical technology highly profitable.

The aim of hospitals to also make a profit makes the market for technology that much more friendly. The CT scanner, for instance, is a million dollar piece of equipment which is used to detect head injuries.

In San Mateo County in California, for example, there are six hospitals within a ten mile radius of each other, and each
usually offers coverage for small expenses like check-ups, physician
her/him to bear alone. The third-party health insurance system, however
against unforeseeable events that may cause damage too extensive for
The traditional purpose of insurance is to protect the uninsured
overutilization lies in the existence of the third-party payment system.
patients (Wohl, 58). The foundation for this development and
physicians groups that prescribe the use of their machinery for the
also own shares in the hospitals that buy their machines and in the
replaced at greater cost. In addition, the suppliers of medical machinery
medical machinery, which quickly become obsolete, requiring them to be
equipment (Wohl, 57). These companies profit from the sale of their
vested interest in the maximum and unnecessary utilization of this
machines, computers, and other very expensive medical equipment have a
health care costs. The corporate giants that supply the CT scanners, X-ray
Expensive medical equipment is one of the prime reasons for escalating
always necessary equipment (Wohl, 39-40)
insufficient to support the proliferation of expensive and not
have an ER. In short, many hospitals’ patient load was
that condition no longer prevalent. In fact, some 200-bed
hospital with an ER seeing 25,00 per year. By 1980, however,
collar CT scanner, the rule of thumb had initially been that the
hospital features a CT scanner. With regard to the million

consultations, and other such services. Economists would argue these types of expenses, which are qualified as small risk expenses, can be purchased more efficiently without an insurance system (Browning, 181). It makes little practical sense to rely on a third party, which will add its own administrative costs to the bill, to pay for these small expenses.

Consider the following example:

To take an extreme case, suppose that you know with certainty that you will have a physical checkup costing $100 next year. An insurance company would be willing to sell you a policy to cover this expense, but only at a price of $110, for example, because it has to cover its own costs in addition to the cost of your physical. You would, of course, be better off paying the $100 bill directly and saving $10. In this case, there would be no insurance protection against risk because there is no risk, and the addition of $10 payment to the insurance company would provide no service. (Browning, 181)

In effect, if small risk expenses were not covered by most insurance as they currently are, the demand for these services might decrease. Thus, the law of demand would dictate that the prices for these small services would also decrease, perhaps to a level that people could afford to pay for from their pocket. This would make the market for small health services more efficient by consumers' use of cost/benefit analysis. After all, the most serious drawback of low-risk insurance is its lack of constraint on the utilization of medical services and the prices charged by providers
insurance, they eventually shift most of their costs to workers in the
the employees wage. Although employers pay for a large portion of this
portion, however, that employers provide these benefits over and above
subjected to taxes, but wages are "(Employment, 3). This does not mean
exclusion--that is, because premiums for health insurance are not
average, 26% less than the true cost of the insurance because of the tax
earned as health insurance. "People who get insurance at work pay on the
Employment." (Also, employees do not have to pay taxes on incomes
employers can deduct insurance spending as a business expense
insurance as a fringe benefit, they get cheaper group rates and the
government through tax incentives. When employers provide health
low-risk basic coverage, dominate because they are subsidized by the
health insurance (Employment, 2). These plans, which most often offer
approximately 60% of the population is covered by employer-provided
Most people's insurance plans are provided by their employers;
been popular (Wilson, 29).
medical policies not tied to low-risk basic plans, such plans have never
Major insurance companies report that despite their efforts to promote
The consequence of the tax subsidy on health insurance is that it acts as an incentive for workers to overinsure themselves. As we have illustrated above, it is inefficient to cover small, predictable expenses because insurance companies charge a loading rate to cover their administrative costs. Employer-provided, government-subsidized health insurance, however, provides incentives to cover all medical expenses.

For example, on average, policies pay $1 in medical benefits at a premium cost of about $1.12. For risky events it may be worthwhile to apply this loading rate of 12 percent, but not for small and predictable ones. In the absence of a subsidy, a predictable medical expense would never be covered by insurance. However, when the rate of subsidy exceeds the loading rate, it becomes cheaper for workers to cover any medical expenses with employer-provided insurance. . . the tax subsidy gives all workers a strong incentive to have extensive coverage of medical services for which insurance is inefficient. (Browning, 187).

This incentive to insure for all medical attention is what leads people to disregard cost, when considering possible therapies and procedures. The subsidy acts to increase the demand for health care services, which causes the price of health care to rise. "More to the point, more resources will be employed to produce more health care, such that output will be expanded to a point where marginal benefit is far below marginal cost. In other words, welfare costs will be produced because of the subsidies" (Browning, 191).
Insurance companies have tried to solve the problem of overutilization of services, by trying to force consumers to consider costs. The use of copayments is one way to do this. Copayments either require that the patient pay a fixed sum of their total health care bill, or that they pay a percentage of that bill. In either case, the insurance companies usually cover costs below a very low ceiling. For example, the insurance company would pay 100% of the costs in excess of $1000 (Browning, 187). Unfortunately, this does very little to affect the incentives of most people with health insurance.

Many health care reform proposals have suggested a change in the tax exclusion policy to establish some cost consciousness among consumers. This can be accomplished in a variety of ways. One way would be to establish a cap on the amount of premiums which would qualify for the subsidy. This proposal aims to create an incentive for employers to contribute less health insurance as compensation to their employees. If employees are receiving less health insurance, they would either have to supplement it through their after-tax wages, or they would eventually demand less expensive health insurance (Employment, 35). "Limiting the escalation of health insurance premiums from personal taxation to a given dollar amount would preserve incentives for employers to sponsor health
higher premiums because of adverse selection (Employment, 48).

