



Georgia Southern University
Digital Commons@Georgia Southern

Electronic Theses and Dissertations

Graduate Studies, Jack N. Averitt College of

Spring 2007

US Health Care Crisis: Implications for Education,
Medical Praxis, and Democracy

Michael W. Kleinpeter

Follow this and additional works at: <https://digitalcommons.georgiasouthern.edu/etd>

Recommended Citation

Kleinpeter, Michael W., "US Health Care Crisis: Implications for Education, Medical Praxis, and Democracy" (2007). *Electronic Theses and Dissertations*. 503.

<https://digitalcommons.georgiasouthern.edu/etd/503>

This dissertation (open access) is brought to you for free and open access by the Graduate Studies, Jack N. Averitt College of at Digital Commons@Georgia Southern. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Digital Commons@Georgia Southern. For more information, please contact digitalcommons@georgiasouthern.edu.

THE US HEALTH CARE CRISIS: IMPLICATIONS FOR EDUCATION,
MEDICAL PRAXIS, AND DEMOCRACY

by

MICHAEL KLEINPETER

(Under the Direction of Rosemarie Stallworth-Clark)

ABSTRACT

This theoretical inquiry sought to critically analyze the various ideological and political aspects of the culture of health care reform in the United States (US) and to investigate the underlying ideologies, values, and purposes of medical practice in a changing democratic society. Using Michel Foucault's cultural studies approach as the theoretical framework for the study, agent and client relationships within the US health care system were examined in efforts to describe the articulation between the health care crisis and the government's social responsibility to prevent the imminent bankruptcy of its health care system.

State and national data were collected from governmental web sites of the Department of Health and Human Services, the Center for Disease Control and Prevention, and the Center for Medicare and Medicaid Services. This data describes the percentage of the uninsured population in both Georgia and US; total health care costs of the private and public sector in the US; total health care costs in both Georgia and the US; breakdown of health care costs in Georgia; breakdown of health care costs in US;

and the Medicare allowables for five random current procedural terminology (CPT) codes.

Socioeconomic trends in the US indicate a health care crisis. This study revealed the numbers of uninsured citizens in this country are steadily increasing and the economic impact on these individuals, as well as the rest of the country, is devastating. Literally every hospital in the US is subsidized by the federal and/or state government for indigent and charity care. Therefore, the tax payers ultimately pay for medical care for these individuals. All in all, there is a tremendous financial and health strain to the entire nation because of the uninsured problem in the US.

Implications of this study included the following: the health care industry must to do a better job of educating patients on health care issues; catastrophic insurance can provide a useful solution to protect patients from rising costs; patients must begin to think *preventive* instead of *curative*; tax deductions should be extended to individuals to pay for health insurance; and a nationwide information system should be implemented.

INDEX WORDS: US, Medical praxis, Democratic society, Medical ethics, Michel Foucault, Health insurance, Medicare, Medicaid, Cultural studies

THE US HEALTH CARE CRISIS: IMPLICATIONS FOR EDUCATION, MEDICAL
PRAXIS, AND DEMOCRACY

by

MICHAEL KLEINPETER

B.A., Armstrong Atlantic State University, 1996

M.H.S.A., Armstrong Atlantic State University, 1999

A Dissertation Submitted to the Graduate Faculty of Georgia Southern University in
Partial Fulfillment of the Requirements for the Degree

DOCTOR OF EDUCATION

STATESBORO, GEORGIA

2007

© 2007

Michael Kleinpeter

All Rights Reserved

THE US HEALTH CARE CRISIS: IMPLICATIONS FOR EDUCATION, MEDICAL
PRAXIS, AND DEMOCRACY

by

MICHAEL KLEINPETER

Major Professor: Rosemarie
Stallworth-Clark

Committee: Ming Fang He
Stephen Jenkins
Joseph Crosby

Electronic Version Approved:
May 2007

DEDICATION

This dissertation is dedicated to my supportive family who have encouraged me throughout this long journey. It would have been impossible to finish without the love and sacrifice of my wife, Ruth, and son, Carter. There is not a day that goes by that I do not thank God for you. I would also like to thank my parents who have given me the love, support, and tools throughout my life to succeed in many different areas. I truly feel blessed and recognize the difference that strong parenting makes in the lives of children.

ACKNOWLEDGEMENTS

I would like to thank my committee members for the invaluable guidance, insight, and encouragement they provided during the dissertation process. Dr. Rosemarie Stallworth-Clark, my chairperson, constantly encouraged me and provided the support and time needed to finish my dissertation. The sacrifice of her personal time and emphasis on perfection are greatly appreciated. Dr. Ming Fang He gave me encouragement and thoughtful feedback throughout my entire doctoral studies program and her dedication to the field is both uplifting and inspiring. I was fortunate to have taken two statistics classes with Dr. Stephen Jenkins, and his time and feedback with my dissertation research has been a tremendous asset. In addition, I would like to thank Dr. Joseph Crosby for his time and mentoring during my studies and my career. Lastly, I would like to thank the Southeastern Orthopedic Center for supporting me throughout my course work and dissertation, both financially, and with my time.

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	vii
LIST OF TABLES	xi
CHAPTER	
1 INTRODUCTION	1
A. Cultural Studies and the Rationale for Theoretical Inquiry	5
B. Michel Foucault and the Culture of Health Care	6
i. Genealogical and Ethical Analysis	6
ii. Architectural Design and Functional Spaces	8
iii. Different Interpretations	9
iv. Agents and Clients	10
C. Statement of the Problem	11
D. The Purpose of the Study	12
E. Research Questions	13
F. Significance of the Study	13
G. Assumptions and Limitations	15
H. Definition of Terms	16
I. Summary	16
2 REVIEW OF LITERATURE	18
A. Scope of Literature Review	18
B. Cultural Studies	18
C. The History of US Health Care	23

	i. The Health Insurance Industry	24
	ii. Medical Education’s Influence on Health Care	28
	iii. Post-World War II Medicine.....	31
	iv. The Making of Medicare.....	35
	D. Canada: A Neighboring Health Care System.....	48
	E. Culture’s Impact on Health Care.....	54
	i. The Baby Boomer Effect.....	54
	ii. The Pharmaceutical Industry.....	56
	iii. The Uninsured Population	58
	F. Summary	64
3	THEORETICAL FRAMEWORK	66
	A. Michel Foucault’s Genealogical and Ethical Analysis.....	66
	i. Michel Foucault’s Hierarchical Observation	69
	ii. Michel Foucault’s Normalizing Judgment.....	70
	iii. Michel Foucault’s Examination	71
	B. Data Collection Procedures and Descriptive Analysis.....	74
	C. US Health Care versus 23 Other Countries.....	84
	D. Summary	85
4	CRITICAL ANALYSIS	86
	A. US Health Care through the Lens of Michel Foucault.....	88
	B. Data Analyses.....	90
	C. Summary	94
5	SUMMATION, IMPLICATIONS, AND SUGGESTIONS.....	95

A. Implications of Study.....	96
i Education.....	97
ii. Medical Praxis.....	101
iii. Democracy	104
iv. Michel Foucault’s Tools for Critical Analysis.....	105
B. Suggestions for Further Research.....	109
REFERENCES	110

LIST OF TABLES

	Page
Table 3.1: Percentage of the Uninsured Population in Georgia and the United States from 1993 to 2002	77
Table 3.2: Total Health Care Costs of the Private and Public Sector in the United States and the Percentage of payments from 1993 to 2002 (Amount in Billions)	78
Table 3.3: Total Health Care Costs in Georgia and the United States from 1993 to 2002 (Amount in Millions)	79
Table 3.4: Total Health Care Costs Break Down of Hospital Care (HC), Physician Services (PS), Other Professional Services (OPS), Dental Services (DS), Home Health Care (HHC), Prescription Drugs (PD), Other Non-Durable Medical Products (ONMP), Durable Medical Products (DMP), Nursing Home Care (NHC), and Other Personal Health Care (OPHC) in Georgia from 1993 to 2002 (Amount in Millions)	81
Table 3.5: Total Health Care Costs Break Down of Hospital Care (HC), Physician Services (PS), Other Professional Services (OPS), Dental Services (DS), Home Health Care (HHC), Prescription Drugs (PD), Other Non-Durable Medical Products (ONMP), Durable Medical Products (DMP), Nursing Home Care (NHC), and Other Personal Health Care (OPHC) in the United States from 1993 to 2002 (Amount in Millions)	82
Table 3.6: Medicare allowables for 5 random CPT codes from 2001-2006.....	84

CHAPTER 1

INTRODUCTION

Technological breakthroughs, cures, and discoveries in the United States (US) continually benefit many Americans as well as other citizens around the world. Indeed, technological and medical advances in the US promote the well being and good health of most all citizens. Medical schools and residency programs require physicians to complete rigorous training programs in an attempt to eliminate anyone that is not focused and dedicated to the medical profession. Our health care facilities are subject to accreditations that aim to reduce the risks to patients and produce high outcomes. Yet, the health care system in the US is in grave trouble.

As a health care administrator, I see daily the severe need for better ways to meet the medical needs of all of our citizens - the insured as well as the uninsured. The growing dilemma of how to provide health care for all US citizens is at the forefront of virtually every debate. Should the uninsured and the poor be offered medical care, and what is the government's responsibility in paying for medical care for these individuals?

I personally think that citizens should take a more active role in the pursuit of better health care. We live in a culture where patients do not think twice about expecting free health care services but would never ask for a free meal at McDonald's. Indeed US culture has greatly contributed to the spiraling disaster known as US health care. How did we get to the point to where patients will walk into a building and utilize a million dollar facility and not bring a wallet? How can a cashier at McDonald's turn away someone without money but US culture frowns upon a physician that does the same?

Yes, we need to examine the way we view health care and realize that we all have a part to play.

In order to discuss how our medical care should look in a democratic society, we should define what type of democratic society we are talking about. For the purposes of this research, we are talking about a *socioeconomic democracy* in which there is a shared responsibility for services provided in a free, democratic society. This usually entails some form of wealth redistribution by which the lower class benefits from the redistribution of taxes. Interestingly enough, the US is the only country in the world without some form of socialized health care, i.e., health care in which the national government provides free health care for all citizens. The government of every other major western country (besides the US) provides health care services to their citizens through a government run health care program funded by taxes. There are pros and cons for this type of program that have to do with national ideology and curriculum of medical practice. The ideological basis for US medical care for its citizens is neither neutral nor apolitical. Medical care reform to meet the needs of all citizens calls for confrontation of the prevailing problems and making the hard decisions that underlie democratic values and ideology.

The number of uninsured citizens in the US has certainly created a problem for everyone who is a stakeholder in the health care system – everyone. Approximately 34,000,000 people do not have health insurance. This represents about 12% of the population (Medical Expenditure Survey, United States Department of Health and Human Services - Agency for Healthcare Research and Quality, 2006). In today's world, the lack of health insurance causes far-reaching problems that continue to grow. To

begin, these uninsured citizens do not have full access to physicians and hospitals – often resulting in less-than-optimal medical care results in a time of need. Also, the uninsured population put a financial strain on physicians, hospitals, the government, and those who do have insurance. This causes physicians and hospitals to write off thousands to millions of dollars every year in charity care. As a result, the government subsidizes these facilities that write off so much in charity care on a yearly basis. Furthermore, those who do have insurance must indirectly pay more money for health insurance premiums in order to keep physicians and hospitals solvent.

While almost every other industry in the US continues to realize an increase in fees for services on a yearly basis, health care practitioners and facilities continue to endure cuts in fees. This phenomenon makes it very difficult to remain solvent when expenses continue to rise every year. Imagine the predicament Fortune 500 companies would find themselves in if they received less every year for their products than they did the year before. If the cost of fuel increases, delivery companies pass on a surcharge to customers. If the cost of food increases, restaurants increase the prices on their menus. However, for the most part, contemporary health care practitioners and medical facilities receive less per service every year while expenses such as rent, salaries, benefits, supplies, malpractice insurance and equipment increase. How is it that physicians and hospitals are paid less per service every year but the total amount spent per patient increases? One obvious reason is the problem of over-utilization. Experiencing good health is essential for everyone who finds success in life. Who is responsible for the payment and rendering of this health care is debatable. As human rights are often

discussed in classrooms and political arenas, our society has a duty to even the playing field in an attempt to give everyone an equal opportunity for health care.