Certainly, the market for health care services is not efficient. Consumers as patients have little control over what they purchase. Their purchasing decisions are largely in the hands of their physicians. And consumers usually do not pay the full cost of their health care bills, which gives them little incentive to economize their spending. Couple these factors with government tax subsidies which provide incentives for people to overutilize health services, and we can begin to understand why America's health care prices are sky-rocketing out of control.
<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>STYLE</th>
<th>HOW IT WORKS</th>
<th>WHERE IT'S BEEN TRIED</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
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<tbody>
<tr>
<td>HMO (Health Maintenance Organization)</td>
<td>managed care</td>
<td>• patients enrolled in an HMO agree to see only the doctors that the HMO approves &lt;br&gt;• the HMO is responsible for both the financing and delivery of health services for a pre-paid fixed price</td>
<td>numerous U.S. cities</td>
<td>• manages peoples’ use of health services efficiently &lt;br&gt;• very popular</td>
<td>• not very flexible &lt;br&gt;• managements’ concern for the bottom line can jeopardize patients’ health &lt;br&gt;• does not provide universal coverage &lt;br&gt;• has not been proven to slow health care costs</td>
</tr>
<tr>
<td>PPO (Preferred Provider Organization)</td>
<td>managed care</td>
<td>• much like an HMO, except patients are allowed to seek medical care outside of the organizations’ network of doctors &lt;br&gt;• financial incentives urge enrollees to stay within the organizations’ network of providers</td>
<td>numerous U.S. cities</td>
<td>• manages health care services while maintaining enrollees’ freedom to choose their own physician &lt;br&gt;• very popular</td>
<td>• does not provide universal coverage &lt;br&gt;• has not been proven to slow health care costs &lt;br&gt;• managements’ concern for bottom line can jeopardize patients’ health</td>
</tr>
<tr>
<td>Managed Competition Act; The Jackson Hole Plan</td>
<td>managed care</td>
<td>• patients enroll in their choice of plans offered through a health plan purchasing cooperative called HPPCs &lt;br&gt;• patients choose plans known as accountable health plans, called AHPs, via HPPCs &lt;br&gt;• competition develops because plans would strive to offer most cost effective options &lt;br&gt;• patients would have access to usable info and performance statistics, which enable them to make better decisions about their health care</td>
<td>not yet been tried in its entirety</td>
<td>• educates patients about quality and price information &lt;br&gt;• gives patients choice &lt;br&gt;• holds physicians accountable through performance statistics and patient satisfaction surveys &lt;br&gt;• universal access available via subsidies to the poor &lt;br&gt;• addresses third-party payment ‘problem via tax on excessive coverage</td>
<td>• uncertain that competition is a good way to distribute medical care &lt;br&gt;• never been tried &lt;br&gt;• standard benefit package has not been defined, making costs difficult to estimate &lt;br&gt;• does not guarantee universal coverage &lt;br&gt;• competition doesn’t always exist</td>
</tr>
<tr>
<td>Health Security Act; The Clinton Plan</td>
<td>managed care</td>
<td>• everyone required to join large purchasing cooperatives which would negotiate their health care coverage and handle payments &lt;br&gt;• people would pay much more to retain free choice of physician &lt;br&gt;• mandated employer coverage &lt;br&gt;• national board of political appointees would regulate and determine benefits</td>
<td>not yet been tried, but borrows ideas from other plans</td>
<td>• comprehensive benefits &lt;br&gt;• uninsured population would diminish considerably with employer mandate &lt;br&gt;• attempts to eliminate Medicare/Medicaid fraud</td>
<td>• more bureaucracy created &lt;br&gt;• employer mandate could hurt small business &lt;br&gt;• comprehensive coverage will increase costs &lt;br&gt;• limits free choice of physician &lt;br&gt;• ignores third-party payer problem &lt;br&gt;• some health services are political and could be subject to party preference under national health board (i.e. reproductive services) &lt;br&gt;• uses average price of competing plans, rather than lowest price to determine contribution to the alliance</td>
</tr>
<tr>
<td>PROGRAM</td>
<td>STYLE</td>
<td>HOW IT WORKS</td>
<td>WHERE IT'S BEEN TRIED</td>
<td>ADVANTAGES</td>
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<tr>
<td>Oregon Plan</td>
<td>rationing</td>
<td>• employer mandated health insurance</td>
<td>Oregon</td>
<td>• everyone gets at least some health care coverage</td>
<td>• rationing has been attacked as inhumane and unfair to the poor</td>
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<td></td>
<td></td>
<td>• subsidized coverage for uninsured</td>
<td></td>
<td></td>
<td>• budget will affect what programs will be available</td>
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<td></td>
<td></td>
<td>• services that provide greatest good for greatest number of people get preference over services that are costly and serve individuals (i.e. prenatal care for low-income women is publicly funded, but transplants for Medicaid patients is not publicly funded)</td>
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<td></td>
<td>• cost/benefit analysis is used to determine what is beneficial to society</td>
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<td></td>
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<td>• those who can pay for services out-of-pocket may do so</td>
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<tr>
<td>American Health</td>
<td>single</td>
<td>• federal government collects and distributes funds to pay for health care services</td>
<td>Canada</td>
<td>• universal coverage</td>
<td>• some health services are political and could be subject to party preference under National Health Board</td>
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<tr>
<td>Security Act</td>
<td>payer system</td>
<td>• national board of political appointees will oversee the program</td>
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<td>• cost effective</td>
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<td>• required budgets for hospitals and fee schedules for providers</td>
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<td>• comprehensive benefits guaranteed for life</td>
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<td></td>
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<td>• progressive tax and savings from simplified administration will fund program</td>
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<td>• breaks tie between employment and health insurance</td>
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<td>• limits competition</td>
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<td>• patients can retain free choice of physician</td>
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<td>• will slow escalating costs</td>
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PART THREE: THE PROPOSALS

MANAGED COMPETITION

Managed competition is a form of health care delivery that aims to stimulate competition between networks of health care providers, while consolidating consumer buying power into more cost-conscious, better informed insurance groups. This idea was developed during the 1970s with the advent of the health maintenance organization, or HMO. The HMO enrollees agree to obtain all health services, except for emergency and out-of-state care, with the authorization of the HMO or its affiliated providers (Merlis, 2). The HMO acts as both insurer and provider. It is responsible for both financing and delivering health services to an enrolled population for a pre-paid, fixed price (Kongstvedt, 12). Although the HMO was innovative, its primary function was to manage peoples' use of services as efficiently as possible. The HMO makes a profit when patients don't use as many services as they pay for. Thus, the HMO was not very flexible in handling the health needs of its clients. However, this type of organization became extremely popular because employers believed that it would decrease their health care costs. "In 1970, there
were 26 HMOs or comparable prepaid plans in the United States, with a total enrollment of 2.9 million. By 1992, according to the Group Health Association of America, there were 546 HMOs reporting a total enrollment of 41.4 million" (Merlis, 2).

During the 1980s, the HMO developed into other types of managed care organization. The PPO, or preferred provider organizations and "open-ended" HMOs allowed enrollees to obtain coverage from providers outside of the organization's pre-determined provider network. However, enrollees were given financial incentive to see providers within the PPO network. These plans gave enrollees the freedom to retain their choice of physician, and have consequently grown faster than HMOs in recent years (Merlis, 2).

The developments made in managed care throughout the 1970s and 1980s led to the attention on managed competition in the 1990s. Both the Clinton plan and the Managed Competition Act formulated by the Jackson Hole Group use health alliances. The proposal called the Managed Competition Act was developed by the Jackson Hole Group, founded by Dr. Paul Ellwood. The group of doctors, economists, and CEOs is known as the Jackson Hole Group because they have been meeting in Dr. Ellwood's Jackson Hole, Wyoming home for twenty-five years discussing possible
ways to restructure health care.

Their proposal seeks to reshape health care markets by forming groups of informed consumers and by forcing providers to compete by becoming more efficient and improving the quality of their services. There are two types of these consumer groups: AHPs, or accountable health plans; and HPPCs, or health plan purchasing cooperatives. Individuals, the self-employed and their families, and those who work for firms which employ fewer than 100 people would be covered by their choice of open AHP offered through an HPPC (Managed Competition, 3). HPPCs would serve a specified geographic area. Those who work for firms of more than 100 people, college students, and those in plans established under a collective bargaining agreement prior to September of 1993 would be covered by AHPs offered independently of HPPCs or would also have the option of setting up their own insurance plan (Managed Competition, 3). These are known as closed AHPs.

The HPPC would offer an annual open-enrollment period, in which enrollees would have the option of enrolling in any open AHP offered through their HPPC. During this period, the HPPC would provide information to all enrollees on each open AHP, including information on price, quality of care, and consumer satisfaction (Managed Competition,
3). An important component of the Jackson Hole plan is consumers' access to data compiled from patient surveys, results of medical treatments, success rates of surgeons, immunization rates, etc. This information would be a useful way to hold physicians accountable for their work, keep them in competition, while learning from the statistics the surveys provide (Castro, 63). With some HMOs, whose main priority is the bottom line, accountability and the patient's health can become secondary.

A distraught San Francisco oncologist reported the troubles he had getting permission from a gate keeper so one of his cancer patients could come to him for the necessary follow-up visits after major surgery. He told her to come six times over a period of months. the gate keeper- a staff doctor in the patient's health plan- told him that she could only come twice. the oncologist insisted that, considering the extremely serious nature of the surgery and the importance of monitoring possible recurrences, six visits were needed. The staff doctor responded: 'Two are enough.' The plan's budget would not cover any more. (Castro, 81)

A health care system that competes by prices alone could be dangerous without some mechanism of accountability.

As previously stated, patient's lack of knowledge about necessity or quality of medical treatments enhances the high costs and overutilization of health care services. AHPs would aim to give patients a more active role in their health care and in choosing their coverage by informing their enrollees on quality and price. Also these types of statistics would help
eliminate wasteful spending. "If researchers are right that anywhere from one-fifth to one-half of American medical treatment is of uncertain value, such research would help eliminate unnecessary treatments and throw light on smart medical practices" (Castro, 63).

The Managed Competition Act would set up a regulatory agency which would oversee the health insurance market, establish rules, and to specify what the "standard benefit package" would entail. This is something that the Jackson Hole Group has not defined, and therefore it is impossible to estimate the costs of implementing this plan. If the plan were to enact comprehensive standard coverage, costs would be great, but the coverage would be more generous than the current average private health insurance (Managed Competition, 16). On the other hand, if it were to enact limited coverage, it would be 20% less expensive than the comprehensive package, but would also provide less benefits than are currently enjoyed by 90% of those with private insurance (Managed Competition, 16). Also, there would be no subsidies to those above 100% of the poverty level. Either package would eventually bring national health spending below the level that they would reach without any means of reform whatsoever. "With the comprehensive package, Congressional Budget Office projects that total spending on health in 2004 would be $30
billion below what it would be if current policies and trends continued. With the limited benefit package, health spending in 2004 would be $50 billion- or 2%- below the baseline” (Managed Competition, 21).

The standard benefit package is an important component of the proposal because the current tax system would be restructured around it. Currently, employers and employees benefit from tax subsidies that provide incentives for them to purchase generous health insurance plans. Employers can deduct spending of health insurance as a business expense, and employees are able to avoid paying income taxes on compensation earned as health insurance benefits. These tax incentives are sometimes blamed for workers having “too much” insurance. It is assumed that “too much” coverage gives them the liberty to disregard costs when seeking care, because they incur none of the total bill. With the Managed Competition Act, however, these laws would be changed. The proposal would limit tax deductibility of health insurance spending to the “reference premium rate” which is the lowest premium charged by an open AHP enrolling a significant percentage of eligible individuals in the local HPPC (Managed Competition, 3). A 35% excise tax would be imposed on consumers who chose to purchase additional insurance beyond the standard package in order to deter them from getting “too much” coverage.
Establishing equity in delivery of health services is an essential component of health care reform. Therefore, ensuring that the poor would be able to attain insurance coverage is key. The Managed Competition Act, however, does not guarantee universal coverage, but it does ensure universal access to health insurance. The plan would provide subsidies to low-income people to help them pay for their coverage. Medicaid would be repealed, and it would be replaced by federal subsidies to enable low-income people below 200% of the poverty level to purchase from AHPs (Managed Competition, 2). States would pay for any long-term care needed by Medicaid beneficiaries. Medicare, for those over age 65 would remain the same, however Medicare beneficiaries could choose to enroll in an AHP. The AHPs would have to provide services for a predetermined periodic payment from Medicare and not on fee-for-service basis.

Also, the subsidies provided to the poor reduce financial “incentives” to remain on welfare. Under the plan, people’s health care insurance cannot be taken away from them. If a welfare beneficiary chose to work, their health insurance would remain intact. Under the current system, when a welfare recipient goes to work and earns income above certain thresholds, the beneficiary loses eligibility for both cash assistance and for Medicaid (Managed Competition, 30). Under the
Managed Competition Act, people who earn 100% of the poverty level will be fully subsidized, and those who earn between 100% and 200% of the poverty level will still be eligible for some subsidy, although it would be phased out as the person earns more money.

The financing for the Managed Competition Act would depend on how the standard benefit package gets defined. Currently, the plan tends to fund the subsidies to low-income people from the savings obtained by the following measures. As previously mentioned, the plan proposes a cap on the deductibility of health insurance expenditures for employers. It also plans to reduce payments to providers under Medicare, while also increasing Medicare premiums for upper-income beneficiaries (Managed Competition, 5). Although the authors of the Managed Competition Act also planned for the possibility that the saving might not equal new costs. In the event that the savings fell short, they propose to scale back the amount of subsidy provided to low-income people to help them pay for the basic AHP (Managed Care, 5). The Congressional Budget Office estimates that most of the increase in health insurance coverage with this plan would occur for people in poor families, whose purchase of insurance would be fully subsidized (Managed Competition, 19). CBO believes that the proposal would still leave 24 million people uninsured, but the
proportion of the population without health insurance coverage would drop from 15% in 1995 to 9% in 1996 and remain roughly the same thereafter.