Another reason for the rising cost of patient care is the rising cost of malpractice insurance. The cost of malpractice insurance rises every year at an alarming rate. Working in a health care clinic, I observe the work of the malpractice attorneys who are single-handedly ruining health care in certain areas. Malpractice insurance premiums have skyrocketed and many physicians have gone out of business, changed professions, and/or retired early as a result. Those physicians who survive are forced to practice *defensive medicine*; many times, ordering too many tests in attempts to defend their treatments. Health insurance companies are obviously not going to absorb this “over-ordering” and health care consumers are left to foot the bill. These forced increases in expenses for physicians, hospitals, and consumers have also resulted in less attention to patients and an increase in the number of patients treated in a given day. In one such example, obstetricians who lived in Las Vegas, Nevada, in 2002, stopped delivering babies because they could not afford the malpractice insurance associated with practicing obstetrics. For the most part, physicians and hospitals are unable to control their expenses, but they *can* control the types of services and number of patients they treat in a given day.

A recent study published in *Health Affairs* reports that the US is the leader in spending on health care but is inferior to some other countries on quality of care and health information technology (Schoen, Davis, How, & Schoenbaum, 2006). Statistics reveal that the US is deficient in the timeliness of patient care and the emergency rooms are being over-utilized as a result (Schoen, Davis, How, & Schoenbaum, 2006).

Cultural Studies and the Rationale for Theoretical Inquiry

Cultural studies as theoretical inquiry was chosen for the framework of this study because it is a multidisciplinary and transdisciplinary field that embraces both “a broad, anthropological and a more narrowly humanistic conception of culture...committed to the study of the entire range of a society’s arts, beliefs, institutions, and communicative practices” (Grossberg, Nelson, & Treichler, 1992, p. 4). US culture, both historically and modern-day, has defined our health care delivery system and the shambles in which we find it today. Cultural studies is an evolving field that attempts to deconstruct our societal experiences and shed light on the ideological and political views of the citizens that comprise that society.

The word *culture*, “refers to a dynamic system of social values, cognitive codes, behavioral standards, worldviews, and beliefs used to give order and meaning to our own lives as well as the lives of others” (Gay, 2000, p. 8). Even when we are not subconsciously aware of it, US culture defines and helps shape the way we behave, think, and interact with others. A society’s culture is largely responsible for its health care. Especially in a democratic society, the citizens of that society are responsible for laying (and voting) the groundwork of an industry such as health care through its cultural and historical views.

Furthermore, it is a society’s cultural views that help define the role of its federal government in providing for health care to the citizens. While the governments of most modern countries provide health coverage for their citizens, the US has chosen to stay with the capitalistic approach of the health insurance industry while covering health benefits to approximately a third of the people through government programs. The

culture of capitalism, largely responsible for the economic growth and power of this country, is also responsible for this country's stance on health care issues; thus the lack of health insurance coverage can be correlated to the non-socialistic approach of our political history.

Michel Foucault and the Culture of Health Care

I chose to do a cultural studies theoretical inquiry of the US health care system using the framework of Michel Foucault as his approach is illustrated in *Discipline & Punish: The Birth of the Prison* (1975) and *The Birth of the Clinic* (1973). Through his psychological work and writings, he shows how effective discipline can alter behavior and shape the self-image of an individual to become a more effective component of society. Furthermore, I found a strong correlation between his writings on genealogical and ethical analysis to the health care delivery system in the US.

Genealogical and Ethical Analysis

Michel Foucault (1926-1984) was a French philosopher most known for his teachings and writings on medicine, the prison system, and psychiatry. He held faculty positions at the University of Lille, Warsaw University, the University of Hamburg, the University of Clermont-Ferrand, the University of Tunis, and the University of Vincennes. He was very involved in politics in France and was instrumental in setting up the Prison Information Group, an organization that provided a way to help prisoners voice their concerns.

Much of Michel Foucault's genealogical work is centered on how *institutional regulation* and *discipline* change individual behavior and in doing so shape their self-images, attitudes, and values (McFarlane & Prado, 2002). It is through analysis of the

prison institution that Foucault gives insight into how an institute functions. Foucault's strategy is to connect marginal and hidden elements and events to present an image of the institution as it should be. These hidden elements can be described as the culture that indoctrinates its members since birth. By having behavior regulated, individuals are personified and indoctrinated with certain values and self-image. Foucault introduces ethical ideas as an individual's relationship to himself (not others) and how he changes himself in the process of trying to be the person he wants to be. Importantly, Foucault's extension of ethics "allows us to show how health care's agents and clients redefine themselves and how, in doing so, they act in ways that affect the health care management policies and techniques that regulate their behavior and imbue them with values and images of themselves" (McFarlane & Prado, 2002, p. 15).

Further, Foucault emphasizes how institutional disciplines define its governed subjects and he casts the self-awareness of subjects as a product of the way the subject is controlled (McFarlane & Prado, 2002). Foucault states:

The factory was explicitly compared with the monastery, the fortress, a walled town; the guardian 'will open the gates only on the return of the workers, and after the bell that announces the resumption of work has been rung'; a quarter of an hour later no one will be admitted; at the end of the day, the workshops' heads will hand back the keys to the Swiss guard of the factory, who will then open the gates. The aim is to derive the maximum advantages and to neutralize the inconveniences as the forces of production become more concentrated; to protect materials and tools to master the labour force. (Foucault, 1975, p. 142)

Foucault stresses how self-aware subjects govern and define themselves as each individual has a different history and different experiences which affect the way he behaves in response to being governed. Further, individuals who are being controlled are shown to continually adjust to various external and internal influences (McFarlane & Prado, 2002).

Architectural Design and Functional Spaces

When speaking of functional sites in a medical institution, Foucault demonstrates the effectiveness of architecture and the capacity for multiple uses for the same space:

Particular places were defined to correspond not only to the need to supervise, to break dangerous communications, but also to create a useful space. The process appeared clearly in the hospitals, especially in the military and naval hospitals. In France, it seems that Rochefort served both as experiment and model....The naval hospital must therefore treat, but in order to do this it must be a filter, a mechanism that pins down and partitions; it must provide a hold over this whole mobile, swarming mass, by dissipating the confusion of illegality and evil. The medical supervision of diseases and contagions is inseparable from a whole series of other controls: the military control over deserters, fiscal control over commodities, administrative control over remedies, rations, disappearances, cures, deaths, simulations....each individual treated was entered in a register that the doctor had to consult during the visit; later came the isolation of contagious patients and separate beds. Gradually, an administrative and political space was articulated upon a therapeutic

space; it tended to individualize bodies, diseases, symptoms, lives and deaths; it constituted a real table of juxtaposed and carefully distinct singularities. Out of discipline, a medically useful space was born.

(Foucault, 1975, p. 144)

If the architectural design made the space useful, the management and physicians were better equipped to treat patients and control the “swarming masses.”

Different Interpretations

It is important to point out that directives are always interpreted differently and therefore carried out differently. For instance, management can give the same directive to two different physicians, but they will, more than likely, be carried out in two different styles because of the different conditions in which they practice in (McFarlane & Prado, 2002). In this scenario, each of the two physicians will implement the procedure in a different fashion. If one physician carries out the procedure begrudgingly, and the other is more accepting of the new regulation, each will invent two different cultures (McFarlane & Prado, 2002). The area the first physician works in will be more prone to adopt his or her attitude to the change while the area the second physician works in will be more adaptable to change based upon his or her individual attitudes. There are many factors that could possibly affect individual attitudes, such as the economic status of the community the physician works in, the physician’s personal feelings and experiences, and the particular clientele that the physician works with.

In like manner, the patients can also perceive procedures in a different light. For instance, if one insurance policy covers a procedure and the other does not, two different patients will have a different feeling and interpretation of the situation. One patient may

be able to pay more out of pocket while the other one may not. Furthermore, whether or not the patients are able to pay for procedures out of pocket will have a bearing on how they view themselves, which traces back to Foucault's ethical dimension of self-identity and response to being controlled (McFarlane & Prado, 2002).

Agents and Clients

When an institution regulates agents (health care providers) and clients (health care recipients), there is a reciprocal effect on the institution. For example, health care managers affect agents by discouraging them from ordering expensive tests for patients, and they affect clients by requiring longer waiting periods for tests or surgery (McFarlane & Prado, 2002). The way health care management handles these particular situations, the way agents and clients handle them, and the attitudes of all of the participants will combine in unpredictable ways to make health care for members of society a complex system to manage.

Let's assume that one insurance company will pay for a coronary artery bypass graft every time without hesitation, but another insurance company will only pay for it under urgent conditions (i.e. life or death situation). The physician treating the patient with the second insurance policy may be prone to exaggerate or over-emphasize the situation in order to have the health insurance company pay for the procedure. Some physicians may bend the rules and rationalize the situation by saying it is in the best interest of the patient and medicine in general. Others will follow the rules. In the end, most likely, the insurance company's directives will not be followed, and the cost-savings will be lost. This unpredictability adds a challenging dimension to health care because of

the multiple factors and local conditions in which a set of rules is supposed to be governed. As McFarlane and Prado point out:

...regardless of their assigned roles and status, agents and clients redefine themselves relative to how health care affects each of them and, as important, how they perceive it affects them. As a consequence, inevitable differences develop between, on the one hand, the agents and clients the planners had in mind, and that managers think they are dealing with, and, on the other hand, the agents and clients. (McFarlane & Prado, 2002, p. 20)

Agents and clients will always respond differently based upon how they perceive that different changes in health care will affect them. Again, it is not just the manner in which changes will realistically affect the agents and clients, but more importantly, their perception of how the changes will affect them. Their history, rearing, education, gender, race, religion, and political philosophy will help determine their self-definition (McFarlane & Prado, 2002). And their responses to change will depend on this self-definition and how other agents and clients respond in the same setting. Foucault shows how the imposition of behavioral habits on individuals shapes and reshapes their perspectives, attitudes, values, desires, and other affective aspects to form the culture in which they live.

Statement of the Problem

We have approximately 34 million people who are living without some form of health insurance in the US (Agency for Healthcare Research and Quality, 2006). This creates an obvious problem for those without health insurance but also presents a

problem for the rest of the nation as well. Our health care system is over-utilized by some and under-utilized by others, and too much of our Gross Domestic Product is spent on health care (16%) (Schoen, Davis, How, & Schoenbaum, 2006). This health care problem has many adverse implications for US education and society, the worst of which is the eventual bankruptcy of our health care system. Yet, the burden of increasing health care costs is a problem often discussed without a solution. As the cost of health care increases every year, the gap between those who have insurance and those who do not continues to widen. We must have greater knowledge of the critical health care needs of the *multicultural* members of the US society, as well as an insight for structuring and managing a solvent health care system that is effective to serve these expanding needs. Broad and sweeping systemic reforms, including comprehensive patient education and the transformative rearrangement of medical praxis in the US must be forthcoming in the near future. Only those reforms that are grounded in the values and sound ethics of democratic society will assist to avoid an imminent cultural catastrophe.

The Purpose of the Study

The purpose of this theoretical inquiry is to critically analyze the various ideological and political aspects of the culture of health care reform in the US and to investigate the underlying ideologies, values, and purposes of medical practice in a changing democratic society. Using Michel Foucault's cultural studies approach as the primary theoretical framework for the study, agent and client relationships within the US health care system were examined in efforts to describe the articulation between the health care crisis and the government's social responsibility to prevent the imminent bankruptcy of its health care system.

Research Questions

The guiding research questions examined in this theoretical inquiry were:

1. What are the current socioeconomic, cultural, and political issues affecting the accessibility of health care in the US?
2. What are the needed changes that would improve the economic conditions and accessibility of the US health care system?

Significance of the Study

Access to health care or a lack thereof, has a tremendous impact on every human life. Most individuals in the US have been very fortunate and have grown up viewing health care as a benefit that insurance covers. Other less fortunate individuals go without essential medical care because they do not have health insurance or cannot afford health care services. The rising cost of technological advances and high utilization of services are causing employers (private sector) and the government (public sector) to cut back on health care benefits for US citizens. Health insurance companies and other health care payers try to restrict health services to better predict patient behavior; however, the costs continue to rise every year.

Current socioeconomic trends indicate that we will see a dramatic change in both the delivery and payment of health care services over the next ten years. These changes are likely to drastically affect the way citizens are able to utilize health care services, the way they pay for these services, and the way US culture views the structure, delivery, and management of its health care system. The government (who insures a third of the population) is starting to make these drastic changes now. Health insurance companies are likely to follow these same trends.

Without access to health care, every aspect of democratic life is threatened. John Dewey, one of the world's most recognized educational philosophers, believed one's health was critical to achieving social status. He wrote:

The person who is ill not merely suffers pain but is rendered unfit to meet his ordinary social responsibilities; he is incapacitated for service to those about him, some of whom may be directly dependent upon him.