Although managed competition could help bring American health care costs under control, it could also pose some problems. For instance, if competition among providers is to be the key, at least two managed care set-ups must be present in a community. Judith Randall, who is a health and science writer for the Progressive, points out that each purchasing cooperative needs a market of roughly 250,000 people to achieve economies of scale, and that only about half of Americans live in places densely populated enough to support two or more such programs (Viewpoints, 181). This problem is also being faced by governments which want to privatize their services such as garbage removal, or street sweeping. If there are not enough parties which are able to compete with each other, government then risks being subject to monopoly power, which is primarily the thing they sought to do away with through privatization (Kettl, 252). So, managed competition may not be the right solution for many rural areas, and presumably, many small cities as well.

Although competition may do great things for controlling costs and improving the flow of information, the doctor/patient relationship could be jeopardized. Remember that consumers in the health care market are
not like consumers in the market for M&Ms or other such goods. Consumers in this market are, first and foremost, patients who are seeking help. Their relationship with their health care provider is based on a relationship of mutual trust and cooperation.

Physicians have traditionally idealized the ethic of duty to their patients, and patients have derived considerable comfort from believing that physician will hold to this ethic. As physicians increasingly practice in organized groups, and as these groups are subject to more competition, the conflict between commitment to the patient and commitment to organization may grow. Patients perception of a conflict of interest can lead to an erosion of trust... (Fuchs, 189)

The doctor patient relationship is of extreme importance in delivering quality medical care. As the popularity of the preferred provider organizations, PPOs, of the 1980s demonstrated, patients are substantially more apt to favor a plan to keep this relationship secure. The biggest criticism of managed care plans, which police medical practice, is that it often disrupts physician discretion for the patient’s well-being. For example, when a Massachusetts woman saw an orthopedic specialist for tendinitis in her shoulder, he recommended anti-inflammatory drugs and physical therapy. But when she called her HMO to get authorization for physical therapy she was informed that her insurance company would not approve physical therapy until she finished a
two-week course of the drugs. "Company policy," said the nurse on the
other end of the telephone. Two weeks later the woman arrived at
physical therapy almost unable to move her arm, the clinician was
shocked. "Why have you waited so long to come to me? You should have
come much sooner!" (Gordon, 657).

Another example involves an elderly woman dying of bone marrow
cancer. She had already established a program of treatment with her
oncologist before her health plan switched to managed care. Once that
happened, she needed to go through a primary care physician to "refer" her
to her original oncologist. So, before each oncology visit she had to
appear at the primary care physician's office to get a signed permission
slip to see her oncologist. The physician billed the HMO $85 for each
signature. This went on until the dying woman eventually became eligible
for Medicare (Gordon, 657). Managed care needs to be revised to avoid
these types of incidents if it is to be implemented as a national plan.

Finally, managed competition has never been tried in its entirety.
And since we are unable to estimate its costs and benefits without
knowing the details of the "standard benefits package", we cannot know
for sure that the plan would save us money. The Congressional Research
Service reports that the dramatic increase in HMOs and PPOs has not been
accompanied by any slowdown in the growth of national health spending (Merlis, 3). Although advocates of the Managed Competition Act argue that with tax incentives remaining unchanged, consumers' inability to get adequate information about price and quality, and HMOs' ability to screen high-risk applicants, the entire market remains ineffective and merely consolidating consumers is not enough.
THE CLINTON PLAN

The American Health Security Act, or the Clinton Plan, is somewhat similar to the Managed Competition Act formulated by the Jackson Hole Group. The Clinton Plan proposes to use health alliances just as Jackson Hole suggests. But the Clinton Plan is far more regulatory than the Managed Competition Act. With the Clinton Plan, everyone would be required to join purchasing cooperatives, which Clinton calls health “alliances.” These alliances would negotiate their health coverage, as well as handle the payments. Only employers with 5,000 or more workers could choose to set up their own health alliances, as opposed to the Jackson Hole plan which would allow firms with 100 or more workers to do the same. The purpose of the health alliance is to give patients bargaining power with physicians in order to attain affordable coverage. But, President Clinton wants these alliances to be more like state agencies, collecting people into very large groups to often win monopolies on medical demand (Castro, 89).

The Clintons’ proposal would nudge patients into the most cost-effective alliances, because they would pay much higher deductibles to keep the freedom to choose their own doctor. This would make up the price difference, the Clinton camp says, of an unmanaged care plan. The
Administration defends this aspect of their plan by arguing that most people would probably follow their family doctor into a plan. Also, they say that too many Americans do not enjoy that type of freedom of choice because they are uninsured (Health Security, xiv).

The Clintons offer a comprehensive package of benefits. Their plan includes hospital services, emergency services, clinical preventive services, mental health and substance abuse programs, family planning services and pregnancy related care, hospice, home health care, prescription drugs, preventative dental care for children, and many other services (Health Security, 21). The problem, as the CBO reports, is that a comprehensive plan is extremely costly. Some estimates put total costs of the Clinton objectives at an additional $100 to $150 billion annually if the uninsured are really going to be covered (Konner, 238).

The Clinton Plan favors mandated employer coverage of employees and their families. Clinton proposes that employers be forced to assume 80% of health insurance costs up to 7.9% of their payroll expenses, with employees paying the balance. Employer-mandated coverage would, indeed make the problem of the uninsured diminish considerably. Of the 39 million uninsured, 85% are workers and their dependents (B. Fuchs, 1). So, the workplace is an ideal place to start the fight for universal coverage.
Also, proponents of the plan argue that providing health insurance is just as much an employers responsibility as paying a minimum wage or contributing to retirement through Social Security (B. Fuchs, 1). Opponents argue that many small businesses can’t afford to cover their employees, and doing so would jeopardize their existence. Estimates place insurance costs for small business anywhere from 10% to 40% higher than for large employers which enjoy a larger risk pool (B. Fuchs, 7). But Clinton has proposed subsidies for small businesses. And small businesses could also join together with other small businesses to take advantage of lower premiums that large employers get.

Along with mandated employer coverage, the Clintons seek to finance their plan by eliminating Medicaid and Medicare fraud. They estimate cutting $238 billion within the first five years of the program by cracking down on fraud and eliminating waste (Castro, 95). The plan also proposes levying federal taxes on cigarettes because of the increased health risks smokers impose on themselves and others. Local taxes would be levied to help pay for health care for the poor in local alliances. Also, health insurance premiums would eventually be prevented from going up by more than the consumer price index, which is the measure of annual inflation (Castro, 92).
Among other regulations set forth in the Clinton Plan, there would be a national board which would decide which benefits Americans could receive. The President would appoint the members to this board, which would be called the National Health Board. On a state level, political appointees chosen by governors would govern health alliances (Health Security, 140). The Secretary of Health and Human Services would have considerable power over the medical profession. Not only would she be able to establish drug prices, she would also determine how many students would be allowed to become specialists. Medical schools would be required to graduate 55% of their students in the basic areas of medicine, or primary care (Health Security, 140).