Moreover, his removal from the sphere of social relations does not merely leave a blank where he was; it involves a wrench among the sympathies and affections of others...To cure disease and prevent death is to promote the fundamental conditions of social welfare; is to secure the conditions of requisite to an effective performance of all social activities; is to preserve human affections from the frightful waste and drain occasioned by the needless suffering and death of others with whom one is bound up.

(Hester, 1998, p. 374)

As a pragmatist, Dewey sought to educate students so that they, in turn, could go out and make significant societal changes (Widmaier, 2004). Further, he wrote that children should practice critical thinking skills and democracy in the classroom (Dwornik, 2003). Dewey stated that health was vital to the success of every student:

How to live healthily...is a matter that differs with every person. Healthy living is not something to be attained by itself apart from other ways of living. A man needs to be healthy in his life, not apart from it, and what does life mean except the aggregate of his pursuits and activities? Surely,

once more, what a man needs is to live healthily, and this result so affects all the activities of his life that it cannot be set up as an independent and separate good. (Hester, 1998, p. 374)

Dewey was an advocate for health care and a defender of individual freedom which cannot be accomplished without access to an adequate health care system. Certainly, we must find new ways to meet the health care needs of all citizens. Implications of this theoretical inquiry can lead to the improved lives of all members of US society.

Assumptions and Limitations

Assumptions were inherent in conducting this study. First, it was assumed that the examined socioeconomic problems and issues represent the primary contributing issues to the current management and delivery of the US medical system. Second, for those data reported, it was assumed that sources were accurate and valid. Thirdly, it was assumed that the issues identified are the most important issues involved in the ethical and democratic management and delivery of US medical praxis.

Limitations of the research were also present. First, there was no data collected directly from administrators, staff, physicians, pharmacists, patients, persons without medical care, or others involved in the US medical care industry. Second, there were no follow-up interviews with anyone involved in the ethical and democratic implementation of medical care in the US. Lastly, this study only examined data since the beginning of the twentieth century and does not account for the health care delivery system in the US before this period.

Definition of Terms

US – the nation of the United States.

Medical Praxis – the practice of medicine as delivered and managed in US health care facilities by physicians or other health care providers.

Democratic Society – a socioeconomic democracy in which there is a shared responsibility for services provided the society, generally managed through some form of wealth redistribution by which the lower class benefits from the redistribution of taxes.

Medical Ethics – the ethical standards accepted in the medical profession in the US.

Michel Foucault – a French philosopher and author of *Discipline & Punish: The Birth of the Prison* and *The Birth of the Clinic*, whose cultural studies work provided the theoretical frame for this study.

Health Insurance – the insurance product used to cover patients for health care services.

Medicare – a law passed in 1965 and enacted in 1966 by the federal government to provide federal health insurance to US citizens 65 or older.

Medicaid – a law passed in 1965 and enacted in 1966 by the federal government to provide health insurance to the disabled and those who met certain low income eligibility requirements. This insurance is partially funded by both US federal and individual state governments.

Cultural Studies – the study of a society's defining culture.

Summary

The health care delivery system in the US is in transition, needs to be severely critiqued, and reform is needed. As technology and the sophistication of medicine have evolved over the years, the gap between those who can afford health care and those who

cannot grows wider and becomes more prevalent. In the health care profession, I have found that everyone demands and seeks high-quality health care and expects excellent results whether they can afford the services, or not.

I will further my research study in the second chapter with an in-depth review of literature that will explore how our health care system evolved in the twentieth century. This chapter will detail the evolution of health insurance, Medicare and Medicaid, and our current managed health care system today. The third chapter will consist of a theoretical inquiry using Michel Foucault's genealogy and ethical analysis, hierarchical observation, normalizing judgement, and examination. In addition, I will collect data that will be used to support the notion that our health care system is in jeopardy and for solutions for tomorrow's health care need. In the fourth chapter I will critically analyze the collected data through the lens of Michel Foucault. Lastly, the fifth chapter will summarize the study, draw this particular research to a conclusion, list meaningful implications for education, medical praxis, and democracy, and make suggestions for future research.

CHAPTER 2

REVIEW OF LITERATURE

The purpose of the review of literature is to provide a historical overview of the health care delivery system in the US, to review the literature explaining cultural studies theoretical inquiries and Michel Foucault's specific framework for deconstructing a society's health care system, to review the literature reporting the socioeconomic data relative to the democratic management and implementation of the US health care system, and to identify the ideologies and political perspectives that drive US health care.

Scope of Literature Review

The literature review for the present theoretical inquiry was primarily restricted to those cultural studies, historical writings, and data reports concerned with the analysis of the US health care system. The review of literature included the use of the Georgia Southern University Library, text books discovered during my doctoral course work, text books from my master course work, GALILEO, and the web sites of the Centers for Medicare & Medicaid Services, Centers for Disease Control and Prevention, and the United States Department of Health and Human Services.

Cultural Studies

Cultural studies is a multidisciplinary and transdisciplinary field that embraces both "a broad, anthropological and a more narrowly humanistic conception of culture...committed to the study of the entire range of a society's arts, beliefs, institutions, and communicative practices" (Grossberg, Nelson, & Treichler, 1992, p. 4). It is US culture that defines the way we view life, education, health care, and politics – virtually every aspect of our life. Grossberg, Nelson, and Treichler (1992), stress that

“cultural studies draws from whatever fields are necessary to produce the knowledge required for a particular project” (p. 2).

Foucault wrote about the use of three instruments to derive a successful discipline – *hierarchical observation*, *normalizing judgement*, and *examination* – along with the usefulness of *panopticism*. He described *hierarchical observation* as physically structuring the work spaces to allow those in authority to oversee the particular environment in which he or she is managing (Foucault, 1975). Foucault stated,

These ‘observatories’ had an almost ideal model...in the perfect camp, all power would be exercised solely through exact observation; each gaze would form a part of the overall functioning of power. For a long time this model of the camp...was found in urban development, in the construction of working-class housing, estates, hospitals, asylums, prisons, schools: the spatial ‘nesting’ of hierarchized surveillance (Foucault, 1975, p. 171).

Again, Foucault demonstrates the power of observation and the architectural effects of arranging observatories in a fashion that are conducive to managing. Likewise, he points out that the ideal central point would be one which:

would make it possible for a single gaze to see everything constantly....a perfect eye that nothing would escape and a centre towards which all gazes would be turned....which a high construction was to house the administrative functions of management, the policing functions of surveillance, the economic functions of control and checking, the religious functions of encouraging obedience and work; from here all orders would come, all activities would be recorded, all offences perceived and judged;

and this would be done immediately with on other aid than exact geometry. (Foucault, 1975, p. 175)

Another method used to control behavior is what Foucault calls *normalizing judgement* (Foucault, 1975). This is the process of comparing various groups to one particular group to show the others how it should be done. This is done with a subtle suggestion as to who to watch and who to compare your group to. The main idea is to hope that the insufficient groups will mimic the behavior of the more favorable group. Foucault refers to this modeling as a gratification effect (Foucault, 1975). He believes that agents and clients have a desire to do well and want to be viewed as being a member of the favorable normal group.

In addition to gratification modeling, Foucault points out that disciplinary punishment is useful for corrective action. However, he encourages the use of rewards first before resorting to punishment as he feels subjects are more responsive to rewarding provisions versus punishment (Foucault, 1975). In *Discipline & Punish: The Birth of the Prison*, he states:

The Normal is established as a principle of coercion in teaching...it is established in the effort to organize a national medical profession and a hospital system capable of operating general norms of health; it is established in the standardization of industrial processes and products. Like surveillance and with it, normalization becomes one of the great instruments of power at the end of the classical age. (Foucault, 1975, p. 184)

By establishing the *normal* behavior, we are inducing others to follow suit and will even reward them for doing so. Because everyone is intrinsically and extrinsically motivated differently, good health care managers will adapt to the individual agent and client in order to get the results they seek.

In an attempt to present an *examination*, Foucault combines the techniques of an observing hierarchy and those of a normalizing judgement (Foucault, 1975). The examination is the tool by which the manager surveys the situation and thereby the tool that he or she judges, punishes, or praises the agents and clients. This can be in the form of a formal written exam or by some form of surveillance. Foucault states:

The ritual of the visit was its most obvious form. In the seventeenth century, the physician, coming from the outside, added his inspection to many other controls – religious, administrative, etc.; he hardly participated in the everyday administration of the hospital. Gradually, the visit became more regular, more rigorous, above all more extended: it became an ever more important part of the functioning of the hospital. (Foucault, 1975, p. 185)

Physicians give their examinations in a personal form of observation, conversation, and touch. As hospital care evolved, physicians became more and more important in not only the care of patients but an active role in the way the hospitals were run.

Foucault further explores the essence of *panopticism*, defining the term as a state of always being seen and always being in a state of submission, i.e., being able to see the subject but the subject not seeing his observer (McFarlane & Prado, 2002). Surveillance can turn reluctant submission into willing conformity to norms which can turn deliberate

obedience into habitual compliance and result in the internalization of obedience (McFarlane & Prado, 2002).

In *Discipline & Punish: The Birth of the Prison*, Foucault demonstrates panopticism in both a prison and a hospital. As prison cells are separated and only visible from the front so that prisoners cannot converse and plan their escape; likewise, patients' rooms are set up much the same in order to limit the amount of disease spreading (Foucault, 1975). Likewise, if the subjects are students, there will be no copying, talking, and waste of time (Foucault, 1975). There are two points that Foucault wants to reiterate in regards to panopticism: "...the principle that power should be visible and unverifiable. Visible: the inmate will constantly have before his eyes the tall outline of the central tower from which he is spied upon. Unverifiable: the inmate must never know whether he is being looked at any one moment; but he must be sure that he may always be so" (Foucault, 1975, p. 201).

The *panopticon* can be a laboratory where experiments are carried out, behavior is altered, subjects are corrected, and medicines are experimented with while effects are monitored (Foucault, 1975). In health care, making the agents and clients monitor themselves for compliance with the principles and regulations of the institution changes the institution (McFarlane & Prado, 2002). It is important to realize that the influence of other agents or clients can also have an unrecognized mutual influencing effect (McFarlane & Prado, 2002).

Foucault's real point of discipline is to eventually allow the agent and client to control their behavior through normalization (McFarlane & Prado, 2002). He implies that control is not only achieved through restrictions but also through enabling

descriptions and self-images. Effective control does not only proscribe someone from a particular action, it encourages particular ways of behaving and construction of self-image (McFarlane & Prado, 2002). The ultimate goal is for the agents and clients to want to conform because they are doing the right thing instead of conforming out of fear of consequences. Every agent and client exerts his or her power in one fashion or another because power is people doing things and what they do affecting others and what those others do (McFarlane & Prado, 2002). Agents and clients exert their power in this domino effect and it is up to the managers of an institution to ensure that the first domino is falling in the right direction.

The History of US Health Care

The US health care system first began in the early 1900s. At its inception, physicians were paid a fee-for-service when they treated patients for various illnesses. Members of the American Medical Association (AMA) had a sharp decline in their income during the early part of the 1900s. Early on, the AMA was cooperative with health insurance legislation and recommended that the members cooperate with government authorities for the betterment of the patients (Richmond & Fein, 2005). The Great Depression of the 1930s found many physicians unemployed (Richmond & Fein, 2005). Most of the physicians were general practitioners who attempted to treat most everything. As medicine evolved, physicians started to specialize in certain areas in order to better treat patients (Biedermann, 2002). As physicians began to specialize in particular areas, they developed hospitals in which to treat patients. These advancements in hospitals increased the revenue generated by health care which eventually encouraged

more technology and research, which in turn, led to more expensive health care (Biedermann, 2002).

The Health Insurance Industry

It was obviously in the best interest of hospitals to have funding sources for their services. Besides the early form of managed care in Tacoma, Washington (1910) and the Kaiser plan (1937), Blue Cross and Blue Shield was the first major health insurance provider to enter the picture in 1927 in Dallas, Texas (Miller, 2002). An increasing number of hospital beds had been left empty and an increasing number of bills had been left unpaid (Colins & Tibbits, 1972). The plan started with 1,000 enrollees and launched the most dominant health insurance company in the nation. Hospitals realized the growing expenses that were paid to hospitals, and they sought to become active in the health insurance industry. Of the 39 Blue Cross plans started in the 1930s, about 50% received their start-up funds from hospitals (Miller, 2002). Blue Cross was a politically charged company from the beginning in which it sought the image of public agency (Miller, 2002). Some leaders in the company saw Blue Cross as social insurance while others viewed it as the funding source for hospitals.

Our country's first real discussions about socialized medicine took place in the first two decades of the 1900s. Insurance companies began to insure large groups of employees by which they were able to spread their risk over a large group of individuals (Biedermann, 2002). The Committee of the Costs of Medical Care (CCMC) was developed in the 1920s to look at the rapidly increasing cost of health care due to the hospitals and specialized medicine (Miller, 2002). The committee issued a report suggesting that the nation switch to a group practice, group hospital prepayment

(insurance) plan (Miller, 2002). This recommendation polarized the physician community and the AMA was quick to issue an editorial in response to the recommendation. Dr. Morris Fishbein, the editor for the *Journal of the AMA*, wrote the following:

Briefly, the majority reports recommend that medical practice be rendered largely by organized groups associated with hospitals, and it expresses the hope that these groups will maintain the personal relationship so essential to good medical care. The rendering of all medical care by groups or guilds or medical Soviets has been one of the pet schemes of E.A. Filene....The two reports (i.e. majority and minority) represent the difference between incitement to revolution and a desire for gradual evolution based on analysis and study....The minority is willing to test any plan that may be offered if it conforms to the medical conception of what is known to be good medical practice....The physicians of this country must not be misled by utopian fantasies of a form of medical practice which would equalize all physicians by placing them in groups under one administration....It is better for the American people that most of their illnesses be treated by their own doctors rather than by industries, corporations or clinics. (Fishbein, 1932, p. 1950-52)

Fishbein framed the issue as “Americanism” versus “Sovietism” in an attempt to hide the reality that Americans were having difficulties paying hospital bills (Miller, 2002). He played upon the fears of Americans to protect the status quo and looked to weaken the call for groups to hold power in American Medicine (Miller, 2002).

American employees are used to their employers providing health insurance as part of their benefit package. Keep in mind that employees are actually paying for it. It is an employee cost that employers calculate when looking at the actual cost of an employee. According to the Bureau of Census, in 1988 62.3% of the population was covered under employer-provided health insurance which has steadily declined all the way down to under 57% in 1994 and continuing to decline (Styring & Jonas, 1999). Besides ensuring a healthy and steady workforce, the reason employers started providing health insurance to employees is because it provides a pre-taxed benefit, which was passed in 1943 (Styring & Jonas, 1999). In other words, if an employer contributes \$4,000 a year to an employee's health insurance, the employer looks at that \$4,000 as a cost. However, this is \$4,000 the employee is not taxed on thereby lowering his or her taxable income.

The number one reason employers started offering health insurance to employees is because the federal government limited the amount employers could pay workers, and they would use health insurance as a benefit to lure employees to work for them. In 1953, the Internal Revenue Service reversed the decision they previously made in 1943 regarding the pre-taxed benefit but reversed it again the following year (Styring & Jonas, 1999). To demonstrate the effects of this legislation, under 20 million Americans had private insurance for hospitalization and that figure increased to almost 100 million by 1952 (Styring & Jonas, 1999). This number increased to almost 20 million by 1960 and almost 40 million by 1970 (Styring & Jonas, 1999). Because employees had to purchase individual health insurance with after tax dollars, the political pressure from employees to

employers for employer-provided health insurance was enormous (Styring & Jonas, 1999).

The post-war era was a time of economic prosperity in the US. In 1940, personal consumption expenditures totaled \$595.2 billion, \$874.3 billion in 1950, \$1,210.8 billion in 1960, and \$1,813.5 billion in 1970 using constant 1987 dollars (Styring & Jonas, 1999). Physicians and scientists responded to this post-war prosperity with advanced technology, surgery, and prescriptions (Styring & Jonas, 1999). From 1940 to 1965, the number of hospital beds increased 85% and the number of physicians increased from 133 to 153 per thousand population (Styring & Jonas, 1999). Hospitals found themselves competing for physicians and staff so naturally they spent money on new technology as an incentive for professional staff (Styring & Jonas, 1999).

As noted earlier, the percentage of population that is covered by employer-provided health insurance has steadily declined every year since 1988. Many large corporations have downsized in the past decade and in effect downsized the number of people covered by this type of insurance (Styring & Jonas, 1999). Further, calculations from the Bureau of the Census show that 84 percent of professional employees are covered under employer-provided health insurance versus only 60 percent of service workers (Styring & Jonas, 1999). The effect of this is that the lesser paid fields are less likely to have employer-provided health insurance and, in turn, less likely to pay for individual policies.

Another dynamic affecting employer-provided health insurance is the increase in temporary workers (Styring & Jonas, 1999). The temporary employment market increased from 1.16 million in 1992 to 1.74 million in 1994 and continues to grow every

year (Styring & Jonas, 1999). Almost all of these workers have no employer-provided health insurance. As a result of the increase in health insurance premiums every year, employers are asking employees to share more of the cost. This is the only way they are able to absorb the increases every year. In addition, employers are changing the policies and creating higher deductibles and co-pays that employees have to make.

Small businesses are less likely to offer employer-provided health insurance than larger ones (Weissman & Epstein, 2004). The main reason is that they are not as profitable as larger businesses and the cost of health insurance is usually too expensive (Weissman & Epstein, 2004). Small employers pay 10 to 15 percent more for health insurance than larger businesses for two reasons. First, administrative costs are significantly more per employee for a small business and, secondly, small businesses do not have the large numbers of employees to spread the risk around (Weissman & Epstein, 2004). The smaller the risk pool, the more risk the insurance companies have to take and this results in higher premiums. Interestingly enough, 13 percent of employees nationally elect not to buy health insurance through their employer even when it is offered (Needleman et al., 1990).

Medical Education's Influence on Health Care

Along with changing health insurance plans, American medical education evolved through a period of reformation (Starr, 1982). Only a few of medical schools began with the financial resources to upgrade and expand their faculty and facilities or develop relationships to teaching hospitals in order to provide more advanced studies to keep up with the times (Richmond & Fein, 2005). Abraham Flexner, a renowned educator, developed the Carnegie Foundation for the Advancement of Teaching to survey the state

of medical education in order to make suggestions for improvement (Richmond & Fein, 2005). He subsequently issued the Flexner report in 1910 which is recognized as one of the most important developments in American medical education (Flexner, 1910). This report paved the way for change in medical education. It encouraged the adoption of a four-year medical school curriculum, introduced laboratory teaching exercises, improved the quality of instruction through a full-time faculty, and expanded clinical teaching through the introduction of clinical clerkship (Richmond & Fein, 2005).

As a result of this report, the General Education Board of the Rockefeller Foundation distributed seventy-eight million dollars among the medical schools at twenty-four universities (Richmond & Fein, 2005). Also, the Flexner report brought about institutional accreditation and the processes in which practitioners were licensed and certified (Richmond & Fein, 2005). The Association of American Medical Colleges (AAMC) developed a standard curriculum that incorporated bylaws as a requirement for membership, which ultimately led to the failure of many of the medical schools in the country (Richmond & Fein, 2005). In 1910, there were 131 medical schools, and the number decreased to only 79 by 1950 (Richmond & Fein, 2005). In 1910, the number of graduating medical students was 4,440 and declined to 3,047 in 1920; however, the graduate was far more advanced than his or her peers that graduated 10 years earlier (Richmond & Fein, 2005). Furthermore, the ratio of 158 physicians per 100,000 population in 1906 fell to 136 per 100,000 in 1936 (Fein, 1967).

An important shift happened in the 1930s with the establishment of residency requirements for physicians and growing number of specialty boards (nineteen at the time). The profession had realized that physicians needed more training beyond the 4

years of medical school (Richmond & Fein, 2005). Hospitals were very interested in having residents because they provided for a cheap source of labor in addition to the prestige that accompanied an institution for training physicians (Richmond & Fein, 2005). This actually resulted in more residency slots than actual residents.

Meanwhile, the AMA continued to be very conservative in their approach to national health insurance. Nevertheless, the group had members with different views in the late 1930s. In 1937, a Committee of Physicians, known as the “Committee of 430,” was formed to bring about change and fight the traditional views of the AMA (Richmond & Fein, 2005). The principles of the Committee were concise and to the point: (1) the health of the people was a direct concern of the government; (2) a national public health policy directed toward all groups within the population should be formulated; (3) the problem of economic need and the problem of providing adequate medical care were not identical and might require different approaches for their solution; and (4) the provision of adequate medical care for the population required the participation of four groups: voluntary agencies, and local, state, and federal government (New England Journal of Medicine, 1937). As a result of this committee and their principles, the AMA sent a message to the members in the *Journal of American Medical Association*:

Obviously some of these men must have signed merely after seeing the names of those who signed previously and because it looked like a “good” list. There appear also the names of some members of the House of Delegates [of the AMA] which voted against some of the very propositions which these members here support. Most conspicuous on the list are the names of those deans and heads of departments in medical

schools who may have signed because they saw a possibility of getting government money for clinics and dispensaries. Such careless participation in propaganda as has here occurred is lamentable, to say the least. Certainly the unthinking endorsers of the American Foundation's principles and proposals owe to the medical profession some prompt disclaimers. (JAMA, 1937, p. 109)

Post-World War II Medicine

Following the end of World War II, the medical field incorporated many scientific advances and surgical procedures (Richmond & Fein, 2005). Largely due to the war, the medical field introduced antibacterial drugs, a better understanding of hormones, and the replacement of blood, plasma, and fluids and the general expectations for the preservation and lengthening of life (Richmond & Fein, 2005). The general perspective was that the sky was the limit if medicine could have adequate funding (Richmond & Fein, 2005). The universities and private funding sectors found that they could not keep up with the rapid pace and need for funding during the postwar era; thus, the logical conclusion was to turn to the government for financial help (Richmond & Fein, 2005). The federal government responded with huge support. From 1950 to 1965 the federal government expenditures for medical research increased from \$79 million to \$1.3 billion (Hanft, 1967).

An alternative to this fee-for-service-based insurance protection was a prepaid insurance plan in which a prepayment was given to provide all necessary physician and hospital services (Richmond & Fein, 2005). Once again, the AMA opposed this prepaid arrangement and presented strong opposition stating that physicians working under this

arrangement were violating the AMA code of ethics. As the AMA continued to pressure these groups to stop practicing under these circumstances, the antitrust division of the Department of Justice brought suit against the AMA and the Medical Society of the District of Columbia (Richmond & Fein, 2005). In 1943, the Supreme Court of the US found the AMA guilty of “a conspiracy to restrain trade in the District of Columbia in violation of the Sherman Anti-Trust Act” (1943). The court stated:

Professions exist because the people believe they will be better served by licensing especially prepared experts to minister to their needs. The licensed monopolies which professions enjoy constitute, in themselves, severe restraints upon competition. But they are restraints which depend upon capacity and training, not special privilege. Neither do they justify concerted criminal action to prevent the people from developing new methods of serving their needs. There is sufficient historical evidence of professional inadequacy to justify occasional popular protests. The better educated laity of today questions the adequacy of present-day medicine. Their challenge finds support, as indicated in the margin, from substantial portions of the medical profession itself. The people give the privilege of professional monopoly and the people may take it away. (1943)

The decision made by the Supreme Court in 1943 helped spur more rapid growth of prepaid group practice health plans in the US during the post-war era (Richmond & Fein, 2005). The largest of these plans was in California where Dr. Sidney Garfield developed a small hospital to serve thousands of workers who were building the Los Angeles aqueduct during the Great Depression (Richmond & Fein, 2005). Dr. Garfield

charged them ten cents per day per worker to cover all of their medical needs (Richmond & Fein, 2005). Shortly after, Henry Kaiser asked Dr. Garfield to duplicate his approach for his 6,000 employees who were building the Grand Coulee Dam on the Columbia River in Washington and then again in Richmond, California, where his crew were building the Liberty Ships and naval vessels (Richmond & Fein, 2005). This plan began to grow as it was opened to the general public and started to catch on in other states.

While the politically charged AMA resisted national health insurance, the voluntary health insurance plans grew rapidly in the US. Community and group plans were used to spreading the risk over large masses of individuals in order to keep the cost affordable for everyone (Richmond & Fein, 2005). In the post-war era, the federal government instituted price and wage controls in an attempt to control inflation during an economically prosperous time (Richmond & Fein, 2005). The government also gave tax breaks to companies that offered employee health benefits; consequently, this was a great way for a company to defer income to employees since they figured it would have gone to taxes anyway. In fact, health insurance for employees became so common that a National Labor Relations Board ruled that an employer who refused to give health insurance coverage to an employee was engaging in unfair labor practice (Richmond & Fein, 2005). In 1946, a total of 32 million people were covered under a health insurance plan which grew to 77 million by 1951 (Becker, 1955).