The National Health Board could become a risk to some involved in controversial treatments. If the NHB, a group of political appointees, is allowed to determine which benefits are offered, certain services, like abortion, could be subject to the whim of the political party holding office.

Opponents of HSA point out that the Clintons have ignored one of the most important causes of run-away health care costs: the third-party payment system. It is especially important to deal with the third-party payment problem with any national health plan because it inevitably
increases demand for health services by providing coverage to everyone and reducing costs to consumers. The HSA is based on the idea of managed competition, but it unfortunately violates two important principles of the theory (Butler, 3).

First, managed competition, as planned by the Jackson Hole Group, created a tax penalty for excessive plans above the lowest-cost plan. The point of maximizing competition among plans is to achieve cost-effectiveness and to provide disincentives for people to overinsure, and thus, to overuse health services. The HSA created no such penalty and completely ignores the tax incentive problem which gives workers cause to accept excessive health benefits as added compensation for work (Butler, 3). The lack of tax takes away strong incentive to be the lowest cost plan.

Secondly, while the Managed Competition Act uses the lowest price to determine the employer/individual contribution to the alliance, the HSA uses the average price. "Since the employer would be required to pay 80% of the weighted average under HSA but only 80% of the low-cost plan under managed competition, the result would be a higher set of bids" (Butler, 3). Managed competition is designed to concentrate on the lowest cost plan. Alain Enthoven, one of the member of the Jackson Hole Group
explane

An essential component of managed competition is that it must always be possible for the lowest-priced plan to take business away from higher-priced plans by cutting premiums more. The lowest-priced plan must be able to widen the gap between its price and the next lowest by cutting price (Butler, endnotes).

The Clinton plan does not successfully adapt the theory of managed competition merely by consolidating people into large consumer groups. Although the HSA accomplishes the President's main goal, universal comprehensive coverage, it will not solve other problems like rising costs. The HSA will most likely create more costs, more bureaucracy, and more burdens on employers, while limiting patient freedom and placing more regulations on providers.
THE OREGON PLAN

The Oregon Plan has been among the most controversial solutions to health care reform. The Oregon Plan is controversial because of its innovative use of rationing health services. It began to get attention in 1987 when Coby Howard, a seven-year old boy from Portland died of leukemia. His leukemia could not be treated without a bone marrow transplant that Coby’s unemployed and uninsured mother could not afford. Earlier that year the Oregon legislature had decided to stop funding transplants through the state’s Medicaid program (Leichter, 124).

The Oregon legislature realized that they had limited resources and they decided to use their money to fund programs, like prenatal care, that would benefit a much larger group of people. Oregon aims to eventually achieve universal coverage in their state. Its purpose is to: (1) “provide access to health services for those in need”; (2) “contain rising health services costs through appropriate incentives to providers, payers, and consumers”; (3) “reduce or eliminate cost shifting”; (4) “promote the stability of the health services delivery system and the health and well-being of all Oregonians” (Leichter, 118). Currently, the plan aims to cover the uninsured, even though they may not have access to every service. In the words of one of the plan’s main architects, Senator John Kitzhaber,
"Everyone will be in the health care lifeboat. Not everyone will eat steak, but at least everyone will eat." (Leichter, 117).

The Oregon plan creates an insurance pool of those "uninsurable" because of pre-existing conditions, subsidized by the state (Leichter, 119). More importantly, the plan gives employers tax incentive to insure their uninsured employees. "To take advantage of the credits, however, they must participate in the program by December 30, 1995. After that date they must provide insurance but without the tax incentive" (Leichter, 120). This law affects two-thirds of the uninsured in Oregon.

One of the strongest components of the Oregon plan is that it deals directly with the issue of limited resources. "The Oregon plan directly confronts the fact that the U.S. is not going to provide every conceivable medical service to everyone, especially not through its public programs" (Kissick, 115). The organizers of the Oregon plan say that only by a willingness to embrace orderly rationing can we make progress toward achieving universal coverage, not the other way around (Viewpoints, 189).
THE AMERICAN HEALTH SECURITY ACT: A SINGLE-PAYER PLAN

The single-payer plan is a system of health care delivery that saves money by simplifying administrative bureaucracy through a single, public payment entity. The American Health Security Act (AHSA) of 1993 was introduced into the U.S. Senate by Senator Paul Wellstone. It mirrors the single-payer system currently at work in Canada.

The American Health Security Act deems the federal government responsible for collecting and distributing to the states all funds needed to pay for health care services in the U.S. (Sounding, 1489). Each state would receive allocations based upon size and distribution of its population, and would administer its own program. At the national level, a full-time, seven-member board of political appointees would oversee the implementation of the program. There would also be boards to oversee particular ongoing issues like standards of quality care and rehabilitation programs (Sounding, 1490). Furthermore, billing by physicians would be reviewed quarterly, and those receiving fee-for-service payment would be held to volume-performance standards (Sounding, 1490).

The biggest savings of the AHSA would come from the simplification
of the bureaucracy in the current system. Currently, the U.S. spends 24 cents of every health care dollar or $497 per person on administration. Whereas, Canada, which has a single payer program, spends only 11 cents of every health care dollar or $156 per person on administration (Five Principles, 9). The AHSA requires that administrative costs of the program be capped at 3% of the state budgets. Canada spends less than 3% on administration, while the U.S. is currently spending 15% (Viewpoints, 157). The General Accounting Office estimates that the U.S. could save $67 billion a year in administrative costs by moving to a single-payer plan, while the Congressional Budget Office reports that the single-payer system would save $114 billion by 2003 (Five Principles, 9).

Aside from the savings that will come from simplifying bureaucracy, the AHSA plans to implement a progressive tax specifically earmarked for health care.

Instead of insurance plans that charge individual people and businesses the same amount regardless of income or profits, the public plan would be progressively financed by increases in the top marginal income-tax rates for individuals and corporations, payroll taxes on employers, and a premium equivalent to the Medicare Part B premium to be paid by those over 65 years of age, as well as by closing a variety of tax loopholes (Sounding, 1492).

The authors of this proposal believe that most people will be paying less for health care than they do now, and that the savings will pay for the
added health care tax.