Furthering the growth of Blue Cross, the AMA ran ads for the organization as a way of discouraging national health insurance after World War II (Miller, 2002). The afore mentioned Morris Fishbein publicly debated Henry J. Kaiser on health care reform shortly after the end of World War II which ultimately led to Fishbein's fall from AMA

power (Miller, 2002). The auto industry, which was extremely profitable during the 1940s, led the way in providing health benefits for its employees. However, as health insurance premiums began to increase in the 1950s, Blue Cross (the hospital-based insurance company) enrollment slowed down as other commercial insurers entered the market (Miller, 2002).

Blue Shield enrollment began to take off and quickly became the leading commercial insurance company in the market (Miller, 2002). Unions began to switch from the traditional Blue Cross plans to the prepaid group practice initiatives such as Blue Shield (Miller, 2002). A growing number of physicians felt that Blue Cross was too liberal and not protecting the interests of the medical community and they began to split off from Blue Cross management. The 1950s were characterized by physicians (some of whom owned hospitals) who encouraged employer-sponsored health benefits so they would have a payer for their services (Biedermann, 2002). Physicians and hospitals became pleased with the health insurance model because insurance companies paid for their services without question. Employers liked the model because their expenses became fixed through fixed premium payments and employees were obviously satisfied with free health care benefits (Biedermann, 2002).

This period would ultimately lead to irresponsible (undisciplined) health care consumer behavior in which there was no accountability and no responsibility for any of the costs incurred for treatment. This synergistic relationship between employers, employees, and insurance companies grew over the years. More health care revenue meant advancements in technology and medical care and over time the additional expense solidified the need for the insurance company (Biedermann, 2002). Health care

costs escalated and the greed from product vendors, physicians, and hospitals eventually led a national health care crisis. The insurance companies responded by “cherry-picking” the healthiest, most profitable consumers for their plans and structured premiums to the disadvantage of the poor, elderly, unemployed, and small employer employees (Biedermann, 2002). These disadvantaged citizens cried out for help, which ultimately led to the government’s stepping in and entering the health insurance business.

The Making of Medicare

Medicare and Medicaid laws were passed in 1965 by President Lyndon B. Johnson and later enacted in 1966. Medicare was to provide federal health insurance to those 65 or older. Medicaid, which was to be partially funded by both the federal and individual state governments to provide health insurance to the disabled and those who met certain income eligibility requirements.

Like most bills, Medicare was a political hot potato of its time. Because of the dynamics in the health insurance industry, citizens were calling for some uniform ways of delivering and paying for health care in the US (Vogel, 1999). It is easy to point fingers and critique Medicare today but the reality is that policy-makers of the 1960s did not have the economic and financial information that we have today. They knew nothing about incentive-based health care and how to ensure that covered members were not going to abuse the system (Vogel, 1999). Robert Ball, one of the principal architects of Medicare, explained in an article written in 1995 that a group of people at the Social Security Administration and at the American Federation of Labor-Congress of Industrial Organizations saw health insurance for the elderly (Medicare) as a stepping stone to their primary goal of universal health insurance (Vogel, 1999). Ball was quoted as saying

Medicare design “was based entirely on a strategy of acceptability: What sort of program would be most difficult for opponents to attack and most likely to pick up critical support...we did not intend to disrupt the status quo. Had we advocated anything else, it never would have passed.” (Vogel, 1999, p. 2) Ball also added that the AMA, the American Hospital Association (AHA), and organized labor were involved and supported the initiative (Vogel, 1999). Again, the AMA and AHA tended to be in favor of any health insurance initiative that would be willing to pay for services. Costs were escalating to a point where they needed insurance programs as much as the insurance programs needed providers.

While the first legislation proposing federal health insurance was not introduced until 1952, some point to the administration of President Theodore Roosevelt during the second decade of the twentieth century as the starting grounds for Medicare (Blumenthal et al., 1998). The idea of national health insurance fell by the waste-side with the fear that Social Security (1935) would be adversely affected (Blumenthal, et. al., 1998). In 1939, New York Senator Robert F. Wagner, Sr. introduced a bill that proposed matching federal grants to state public health programs (Blumenthal, et. al., 1998). This would later set the foundation of Medicaid as discussed earlier. President Roosevelt, who supported the bill in early forms, ran for reelection in 1940 and withdrew his support because of political pressure from various health care groups (Blumenthal, et. al., 1998).

Once a supporter of national health insurance, the AMA vigorously opposed the plan in the 1940s and later years (Blumenthal, et. al., 1998). The AMA hired a public relations firm, Whittaker and Baxter, and spent over \$4 million from 1948 to 1951 to oppose the establishment of national health insurance (Blumenthal et a., 1998). During

this period, Whittaker and Baxter distributed millions of posters and brochures in opposition to national health insurance and received individual help from physicians around the country (Blumenthal et al., 1998). Furthermore, the AMA was successful in gaining support from other groups such as the Daughters of the American Revolution (DAR) and the US Chamber of Commerce to fight the plan of national health insurance (Blumenthal, et. al., 1998). They were also helped by a growing number of Republicans and conservative Democrats that viewed national health insurance as a way of the government infringing on the rights of citizens.

Wilbur Cohen and I.S. Falk, two men who were employed by the Federal Security Agency (who administered the Social Security program at the time), turned their attention to health insurance for the elderly (Blumenthal, et. al., 1998). Medicare was enacted out of the same philosophy as the Social Security program in which the elderly needed a way to pay for medical benefits. Cohen was later quoted as saying:

The new idea seemed pretty paltry at first – a trifling two hundred and thirty million dollars a year. In the beginning, we looked at it as a small way to start something big – what the AMA would call a “foot in the door.” But in time the bill we wrote – or, anyway, the idea behind it – became our only goal...Anyway, it’s all been very Hegelian. The state and federal proposals for compulsory health insurance were the thesis, the AMA’s violent opposition was the antithesis, and Medicare is the synthesis. (Harris, 1969, p. 55)

Cohen was simply pointing out that one side wanted national health insurance and the other side did not, so the middle ground was health insurance for a select group – the elderly.

As mentioned earlier, the creation of Medicare was politically charged. The feeling at the time amongst politicians was that citizens were living longer and the elderly were growing in numbers and they had more common interests (i.e. health care); thus, they were more readily organized than the younger electorate (Blumenthal, et. al., 1998). Likewise, if physicians (AMA) opposed national health care for the elderly, they ran the risk of seemingly putting their interest ahead of their largest customers. In addition, conservatives opposed national health insurance because they did not want the government interfering or providing health insurance to individuals who could otherwise provide it themselves (Blumenthal et al., 1998). However, conservative opponents did concede that the elderly were far needier of government assistance since they were poorer than the average American on a percentage basis.

In 1959, the Department of Health, Education and Welfare under the Eisenhower administration reported the following:

Older persons have larger than average medical care needs. As a group they use about two-and-a-half times as much general hospital care as the average for persons under the age of 65....Their incomes are generally considerably lower than those of the rest of the population...Because both the number and proportion of older persons in the population are increasing, a satisfactory solution to the problem of paying for adequate

medical care for the aged will become more rather than less important.

(Corning, 1969, p. 81)

There was a general feeling amongst all of the stakeholders (i.e. citizens, government, physicians, hospitals) that the inevitable was happening and that somebody had to pay for services. As the population grew older, physicians and hospitals realized that government money was better than no money.

Toward the end of the 1950s, proponents of Medicare began to see the tide turn in their favor (Blumenthal, et. al., 1998). Elderly groups soon organized their efforts with the assistance of the American Federation of Labor and Congress of Industrial Organizations and began to speak out thereby pressing Congress for action. President John F. Kennedy, recognizing the hot topic of his time, made health insurance for the elderly the main subject of his platform on which he ran for presidency against President Eisenhower's Vice President Richard Nixon (Blumenthal, et. al., 1998). Kennedy would eventually win the 1960 presidency and would serve with Vice President Lyndon Johnson.

Wilbur Mills, a Democrat from Arkansas, and Robert Kerr, a Democrat from Oklahoma, co-chaired a bill known as the Kerr-Mills bill in 1960 that provided unlimited federal support of health care for the qualified elderly but only as long as the individual's state provided matching funds (Blumenthal, et. al., 1998). This means-tested, welfare program administered at the state level was much easier for the conservatives to accept than a national health insurance program. Proponents of national health insurance viewed the bill as a starting point and felt like it would be easier to use this as a building block to something more advanced in the years to come (Blumenthal, et. al., 1998).

A 1962 study at the University of Michigan revealed that the health care expenses of the elderly were more than twice that of younger Americans and only 50% of the elderly had health insurance (Blumenthal, et. al., 1998). Furthermore, a Senate investigation indicated that only 25% of the elderly had adequate health insurance meaning that 75% of the elderly population was without health insurance or had inadequate coverage for hospitalizations (Blumenthal, et. al., 1998).

By 1963, 88% of the federal funds were going to only five states (California, Massachusetts, Michigan, New York, and Pennsylvania) and only 32 of the 50 states were participating (Blumenthal, et. al., 1998). President Kennedy continued to lead the charge to broaden health insurance for the elderly. In 1962, the Kennedy administration conducted 33 rallies around the country in which they educated citizens on the necessity for Medicare (Blumenthal, et. al., 1998). President Kennedy was later assassinated in November of 2003 and Vice President Johnson took over as President and was equally committed to pushing Medicare through Congress.

In 1964, Johnson won the presidency with a landslide victory over Republican Senator Barry Goldwater and returned to the White House with a two-to-one Democratic majority in the House that was committed to Medicare. At the same time, the AMA and Republicans moved their positions from direct opposition to a more mediocre tone in regards to Medicare. At this point, legislation was on the table to provide health benefits for the elderly for hospitalization services, Medicare Part A, as we know it today (Blumenthal, et. al., 1998). In January of 1965 in a strange turn of events, the AMA sought to counter the legislation that was currently on the table by adding another section in legislation that would cover physician services (Blumenthal, et. al., 1998).

The aforementioned Democratic Senator Wilbur Mills then requested that a third component be added to the bill. He asked if they could expand the previous version of the Kerr-Mills bill which would cover the health care expenditures of all poor Americans – known today as Medicaid (Blumenthal, et. al., 1998). Wilbur Cohen, the head of the committee described what took place next:

I answered that it was possible. I had no specific authority from anyone to underwrite such a proposal, but I had enough common sense not to dismiss it out of hand....Mills did not spell out any specifics to me. Rather, he urged prompt action on a draft of such a proposal. I asked for a little more time to complete such a major undertaking. Mills said no, he wanted it the next day. I felt he sensed he had caught the critics off guard, and he did not want them to have time to regroup. He was like a general who saw he could rout his opposition and follow them as they retreated....It was a brilliant tour de force. (Cohen, 1985, p. 6)

This indeed was a brilliant work. Mills accounted for the AMA's criticism that the initial bill was too narrow and by incorporating the other proposal, he gave the Republicans recognition and a stake in supporting the bill. Years later, Cohen spoke about the chain of events:

Fortunately, I found President Johnson in the nearby office occupied by John Gardner, the Secretary of HEW. I barged in and briefly told the President what had occurred....The President did not bat an eye. He accepted the situation calmly, which I took for approval and clearance. It was a strange and unique way in which to make a major policy decision.

There was no policy clearance with others in the Department or in the Budget Bureau or White House. Mills had scored a coup. Johnson immediately realized it. I was the intermediary for a major expansion of our proposal without any intervening review of the details of the proposal as developed by the staff. In this case, the Federal Government was moving into a major area of medical care with practically no review of alternatives, options, trade-offs or costs. (Cohen, 1985, p. 6)

In the end, Mills had several motives for pushing all three points through legislation in the expedient fashion he did. By handling it the way he did, he avoided any long delays, dealing with lobbyists, and other long bureaucratic processes. He also recognized the inevitable passing of Medicare legislation and wanted to take some responsibility for this policy. Lastly, and perhaps most importantly, Mills wanted to protect Social Security. He felt that if universal health coverage was funded through Social Security it would threaten its financial integrity (Blumenthal, et. al., 1998).

Mills also thought that broadening Medicare to include Part B and adding Medicaid to the bill would prevent the creation of a national health insurance program. Again, years later Cohen provided insight into the exchange between he and Mills in 1965:

The inclusion of Medicaid in the 1965 law evolved when Mr. Wilbur Mills asked me what his answer should be to the inevitable question he thought he would be asked during the legislative debate: “Isn’t Medicare an ‘entering wedge’ to a broader program of nationwide ‘compulsory’ insurance for everyone?” I suggested that if he included some plan to

cover the key groups of poor people he would have a possible answer to this criticism. Medicaid evolved from this problem and discussion. I developed most of the provisions by expanding the plan requirements in the Kerr-Mills bill of 1960. (Cohen, 1985, p. 3)

Even though the bill was a foregone conclusion several weeks earlier, the Senate committee approved the bill on March 23, 1965 and the House passed it two weeks later (Blumenthal, et. al., 1998).

Mill's bill was very successful in including language that also protected physicians and hospitals from the invasion of the federal government on the way they practice medicine. Included in the bill was Section 1801 of Title XVIII which stated:

Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person. (Blumenthal, et. al., 1998, p. 13)

To make sure the federal government would be hands off in administering of Medicare, the bill called for the plan to be administered by intermediaries and carriers which were to be private health insurance companies. Physicians and hospitals were generally comfortable with the insurance companies and they were even to be paid based upon reasonable cost (hospitals) and reasonable and customary fees (physicians) modeled after existing practices of Aetna and Blue Shield (Blumenthal et al., 1998).

There were some inherent flaws in the Medicare bill – some of which were unforeseen and some which should have been ironed out before it passed. As mentioned in the previous paragraph, hospitals were to be paid at a rate based upon their reasonable costs, which gave them no incentive to hold their costs down (Blumenthal, et. al., 1998). There simply was not enough historical economic data on which to base payment for the federal government. It only did what they knew how to do – and that was to copy another method of payment from an industry that was already in the business of insuring patients. Legislators were fearful that physicians would refuse to see Medicare patients and felt like they had no other choice but to implement a payment method similar to the one that they were already accepting. Irwin Wolkstein, who worked with the legislators to pass the bill noted several years later:

Some might think that all the...concessions made to the insurance and health establishment were unnecessary from a political point of view in 1965 since at the time the House of Representatives, following the Democratic landslide victory in the election of 1964, was composed of the highest proportion of liberal legislators in many years. Yet the key vote on Medicare in the House in 1965 carried by a margin of just forty-five votes....The opposition to the bill was based in significant part on concern about the degree of federal invasion into the medical care that would result. (Wolkstein, 1970, p. 699)

Medicare was set up under two parts – Part A and Part B. Medicare Part A covers 4 types of service: inpatient hospital care, certain post-hospital care, home medical care, and hospice care (Vogel, 1999). Part A is where the majority of the Medicare money is

spent due to the longevity of hospital care and rehab. Medicare Part B covers physicians, outpatient hospital services, laboratories, and home health care (Vogel, 1999). Medicare Parts A and B have two different funding sources. Part A was modeled after the Social Security Trust fund in which payroll taxes are applied to employees and employers (Vogel, 1999). The trust fund for Medicare Part B is partially funded by annual premiums from the enrollees (about 25%) and income generated from the general fund by the federal government (about 75%) (Vogel, 1999).

Medicare spending is very unique in that there is no real budget within which participants have to stay. Policy-makers attempt to stay within a budget by tweaking benefits but the payment system is a retrospective system in which trust funds may be well over or under budget. This type of funding is termed “nondiscretionary” because the funding and spending requirements are a function of the legislation that established the program and not annual funding decisions (Vogel, 1999). There are three main factors that affect the money spent by Medicare: (1) the number of eligible participants, (2) what services are covered by the program and how often these services are used by the persons covered, and (3) the unit price per covered service (Vogel, 1999). The federal government can manipulate the expenditures on a year to year basis (retrospectively) by manipulating the three main factors above. Opposite of a nondiscretionary budget is the defense budget. Each year, the Congress authorizes a defense budget and appropriates the money in a discretionary fashion (Vogel, 1999).

Medicare has many accomplishments to be proud of since its inception. The government had the monumental task of enrolling 19 million Americans into the program by the end of the first year (Blumenthal, et. al., 1998). The federal government was able

to effectively delegate some of these tasks to private insurance companies and state governments. Medicare has been able to keep up with a growing enrollment and spends very little on administrative costs. The Department of Health and Human Services reported a cost of \$0.85 per claim in 1984 (Blumenthal, et. al., 1998). As someone in health care, I can personally attest that Medicare is far and away the easiest third party payer to deal with. It is very clear on what it will pay for, what requires authorization, is quick to process applications for credentialing providers, and is even timely on processing claims for payments.

Medicare has certainly given the growing elderly population the financial protection they need from the risks of paying for health care. Medicare paid for 75% of its members health care expenses in 1984 (Gornick et al., 1985). As a result, the elderly obviously have greater access to health care than they did before 1966. It is also safe to say that the enactment of Medicare has improved the health status and increased the life expectancy of the elderly (Blumenthal, et. al., 1998). According to figures from the National Center for Health Statistics, the death rates among Americans over 85 decreased by 28.2% from 1966 to 1977 as opposed to only 12.1% from 1933 to 1966 (pre-Medicare years). According to the Centers for Medicare & Medicaid Services (CMS), Medicare had 19,108,822 covered lives in 1966 and this number has increased to 41,086,981 members in 2003 (Centers for Medicare and Medicaid Services, 2006).

As with anything, there is always the other side of the picture. The federal government spends billions more than our forefathers ever thought possible. Medicare expenditures were \$3.3 billion in 1967 as compared to \$241 billion in 2001 (Centers for Medicare and Medicaid Services). This astronomical figure is mainly due to the

evolution of inpatient hospital care and the increased life expectancy of its members. According to the US Department of Health, Education, and Welfare, the average life expectancy for a US citizen was 70.1 years of age in 1965 when Medicare was passed versus 77.3 years of age in 2002 (Department of Health and Human Services – Center for Disease Control, 2006).

While Medicare has provided some form of health insurance coverage for the elderly, some would argue that this coverage has been inadequate (Blumenthal et al., 1998). Medicare has a separate deductible for both Part A and Part B and only pays 80% of the allowable charges, so many Medicare recipients have to pay the remaining 20% which can be very costly if they have any long period of care in a hospital or skilled nursing facility. Some Medicare members are fortunate enough to have supplemental insurance which pays for part or all of the remaining 20% that Medicare does not pay for.

Medicare also has some gaps in coverage such as long-term care, chronic care, and medications and it's always changing and sometimes difficult for members to keep up with (Blumenthal et al., 1998). As with most insurance, Medicare bills are often confusing and physician offices and hospitals are known to over bill patients. Medicare has also failed to distinguish coverage between classes of recipients (Blumenthal, et. al., 1998). It pays the same no matter what the financial status is of the recipient. In 1977, the average black Medicare member visited a physician five times compared to over six times by white members (Davis & Rowland, 1986). In addition to providing inequities among members, Medicare pays physicians and hospitals at different rates depending on their location (Blumenthal et al., 1998). In fact, reimbursement is so low that some areas are having difficulty getting physicians to participate with Medicare.

Canada: A Neighboring Health Care System

As the US was entrenched in a legal and political battle over whether or not to provide health insurance coverage for citizens through the government or insurance plans, Canada was in the middle of a similar battle. While this is a separate country, it is helpful to compare medical systems in these two countries to compare the ideologies and cultural similarities and differences. Furthermore, Canada's national health insurance plan is often used in national health insurance discussions in the US. The medical profession in Canada did not have a politically active group such as the AMA in the US (Gratzer, 2002). Like the US, physicians in Canada were primarily general practitioners that did a little bit of everything (Gratzer, 2002). There was not a large presence of hospitals, and physician fees were relatively minimal. In 1919, the Liberal Party of Canada adopted a platform that called for extensive social welfare including national medical insurance (Gratzer, 2002). In the 1920s, this attitude subsided as the country was prosperous and most people could afford to pay for their own medical care (Gratzer, 2002). However, during the 1930s, Canada, like the US, was hit with the Great Depression and this social platform reenergized itself (Gratzer, 2002). Like their neighbors to the South, the physicians in Canada were looking for payer sources for their services (Gratzer, 2002). Groups of physicians were starting to participate in private health insurance plans such as Associated Medical Services and Physicians' Services Incorporated. The US and many countries in Europe had adopted plans for social security and Canada would soon follow this same attitude as a way of creating their welfare state (Gratzer, 2002).

In the late 1940s, the province of Saskatchewan introduced Canada's first publicly funded insurance program for hospital services (Eve, et. al., 1995). The federal government then offered to share the cost of hospital and diagnostic services on a 50/50 basis (Eve, et. al., 1995). In 1942, the president of the Winnipeg Medical Society was quoted as saying, "The socialization of medicine is coming as surely as tomorrow's dawn. It is the natural result of public demand for adequate, complete medical service" (Gratzer, 2002). The Canadian government enacted unemployment insurance in 1941 and universal old age pensions in 1951 (Gratzer, 2002). Canadian citizens were cognizant of the talk in the US about national health insurance and were envious of the citizens in Great Britain after their country introduced National Health Insurance in 1948 (Gratzer, 2002).

By 1961, all ten provinces and two territories were provided public insurance for inpatient hospital care (Eve, et. al., 1995). This was again a prosperous time for Canada and citizens were very pleased with their free health care and lack of physician and hospital bills (Gratzer, 2002). Furthermore, many of the physicians were happy because they were paid for their services. By the mid-1970s, the federal and provincial governments saw the cost-sharing arrangement as being inappropriate (Eve et al., 1995). The individual provinces wanted to have more flexibility with federal dollars in order to provide more specialized care based upon each province's particular needs.

In 1977, the Canadian federal government changed the system of funding from cost-sharing to block-funding in which provinces were given money by the federal government based upon the capita of each province (Eve et al., 1995). Because physicians were extra-billing for services, the government was having difficulty funding

the health insurance program (Eve et al., 1995). In fact, many physicians (particularly specialists) opted out of the government reimbursed system and charged patients according to how they saw fit (Gratzer, 2002). Against extreme opposition from organized medicine, the Federal Parliament passed the Canada Health Act in 1984, which consolidated all of the individual provinces into one updated piece of legislation (Eve et al., 1995). In addition, the bill mandated that all private practitioners bill at a provincially accepted fee schedule (Gratzer, 2002). All of the provincial health insurance plans had to comply with five standards in order to receive full federal cash contributions:

1. Universality – each plan must cover all residents of the province who are eligible for coverage after a minimum period of residency of not more than three months on uniform terms and conditions.
2. Comprehensiveness – the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners, dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.
3. Accessibility – Provincial health insurance plans must provide reasonable access to necessary hospital and physician care without financial barriers. No one may be discriminated against on the basis of income, age, or health status.
4. Portability – residents are entitled to coverage when they are temporarily absent from their home province or when moving to another one. All provinces have some limits on coverage for services provided outside Canada and require prior approval for non-emergency out-of-province services.

5. Public Administration – the insurance plan must be administered on a non-profit basis by a public authority responsible to the provincial government. (Office of Consolidation, 1986).

Unlike many of the citizens (most of whom were conservative) in the US, the overwhelming majority of Canadian citizens did not view national health insurance as the government controlling their lives (Gratzer, 2002). While the medical society of Canada was not in favor of the bill, it did not have the backing from the people.

There are very differing opinions when it comes to the success of the Canadian Plan. I will list the discussion points:

1. Everyone citizen is covered under the Canada Health Act. No matter where they live, what race they are, or what they do for a living, the citizens are covered and have access to health care in Canada.
2. Canada has physician coverage within poor urban neighborhoods (Eve, Havens, and Ingman, 1995). Because physicians are guaranteed payment for services under the Canada Health Act, they do not turn away patients as physicians do in the US.
3. Low income Canadians have better access to high technology services than the uninsured or poorly insured Americans (Eve et al., 1995).
4. Less cost for administering the health plans (Eve et al., 1995).
5. Everyone is playing by the same set of rules and regulations. Since they have one payer source it is easier for everyone to be on the same system (Eve et al., 1995).
6. Better economies of scale.

There are many good qualities of the Canadian health care system. At the same time, there are also many poor qualities that are often pointed out by opponents:

1. There is too much focus on curative medicine and not enough on prevention and wellness (Eve et al., 1995).
2. The citizens pay higher taxes as a result (redistribution of money).
3. The physicians and hospitals are paid a fee-for-service so there is no incentive to reduce costs and utilization (Eve et al., 1995).
4. There is very little monitoring of physicians and sub-par quality assurance programs (Eve et al., 1995).
5. Certain physicians tend to get overworked and underpaid which leads to burnout (Gratzner, 2002).
6. Less reimbursement per procedure or office visit for physicians (Gratzner, 2002).
This has created a shortage in the number of physicians because they have less incentive than their peers to in the US. There are a large number of Canadian physicians leaving the country for more money. Furthermore, the health care bureaucrats decreased the number of admissions into medical school a decade ago upon the recommendation by economists that fewer physicians would equal lower utilization and lower expenses. This has added to the problem (Gratzner, 2002).
7. There is a nursing shortage and like the physicians, they are leaving the country for more money (Gratzner, 2002). The US has a shortage in nurses as well but we are better able to address the problem due to our capitalistic nature – we outbid the other team.