Budgets and caps on spending are another crucial component to the AHSA. Competition among hospitals in our current system encourages the duplication of high-tech expensive treatments and equipment. Hospitals buy the equipment in order to remain competitive with other health care facilities in their area. However, in order for them to get their money's worth, they overuse procedures and tests that may be unnecessary for many patients. This problem was described previously in the example of San Mateo County, California. The AHSA requires budgets for hospitals and fee schedules for providers; it will no longer allow an open-ended system in which spending spirals out of control. Also, unlike the managed competition models, the AHSA aims to minimize price competition rather than increase it. Dr. Marcia Angell, a proponent for the single-payer model writes, "When prices for health care are determined by the market, costs nearly always rise, and the type of care provided reflects financial incentives, rather than human needs. It would be preferential to keep prices constant and compete on the basis of patient satisfaction" (Angell, 1779).

Most importantly, the AHSA allows patients to retain their choice of health care provider. The doctor-patient relationship is essential to
patient satisfaction and quality of care. The AHSA would also ensure universal access to health care. Everyone would be provided with an extensive list of comprehensive services including payment for prescription drugs, long-term care, rehabilitation services, vision and dental care, and mental health services (Sounding, 1491). However, additional insurance could be purchased out of after-tax income only for services not covered by AHSA (i.e. elective cosmetic surgery).

The importance of universal coverage ensures health security for everyone, no matter where or whether one is working. This will ultimately improve our nation’s overall health including infant mortality and life expectancy. In addition, the AHSA breaks the link between health care coverage and employment, eliminating the inability to switch jobs because of changing insurance. Also, as Senator Wellstone explains, it takes the responsibility of providing health insurance away from employers. “It would take the increasingly conscientious issue of health care benefits off the bargaining table and further assist businesses by relieving them of the administrative burdens of providing health care” (Sounding, 1491).

Opponents of the single-payer approach criticize the rumored lack of hospital facilities and health care providers of the Canadian system.
Waiting lists and insufficient equipment are stereotypes of a national health plan. However, advocates argue that on a per capita basis, there are more physicians who care for patients in Canada than in the U.S. (Fuchs, 89). The data firmly reject the view that Canadians save money by delivering fewer services. "On the contrary, the quantity of services per capita is much higher in Canada than in the U.S." (Fuchs, 97). What's most important, Canada is able to offer all of its residents comprehensive health care at lower costs than what the U.S. is currently spending to cover only part of its residents.
Real National Health Expenditures per capita, 1961-1995
(In 1991 U.S. Dollars)
Real Health Expenditures Per Capita, Selected Countries
(In 1990 U.S. Dollars)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>United States</td>
<td>592</td>
<td>781</td>
<td>1,059</td>
<td>1,291</td>
<td>1,601</td>
<td>2,010</td>
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<tr>
<td>Canada</td>
<td>468</td>
<td>616</td>
<td>840</td>
<td>1,036</td>
<td>1,215</td>
<td>1,546</td>
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<tr>
<td>West Germany</td>
<td>345</td>
<td>448</td>
<td>608</td>
<td>918</td>
<td>1,120</td>
<td>1,232</td>
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<tr>
<td>Japan</td>
<td>104</td>
<td>230</td>
<td>383</td>
<td>546</td>
<td>772</td>
<td>917</td>
<td>1,113</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>303</td>
<td>363</td>
<td>445</td>
<td>590</td>
<td>665</td>
<td>753</td>
<td>909</td>
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Health Expenditures as a Percentage of GDP, Selected Countries, 1960-1990

Percentage of gross GDP

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<tr>
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<td>5.9</td>
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<td>8.4</td>
<td>9.3</td>
<td>10.7</td>
<td>12.4</td>
</tr>
<tr>
<td>Canada</td>
<td>5.5</td>
<td>6.0</td>
<td>7.1</td>
<td>7.2</td>
<td>7.4</td>
<td>8.5</td>
<td>9.0</td>
</tr>
<tr>
<td>Former West Germany</td>
<td>4.7</td>
<td>5.1</td>
<td>5.9</td>
<td>8.1</td>
<td>8.4</td>
<td>8.7</td>
<td>8.1</td>
</tr>
<tr>
<td>Japan</td>
<td>2.9</td>
<td>4.3</td>
<td>4.4</td>
<td>5.5</td>
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</tr>
<tr>
<td>United Kingdom</td>
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<td>4.1</td>
<td>4.5</td>
<td>5.5</td>
<td>5.6</td>
<td>5.8</td>
<td>6.1</td>
</tr>
</tbody>
</table>

"Trends in Health Spending", p.54
Congressional Budget Office, June 1993
PART FOUR: SOME RECOMMENDATIONS

The most important aspect of any health care reform proposal is that it ensures universal health care coverage. It seems that building upon the current system of employer-provided coverage would be the easiest way to get coverage to those who need it. The employer mandate is the best way to this. In 1990, most of the uninsured—about 80%—were either employed or dependents of workers (Implications, 41). Furthermore, about half of the working uninsured and their dependents were connected to the labor force through a small business employing fewer than 25 people (Implications, 41). A 1989 Congressional Budget Office study found that only 39% of firms with fewer than 25 employees offered health insurance to their workers; while 94% of firms with more than 25 employees offered coverage (Administration, 54). Opponents of the employer mandate argue that requiring firms to foot the health insurance bill would most certainly ruin small businesses and increase unemployment. But, the federal government would provide subsidies to small businesses, especially those firms which offer low wages. The Clinton plan provides subsidies for small businesses and estimates that the subsidies will amount to $33 billion per year. However, the
Congressional Budget Office estimates that small businesses will require $58 billion in subsidies (Administration, 36). Other estimates also vary, so the purpose of this paper I will use the average estimate of $45.4 billion.

In addition to the employer mandate, community rating should be used in order to spread the burden of health care costs more evenly throughout society. This will help ease the costs for industries like mining, which has a higher health risk and consequently higher insurance premiums than an industry like, retail. A study by Aaron and Bosworth suggests that the effects of both the employer mandate and community rating would cause an enormous redistribution of resources among various industries (Administration, 55). These inequities would also be considered for subsidies. (see table on following page.)