8. Many physicians are leaving public medicine for more profitable, less controlling private medicine (Gratzner, 2002). Many of the physicians are doing only elective cases (i.e. laser eye surgery) which is leaving the nation short of physicians to perform urgent and necessary surgery.
9. Many of the specialty physicians are leaving or quitting because there is no difference in pay (versus primary care physicians) for what they do even though their training and procedures are much longer (Gratzner, 2002).
10. Even though this is exaggerated by opponents of national health insurance, there are unnecessary waiting lists for certain procedures (Gratzner, 2002).
11. The technology in the hospitals is under-funded (Gratzner, 2002). This is another area that is subjective in nature, but there are many clinicians in Canada who feel like the technology they use in government hospitals is outdated.
12. Access to health care is different for different people. The Toronto Blue Jays (professional baseball) and the Toronto Raptors (professional basketball) players get MRIs and testing the next day (Gratzner, 2002). In addition, the Workers' Compensation Board pays for quicker MRIs (Gratzner, 2002).

It is important to compare the health care systems of the US and Canada because the countries are neighbors and have shared some of the same political history. In my research I have found resources and writers in favor of the Canadian system. Eve et al. (1995) points out that Canada spends only 9.9% of their Gross Domestic Product on health care, as opposed to 13.2% in the US (Scheiber et al., 1992). They also point out that the US has a higher rate of coronary artery disease (Higginson et al., 1992). These figures would indicate that the myths of bad health care in Canada are just that – a myth.

On the other hand, Dr. David Gratzner, a physician in Canada, is quick to point out that the hospitals have poor technology, the clinicians are leaving for the US, and they are just years away from a major crisis (Gratzner, 2002). You will get a different opinion depending on who you ask. The physicians are overworked and underpaid in Canada. They are not able to take advantage of the capitalistic health care system in the manner their peers do in the US. Overall, they work more and get less and this creates envy and discontentment. The Medicare system in Canada works for the vast majority of Canadian citizens. They receive free health care and even though they are ultimately paying for it, their risk is spread out over the entire population. Only a small group of citizens are truly adversely affected by the waiting lines and delays in care, so in the end, the majority rules.

Culture's Impact on Health Care

Our culture in the US has played a big role in shaping the development of our health care system. As the demographics of our nation change, the culture will continue to change and further develop the policies that run the country. Citizens usually vote for politicians that share the same cultural values (among other values) that they share, which should lead to national policies that best reflect the nature of the country.

The Baby Boomer Effect

Now that we have discussed the evolution of Medicare and the health insurance industry up until the passing of Medicare in 1965, let's look at the world of health insurance post-1965. We have all heard of the words "Baby Boomers" and most of us know that this is the aging generation that was born between 1946 and 1964. The biggest impact to the Baby Boomer generation was World War II (Styring & Jonas, 1999).

Returning World War II servicemen started families later than normal upon returning from the war (Styring & Jonas, 1999). This created a bottleneck effect of two generations producing children at the same time which obviously increased the number of people born between 1946 and 1964. Statistically, there were 2.8 million births in the US in 1945 which jumped to 3.8 million in 1946 (Styring & Jonas, 1999). The next year the number jumped up to 4.0 million through 1964 (Styring & Jonas, 1999).

The Baby Boomer effect has been felt in many areas other than just health care. As the first Baby Boomers began to start school in the 1950s, school districts had a difficult time placing young students because of the numbers (Styring & Jonas, 1999). Some districts had to run two shifts to keep up with the pace while others started mass building projects (Styring & Jonas, 1999). There are even some school districts today that have more school buildings than they need and are tearing them down for other needs. As the Baby Boomers hit the college years, many of the universities encountered the same problems as did the elementary schools in years past (Styring & Jonas, 1999). Many believe it was this post-World War II mentality that led to many revolts to the Vietnam War of the 1960s on college campuses (Styring & Jonas, 1999).

In the year 2000, 12.6% of the population was 65 years or older and that number is projected to be 20.2% by the year 2030 (Styring & Jonas, 1999). This is the magic year that we often hear about when politicians speak of Medicare and Social Security. How will a much smaller generation pay for the entitlements that Baby Boomers rightfully deserve when they reach 65? Medicare as we know it today has plenty of gaps and downfalls with the current elderly demographics. By the year 2030, the numbers will

be such that something major is going to have to take place in order to keep the Medicare system afloat.

The Pharmaceutical Industry

Most insurance companies will tell you that an individual or business's insurance premiums fluctuate dramatically based upon their utilization of pharmaceuticals. Besides the increased cost of technology and in-patient hospital visits, the amount of money people spend (and, in turn, health insurance companies) on pharmaceutical drugs has greatly contributed to the rising expense of health insurance. We increased spending from \$87,300,000,000 on prescription drugs in 1998 to \$179,200,000,000 in 2003, representing over a 200% increase (Centers for Medicare and Medicaid Services, 2006). The prices constantly increase year after year especially when a company's patent is nearing the end (Angell, 2004). The price of Claritin, a top-selling allergy pill, was raised thirteen times over a five-year period (Angell, 2004). When questioned about it, a spokeswoman for the company replied, "Price increases are not uncommon in the industry and this allows us to be able to invest in R & D (research and development)" (Lueck, 2003, section D2).

Pharmaceutical companies do a good job of promoting their R & D cost as the backbone of the industry and rationalize the cost of their drugs with future R & D. They claim if the profit margins are not high, they will not be able to discover the new drug that will save America in the future. Alan F. Holmer, the president of Pharmaceutical Research and Manufacturers of America was quoted as saying, "Believe me, if we impose price controls on the pharmaceutical industry, and if you reduce the R & D that this industry is able to provide, it's going to harm my kids and it's going to harm those

millions of other Americans who have life-threatening conditions” (Talk of the Nation, 2001).

The amount of money pharmaceutical companies spend on R & D is up for discussion. The pharmaceutical companies do report the total amount they spend on R & D each year, but they will not give a breakdown of the expense, claiming it is proprietary (Angell, 2004). This leads most people to believe that they are including marketing and other expenses not directly related to R & D. Perhaps a better question is how much they spend on R & D for each new drug. When looking at the number of new drugs put on the market over a 7 year period and the reported R & D for that period, Public Citizen, a consumer advocacy group, estimates that the R & D cost per new drug is about \$100 million (Citizens for Health, 2006). The group reports that they do not have a good comfort level with the amount of money pharmaceutical companies spend on R & D every year, but they know that the pharmaceutical industry has consistently been the most profitable business over the past two decades, the utilization of prescription drugs increases every year, and it is our fastest rising health care expenditure every year.

Individuals spend an extraordinary amount on prescription drugs. In 2002, the average cost of the 50 most commonly used drugs was about \$1,500 per year (Angell, 2004). When Medicare was enacted in 1965, people were taking far fewer prescriptions, and they were relatively cheap; thus, Medicare legislators did not think about making any provisions for prescription coverage (Angell, 2004). In 2003, Congress passed a Medicare reform bill to add a prescription drug benefit but the coverage is minimal at best and confusing. Angell (2004) contends that furthering the problem with elderly patients is the fact that Medicare does not use its strengths in numbers to bully the

pharmaceutical companies into lower prices for the elderly. Medicare patients pay much more for their drugs than do younger patients covered by private health insurance because their insurance company (Medicare) has refused to negotiate on their behalf. Medicare provides some form of *capitated protection* for recipients for physician and hospital charges by negotiating very low rates, but it has never accomplished this in the pharmaceutical industry.

The Uninsured Population

The uninsured population puts a tremendous burden on hospitals, physicians, insured patients, and both the federal and state governments. A survey performed by the Current Population Survey in 1993 revealed that 16% of all children at that time were uninsured (Styring & Jonas, 1999). To the naked eye, the survey showed two buckets of children – the insured and uninsured. In reality, these buckets are always spilling over into one another. One month a certain percentage of insured children become uninsured only to go back to being insured at some other point. Likewise, some uninsured children will become insured during that same month. The point is that some statistics we see are the number of uninsured people at any given point and other statistics will show the number of uninsured people at any point throughout the year. These two numbers are obviously very different because a certain percentage bounces back and forth between the two buckets discussed above. To demonstrate, see data from the Survey of Income and Program Participation. This organization did a study of persons and families over a thirty-two-month period from February of 1991 to September of 1993. According to the results, fewer than 3% of children are considered permanently uninsured, about 70% have

insurance all the time and the remaining 27% are sometimes with health insurance and sometimes without it (Styring & Jonas, 1999).

The uninsured is not always the poorest population. According to the Medical Expenditure Panel Survey by the Agency for Healthcare Research & Quality (2006), 11.75% of Americans did not have health insurance in 2002, which comprises approximately 33,870,320 people (Medical Expenditure Survey, United States Department of Health and Human Services - Agency for Healthcare Research and Quality, 2006). Of these 33,870,320 people, 15,506,158 were considered middle or high income earners, which is defined as earning greater than 200% of the poverty level (Medical Expenditure Survey, United States Department of Health and Human Services - Agency for Healthcare Research and Quality, 2006). Thus, nearly 46% of the nation's uninsured population in 2002 were considered middle to upper class. In 1996, the MEPS estimated 32,929,442 Americans without health insurance. At the time, that number represented 12.25% of the population. In 2002, the number of uninsured lives jumped up to 33,870,320 – almost a million more people. However, the percentage of population that was uninsured was only 11.75% (Medical Expenditure Survey, United States Department of Health and Human Services - Agency for Healthcare Research and Quality, 2006) revealing that the epidemic is not growing at the rate most people might think.

Identifying the uninsured is no easy task. Who were the historically uninsured population? 1991 data shows that if the heads of the household were full-time workers, 12.6 percent of families were uninsured (Foley, 1993). Families that were headed by part-time or part-year workers were uninsured 28.3 percent and families with non-

working heads were uninsured 22.5 percent (Foley, 1993). This last figure may seem low but most of the time the family was covered by Medicaid. In that same year, 53 percent of the uninsured population were members of full-time, full-year working families (Foley, 1993). By contrast, only 15.3 percent of the uninsured population were members of families with non-working heads (Foley, 1993). In addition, 41 percent of workers in agriculture were uninsured, 31 percent in construction, 25 percent in retail trade, and 17 percent in the service industries (Foley, 1993). As mentioned earlier, the smaller the company, the more likely the employee is to be uninsured. 32 percent of employees in businesses with fewer than 10 employees were uninsured as compared to 22 percent of self-employed workers, and only 9 percent of employees in businesses with more than 1,000 employees were uninsured (Foley, 1993).

The breakdown of uninsured workers in 1991 was as follows: retail/wholesale – 26%; self-employed – 13%; manufacturing – 12%; construction – 9%; professional services – 9%; business/repair services – 7%; government – 6%; personal services – 6%; agriculture/mining – 4%; transportation – 4%; finance/insurance – 3%; and entertainment – 2% (Foley, 1993). Keep in mind that these numbers are all relative. For example, in 1991, self-employed workers comprised 13 percent of the uninsured working population while construction workers comprised 9 percent. That does not necessarily mean that a higher percentage of self-employed workers were uninsured versus construction workers. If there were twice as many total self-employed workers in 1991 versus construction workers that would mean a construction worker was more likely to be uninsured.

Personal income is obviously a big determinant in whether or not one has health insurance. Low income earners are less likely to afford the cost of insurance; low-wage

industries such as retail and personal services are less likely to offer group insurance; and low-wage industries also tend to make the lowest employer contributions to health insurance which often results in employees declining employer-provided health insurance (Foley, 1993).

The strong correlation between education and income also affects health coverage. The less educated someone is, the more likely they are to be uninsured. Medicaid is supposed to cover individuals that are considered poor, but it fluctuates from state to state and even from month to month, based upon the budgets for different states. In 2001, 30.4 percent of individuals who earned less than \$10,000 per year were uninsured (Foley, 1993). About 1.0 percent of the elderly population did not have any form of health insurance (i.e. Medicare) because they never paid Social Security taxes, they were unaware of their eligibility, or they just chose not to apply for coverage (Foley, 1993). The following is a breakdown of the percentage of the uninsured population based upon education level: no high school – 15.8%; some high school – 18.3%; high school graduate – 36.8%; some college – 15.2%; associates degree – 4.4%; bachelors degree – 6.8%; masters degree – 2.0%; professional degree – 0.5%; and doctoral degree – 0.3% (Foley, 1993). It is important to point out that these numbers are all relative. Even though someone with no high school education is more likely to be uninsured than someone with a high school diploma, the reason that high school graduates comprise a higher percentage is because there are many more high school graduates in this country than those with no high school education.