Aaron and Bosworth estimate that it would cost $2,253 per year to insure the average individual employee. We have almost 39 million uninsured Americans and approximately 80%, or 31.2 million, of them are employed. So, it would presumably cost $70,293,600,000 to cover the 31.2 million working uninsured through an employer mandate. (For simplicity of calculations, I am assuming that all 31.2 million are insured at an individual rate of $2,253 per year. In reality, cost estimates vary to
### Economic Issues in the Prime of Health Care Financing


<table>
<thead>
<tr>
<th>Industry</th>
<th>All Industries</th>
<th>Private Households</th>
<th>Services</th>
<th>Health Insurance, and Real Estate</th>
<th>Retail Trade</th>
<th>Wholesale Trade</th>
<th>Finance, Cus, and Real Estate</th>
<th>Community</th>
<th>Transportation</th>
<th>Manufacturing</th>
<th>Agriculture, Forestry, and Fishing</th>
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<tr>
<td>Percentage Difference of Wages Per Worker</td>
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<td>Difference</td>
<td>Percentage Difference of Wages Per Worker</td>
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<td>Percentage Difference of Wages Per Worker</td>
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<td>Percentage Difference of Wages Per Worker</td>
<td>Difference</td>
</tr>
<tr>
<td>1992</td>
<td>.8%</td>
<td>2041</td>
<td>.2%</td>
<td>2019</td>
<td>.5%</td>
<td>1967</td>
<td>.6%</td>
<td>1916</td>
<td>.1%</td>
<td>4019</td>
<td>.1%</td>
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</tbody>
</table>

### By Industry, 1992

The Health Insurance Costs of Private Employers' Effects on Community Rating and Requiring Firms to Pay on...
insure families and the elderly.) I would mandate, just as the Clintons do, that 80% of the total premium by paid by employers. This amounts to $56,234,880,000 for American businesses to pay. However, when we subtract the estimated $45.4 billion in subsidies, businesses actually contribute approximately $10,834,880,000, or an average of $29 per month per employee. In addition, individual premiums for workers would amount to the remaining 20% of the premium, or an average premium of $38 per month per worker.

A good starting point for the definition of the standard benefit package would be the insurance plan offered by St. John’s University (see appendix A). Of course, the decisions about what services would and would not be included in the package is an issue for serious debate. These are judgments that will be controversial and always open to argument.

The employer mandate takes care of the majority of uninsured Americans, but still leaves 7.8 million people who are neither employed or insured. At the average rate of $2,253 per year per person, it would cost our society approximately $17,573,400,000 to insure them by extending Medicaid coverage to them.

In order to raise an additional $63 billion to pay for the expansion of health care access, I propose that we distribute the financial burden
evenly by raising income taxes. In 1992, the total amount of taxable income was $2,396,902,000,000. In order to raise $63 billion, we would need to raise taxes by 2.6%.

\[
\frac{63,000,000,000}{2,396,000,000,000} = r \\
0.026 = r = 2.6\%
\]

Another way to raise $63 billion would be to attach a tax surcharge of 13.2% to the $475,964,000,000 in income tax paid by individuals in 1992.

\[
\frac{63,000,000,000}{475,000,000,000} = 0.132 = 13.2\%
\]

Either way, this new revenue would be especially earmarked for health care, and thus, would pay for insurance subsidies to small businesses as well as the expansion of Medicaid.

<table>
<thead>
<tr>
<th>ALYSSA'S HEALTH CARE REFORM PROPOSAL</th>
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<tbody>
<tr>
<td><strong>EXPENDITURES</strong></td>
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<tr>
<td>Subsidies to business............... $45,400,000,000</td>
</tr>
<tr>
<td>Expanding Medicaid.................... $17,573,400,000</td>
</tr>
<tr>
<td>Difference between subsidies and total cost to insure employed............... $24,893,600,000</td>
</tr>
<tr>
<td>Total</td>
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<td>$87,867,000,000</td>
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</table>
We can't just give everyone health care coverage and neglect to install mechanisms to control costs. We need to develop a regulatory system that will control spending by setting uniform payment schedules for insurers and developing a prospective payment system for hospitals and providers.

According to John Goodman of the National Center for Policy Analysis/Fiscal Association Health Care Model, the current system of third-party payment encourages those treatments with the lowest out-of-pocket costs, even though they may be the most expensive for society as a whole (Hearing, 107). "Private payment borne by third-parties range from 87.7% of hospital bills to 15.1% for drugs. If private insurers reimbursed all medical expenses at the same rate, patients and their doctors would substantially change their behavior reducing their spending on hospitals [which is the most costly of health spending], and increasing their spending on pharmaceuticals and nurses" (Hearing, 107). Goodman and his colleagues estimate that uniform payment rates could bring down hospital costs by half, while increasing spending on drugs by one-third, and on non-physician staff by 60%, an overall saving of an estimated $85 billion (Hearing, 108,109).

A federal regulatory agency could mandate uniform payments for
insurers. The agency could calculate hospital and provider spending for the previous year, adjusting for inflation, and the insurers could then pay the hospitals and providers the specified amount on a prospective basis. In this way, hospitals would be constrained to budget caps, forcing them to operate more efficiently. Since they are being paid prospectively, physicians would become salaried employees of the hospital or clinic where they practice. Physicians will no longer be motivated to offer additional services so as to increase their incomes. Currently, health care is provided retrospectively on a fee-for-service basis, as I've previously explained. This leads to higher costs from additional services and the over-use of expensive technology. Retrospective payment ultimately leads to higher physician salaries.

Needed goods, like health care services, should not be restricted from the poor. Therefore, practitioners of needed goods are most often conscripted in the public service (Walzer, 89).

They then serve for the sake of the social need and not, or not simply, for their own sakes: thus, priests for the sake of eternal life, soldiers for the sake of national defense, public school teachers for the sake of their pupils' education...I would look for similar effort in any fully developed national health service. But I see no reason to respect the doctor's market freedom. Needed goods are not commodities (Walzer, 90).
Just as teachers and soldiers do, health care providers who work for a salary will be providing their services out of an essential social need for them, rather than out of market incentives to do so.

There is no need to make doctors into efficiency experts. After all, doctors are not trained to be agents of bureaucracy. Physicians can develop standards of professionalism for acting as advocates for their patients. The relationship between patient and doctor should remain the exclusive partnership of trust into which it has developed. Doctors should not be made into the adversaries of the subjects of their work.

Health care providers are interested in the health of their patients and their workplace should cultivate that interest, rather than smother it. Therefore, administrators need to set up efficient systems of delivery by budgeting their hospitals, creating fair salary schedules for providers, and looking for technological innovations that reduce their costs of delivering health services, while sustaining the quality of the care they provide.

A prospective payment system would help to curb the unnecessary use of expensive medical technology. With a prospective payment system, providers would be forced to bear more of the costs of unnecessary care from which they currently benefit (Implications, 23). Medical technology is extremely costly, but it is readily available for use in the United
States. Some countries control the acquisition of this equipment by hospitals in ways that have led to lower costs. A comparison of the availability of medical technology in the United States, Canada, and the former West Germany showed much greater availability in the U.S. “For example, the numbers of open-heart surgery units per million people were .7 in the former West Germany, 1.2 in Canada, and 3.3 in the United States. Similarly, the U.S. had 3.7 magnetic resonance imaging machines per million people compared with .9 in Germany, and .5 in Canada” (Implications, 24-26). If hospitals competition were based upon prices, the overabundance of duplicative advanced technology would take care of itself through market forces. However, hospitals don’t compete on price, they compete by offering access to the most advanced medical technology and quality care. Therefore, a given region will have say, three CAT scan machines, when it would be most efficient for it to have only one. the overabundance of this equipment leads to higher prices for its use. As long as health insurers pay for new technology on a fee-for-service basis, the private sector will keep developing new machines and doctors will keep using these services, regardless of cost (Implications, 22).

Developing strategies that would decrease the proliferation of repetitious health technology would be beneficial in the struggle to
control costs. Perhaps hospitals in a given region could cooperate by sharing technology. Say, one hospital could have the MRI machine and another could have the CAT scan, in this way they could reduce redundancy and promote efficient use of the equipment. Another strategy for curbing technology costs would be to control the introduction of new machines which provide little benefit compared to their high costs.

In addition to controlling the costs of technology, statistical information would be a benefit in developing efficient and feasible practice guidelines to help eliminate unnecessary procedures. The reform proposal formulated by the Jackson Hole Group suggests that we start collecting data on procedures, providers, and outcomes. By developing this information, we will be better at educating patients on their options for treatment, as well as learning about the successfulness of certain procedures and treatments.

Finally, Americans could ease some of the burden on the health care system by taking responsibility for their own healthy lifestyles. Substance abuse and smoking cause longer hospital stays as well as increasing the risks for cancer and other terminal disease (Hearing, 95). At least one out of every five dollars Medicaid spends on hospital care are attributable to substance abuse (Hearing, 65). Substance abuse related
complications of newborns account for a staggering 32.2% of all Medicaid hospital days (Hearing, 73). In addition, illness related to smoking are responsible for $24 billion in health care costs (Financing Provisions, 21). If we were to impose a $.75 sales tax on tobacco, we could raise almost $10 billion as well as creating a financial incentive for smokers to curb their habit.
Average Length of Stay for Babies with and without Exposure to Substance Abuse

Average Length of Stay (Days)

All Births
National Hospital Discharge Survey, 1991
Presented before the U.S. Senate
March 10, 1994
Medicaid Length of Hospital Stay with and without Substance Abuse

Average Length of Stay (Days)

- w/o substance abuse
- drug abuse only
- alcohol abuse only
- both drug and alcohol abuse

National Hospital Discharge Survey, 1991
Presented before the U.S. Senate
March 19, 1994
CONCLUSION

Too many people do not have access to the health care that they need and deserve. However, no one should have to suffer through an illness because they do not earn enough money to be able to be cared for. It is our responsibility to make sure that our entire community, regardless of their income, has access to these essential services that our medical community is capable of providing.

Because our community is capable of providing these services, our providers feel the responsibility to do whatever they can in order to help their patients, no matter how small the benefit. With the spiraling costs and constant development of advanced technology in health care, along with the existence of the third-party payment system, our country has created the most costly health care system in the world. Arguably, we have the best quality care money can buy, but too many people can't afford access to its valuable features.

Many proposals have been formulated to resolve the growing inequities and outrageous costs of American health care. Some aspect of our current system has to give way to developing a more fair delivery strategy. Quality and easy access suffer as a result of creating a more efficient system, and vice versa. Although whatever measures we employ
to offer our uninsured neighbors the security of health care, we will inevitably pay. Health care for all will not come without a bill, but as I have estimated, it is reasonable for us to assume we can afford the expanded coverage.

I have speculated that the most effective way to deliver universal health care coverage would be to mandate that all employers offer health insurance to their workers and to expand Medicaid for the unemployed. In this way, we would be able to ensure that no one will suffer with an illness because of their inability to afford adequate health insurance.
APPENDIX A

SUMMARY OF BENEFITS IN THE HEALTH CARE PLAN
OFFERED TO THE EMPLOYEES OF ST. JOHN'S UNIVERSITY

INCLUSIONS:
Alcoholism treatment
Ambulance transportation
Anesthesia
Blood
Braces, Crutches, Casts, Splints, Trusses
Chemical Dependency treatment
Chemotherapy
Diagnostic services
Durable Equipment (rental of an iron lung, wheelchair, hospital bed, etc.)
Extended Care Facility
Hair prosthesis
Hospital room and board
Hospital ancillary services
Hospital intensive care
Insulin
Mammography
Mental and Nervous conditions
Nursing
Orthognathic surgery
Oxygen
Pap tests
Phenylketonuria
Physical therapy and respiratory therapy
Physician services
Pregnancy
Prescription medicines
Prosthesis
Radiation therapy
Routine physicals
Speech therapy
Spinal treatment

OUTPATIENT SURGICAL PROCEDURES:
Digestive System: hernia repair, varicose vein stripping, hemorrhoidectomies, fistulectomy
Eye: cataract
Integumentary System: excision of lesion or skin biopsies, wound repair
Female Genital System: excision of breast tumor, excision of Bartholin's cyst, normal vaginal delivery
Male Genital System: Orchiopexy
Orthopedic: reconstruction of nail bed, tenotomies or arthrotonies, fractures, bilateral bunionectomy
Otolaryngology System: treatment of open nasal fracture, tonsillectomy
EXCLUSIONS AND LIMITATIONS

Air purification units
Cosmetic Surgery (unless done to lessen damage caused by an accident, done because of a disorder of normal bodily function or it is incidental to or follows Medically Necessary surgical removal of all of a body part, or is reconstructive surgery due to sickness, injury or is performed on a dependent child because of a congenital disease which has resulted in a functional defect)
Counseling
Court-ordered confinement
Criminal acts (any injury resulting from attempt to commit an assault or a felony)
Custodial care
Dental care
Diagnostic hospital admissions
Drugs in testing phases
Excess charges
Exercise equipment
Experimental procedures
Food care
Forms completion
Government -operated facilities
Health club
Hearing aids or related examinations
Home health care
Immunizations (other than those specified in the schedule of benefits)
Infertility treatment
Maintenance care
Military hospital
Military service
Nicotine addiction
Nuclear energy release, illness resulting from
Occupational injury or illness
Other coverage
Other plan sponsor plans
Outside United States
Personal comfort or convenience items (T.V.s, pillows, non-prescription drugs)
Pre-existing conditions
Relative care (services rendered by a relative of the covered person)
Reversal of sterilization
Self-inflicted injury
Self-procured services
Sex change procedures
Therapy
Transplants (except for: kidney, cornea, skin, bone marrow, liver, heart, heart-lung, pancreas)
Vision care
War
Weight control programs
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