Foley (1993) reported that gender plays a role in whether or not someone has health insurance. Because women of twenty-five years of age or more are likely to have

a baby, they are more often covered than men and Women and children are more likely to be covered by Medicaid than men. Based upon Foley's 1991 figures, men made up 49 percent of the population but made up 55.8 percent of the uninsured population. The largest age range of uninsured for both men and women are between the ages of 21 and 24 while they are both least likely to be uninsured between the ages of 55 and 64 (Foley, 1993).

Also, race and ethnicity play a role in whether or not someone has health insurance. Based upon Foley's (1993) 1991 statistics, 13.0 percent of whites were uninsured, 23.7 of African Americans, and Hispanics were at 33.9 percent uninsured. While whites accounted for 73.9 percent of the nonelderly population, they comprised only 57.8 percent of the population. Meanwhile, African Americans and Hispanics comprised 12.8 and 9.5 percent of the population respectively and 18.2 and 19.4 percent of the uninsured population respectively (Foley, 1993).

Another important factor in the world of the uninsured is family composition. 12.9 percent of members in a married family with children are uninsured, 13.5 percent for married families without children, 20.1 percent for single families with children, and 27.9 percent for single families with children were uninsured (Foley, 1993). As stated earlier, families with children are less likely to be uninsured because Medicaid is more likely to cover families with children versus those without. Further, 67 percent of single-parent families with children at 125 percent of the poverty level receive Medicaid compared to only 25 percent of married couples without children (Foley, 1993).

As health insurance rates escalate, employers are requiring larger deductibles and employee co-pays to help keep the costs down. According to their research, Schoen, et.

al., (2006) found that 61 million US adults were either uninsured or underinsured (Schoen, Davis, How, & Schoenbaum, 2006, p. 466). Forty percent of US adults reported that they went without health care because of the high costs, which is four times higher than the United Kingdom (Schoen, et. al, 2006, p. 466).

Data also reveals that hospital readmission rates are very high in the US. We spend billions of dollars on patients being readmitted to the hospital within 30 days of being discharged for the same diagnosis (Schoen, et. al, 2006, p. 469). This is due to being discharged too early or not being properly educated upon discharge. We also spend 2 to 3 times that of other countries for insurance administrative costs (Schoen, et. al, 2006, p. 470). This is one reason that health insurance rates continue to escalate at a record pace.

Looking at the entire nation, there are huge gaps between states, hospitals, and the quality of care received from individuals. On average, our country lacks the quality, efficiency, and cost-effectiveness that some other countries demonstrate. Our national health care expenditures increased from 7.1 percent of our gross domestic product in 1970 to 16 percent in 2006 (Schoen, et. al, 2006). Due to the misaligned incentives of hospitals, physicians, and patients, we have found ourselves in a mess in which services are being over-utilized and the costs are out of control. As the expenses over the past three decades for health care services have skyrocketed, more and more employers are not offering health insurance to employees or they are cutting back on benefits and implementing more cost-sharing measures.

Summary

History has shown us that the health care system in the US has evolved over the years based upon the political and cultural climate of its time. The structure for payment and accessibility of health care has always been a power struggle between the physicians, hospitals, insurance companies, the government, and the citizens. The practice of medicine and the delivery of health care has always been very complex due to the unpredictable nature of the field. Insuring health care needs is a risky business because of this unpredictability, and the government is perhaps too big and bureaucratic to control the costs.

Medicare and Medicaid were enacted with good willed intentions but the unpredictable life expectancy, baby boomer generation, escalating costs, and non-managed approach to these systems have created a financial strain on the government and the citizens that pay for the bills. Managed health care organizations have tried to constrain the soaring costs of health care but have done a poor job in controlling the utilization. With so many laws and regulations that exist within the managed care insurance business, it is very difficult to control costs and the risk and expense of covering a group of individuals is passed along to the consumer. In many ways, it is easier for a health insurance company to predict medical bills than it is to predict pharmaceutical bills.

In Chapter 3, I will use Michel Foucault's cultural studies approach to critically analyze the various ideological and political aspects of the culture of health care in the US. Foucault lends valuable perspectives for examining the dynamic and intricate world of health care and provides significant lessons for changing the behaviors of the key

agents and clients within this dynamic system. In addition, I will discuss the collection of US health care data and how data will be used to determine weaknesses as well as possible solutions to transform the US health care system for meeting the medical needs of all members of US society.

CHAPTER 3

THEORETICAL FRAMEWORK

A theoretical inquiry involves a process by which a researcher or student investigates, creates, discusses, and reflects on a particular subject. During this theoretical inquiry, I used Michel Foucault's cultural studies approach to critically analyze the various ideological and political aspects of the culture of health care reform in the US. By thoroughly researching Foucault's theories, I was able to apply his knowledge and philosophy to today's concerns for US health care.

Michel Foucault's Genealogy and Ethical Analysis

As mentioned in the introduction, Michel Foucault's genealogy analysis emphasized how institutional disciplines define their governed subjects and cast the self-awareness of subjects as a product of the way the subject is controlled (McFarlane & Prado, 2002). Foucault stressed how self-aware subjects govern and define themselves, i.e., each individual has a different history and different experiences which affect the way he or she responds to being governed. Further, individuals who are being controlled continually adjust to various external and internal influences (McFarlane & Prado, 2002).

When speaking of functional sites in a medical institution, Foucault wrote about the effectiveness of architecture and the ability to have multiple uses for the same space. If the architectural design made the space useful, the management and physicians would be better equipped to treat patients and control the swarming masses. When an institution regulates agents and clients, there can be a reciprocal effect on the institution. Health care managers can affect agents (health care providers) by discouraging them from ordering expensive tests for patients or they can have an effect on clients (health care

recipients) by requiring longer waiting periods for tests or surgery (McFarlane & Prado, 2002).

Directives, as Foucault identified them, are always interpreted differently and therefore carried out differently. For instance, management can give the same directive to two different physicians, but they will, more than likely, be carried out in two different styles because of the different conditions in which they practice (McFarlane & Prado, 2002). Under this scenario, each of the two physicians might implement the procedure in a different fashion. If one physician carries out the procedure begrudgingly and the other is more accepting of the new regulation, they will invent two different cultures. The area the first physician works in will be more prone to adopt his or her attitude to the change while the area the second physician works in will be more adaptable to change just based upon their individual attitudes. There are many factors that could possibly affect these individual attitudes such as the economic status of the community they work in, the physician's personal feelings and experiences, and the particular clientele that they work with (McFarlane & Prado, 2002).

Patients, also, can perceive directives in different lights. For instance, if one insurance policy covers a procedure and the other does not, two different patients will have a different feeling and interpretation to the situation. One patient may be able to pay more out of pocket while the other one may not. Furthermore, whether or not the patients are able to pay for procedures out of pocket will have a bearing on how they view themselves, which traces back to Foucault's ethical dimension of decision-making (McFarlane & Prado, 2002). The way health care management handles these particular situations, the way agents and clients handle them, and the attitudes of all of the

participants combine in unpredictable ways making health care a complex system to manage (McFarlane & Prado, 2002). In the end, you will likely have a situation in which the insurance company's directives were not followed and the cost-savings are not there. This unpredictability adds a challenging dimension to health care because of the multiple factors and local conditions in which a set of rules are applied.

Agents and clients will always respond differently based upon how they perceive that different changes in health care will affect them. It is not just the manner in which changes will realistically affect the agents and clients, but more importantly, their perception of how the changes will affect them. Their history, rearing, education, gender, race, religion, and political philosophy will help determine their self-definition (McFarlane & Prado, 2002). Responses to change depend on self-definition and how other agents and clients respond in the same setting.

Foucault contends that imposing behavioral habits on individuals shapes and reshapes their perspectives, attitudes, values, desires, and other affective aspects; and further, that it is the individual's perspectives, attitudes, values, and desires that make up the culture in which they live in. A particular hospital may have many different cultures within its setting; consequently, this *multicultural* setting often makes it more difficult to control. Multicultural in this case is not necessarily speaking of ethnicity as much as the history, experiences, and view point of the individual agents and clients. Within such a multicultural context, Foucault advocates for a deep internalization of a carefully designed understanding of the self (McFarlane & Prado, 2002).

Michel Foucault's Hierarchical Observation

Foucault describes hierarchical observation as physically structuring the work spaces to allow those in authority to oversee the particular environment in which he or she is managing (Foucault, 1975). Foucault states, "These 'observatories' had an almost ideal model...in the perfect camp, all power would be exercised solely through exact observation; each gaze would form a part of the overall functioning of power. For a long time this model of the camp...was found in urban development, in the construction of working-class housing, estates, hospitals, asylums, prisons, schools: the spatial 'nesting' of hierarchized surveillance" (Foucault, 1975, p. 171).

It is through hierarchical observation that one is better able to view the behavior of all agents and clients in the institution. This perfect disciplinary arrangement in the institution allows the observer to choose one central point so that nothing escapes from the view point (Foucault, 1975). As Foucault writes:

The pyramid was able to fulfill, more efficiently than the circle, two requirements: to be complete enough to form an uninterrupted network – consequently the possibility of multiplying its levels, and of distributing them over the entire surface to be supervised; and yet to be discreet enough not to weigh down with an inert mass on the activity to be disciplined, and not to act as a brake or an obstacle to it; to be integrated into the disciplinary mechanism as a function that increases its possible effects. (Foucault, 1975, p. 174)

Michel Foucault's Normalizing Judgment

The process of comparing various groups to one particular group to show the others how behavior should be is what Foucault termed normalizing judgement (Foucault, 1975). This is accomplished with a subtle suggestion as to who to watch and who to compare your group to. The philosophy behind this term is that the insufficient groups mimic the behavior of the more favorable group. Foucault calls this modeling a gratification effect (Foucault, 1975). He believed that agents and clients have a desire to do well; i.e., to be *normalized* and to want to be viewed as doing such.

In addition to gratification modeling, Foucault showed that disciplinary punishment is useful for corrective action. Nevertheless, he encouraged the use of rewards first before resorting to punishment as subjects are more responsive to rewarding provisions than to punishment (Foucault, 1975). In *Discipline & Punish: The Birth of the Prison*, he stated:

The Normal is established as a principle of coercion in teaching...it is established in the effort to organize a national medical profession and a hospital system capable of operating general norms of health; it is established in the standardization of industrial processes and products. Like surveillance and with it, normalization becomes one of the great instruments of power at the end of the classical age. (Foucault, 1975, p. 184)

Foucault further wrote that by establishing the *normal* behavior, we are inducing others to follow suit and will even reward them for doing so. Because everyone is intrinsically and extrinsically motivated differently, good managers will adapt to the individual agent and

client in order to get the result they are after. This process attempts to differentiate individuals according to the rules; it measures and ranks individuals in terms of ability; it introduces the constraint of conformity that must be achieved; and it traces the limit that will define difference in relation to all other differences (Foucault, 1975).

Michel Foucault's Examination

In an attempt to present an examination, Foucault combines the techniques of an observing hierarchy and those of a normalizing judgement (Foucault, 1975). The examination is the tool by which the manager surveys the situation and thereby the tool that he or she judges, punishes, or praises the agents and clients. This can be in the form of a formal written exam or by some form of surveillance. Foucault stated:

The ritual of the visit was its most obvious form. In the seventeenth century, the physician, coming from the outside, added his inspection to many other controls – religious, administrative, etc.; he hardly participated in the everyday administration of the hospital. Gradually, the visit became more regular, more rigorous, above all more extended: it became an ever more important part of the functioning of the hospital. (Foucault, 1975, p. 185)

Physicians give their examinations in a personal form of observation, conversation, and touch. As hospital care evolved, physicians became more and more important in not only the care of patients but an active role in the way the hospitals were run. The examination gave power to those who viewed the subjects. This disciplinary power was exercised over those who were constantly seen and the examination was the technique in which that

power was used (Foucault, 1975). Furthermore, it gave the subjects individuality and differentiated them from other subjects.

Foucault's real point of institutional discipline was to eventually allow the agent and client to control their behavior through normalization (McFarlane & Prado, 2002). He implied that control is not only achieved through restrictions but also through enabling descriptions and self-images. He showed that effective control does not only proscribe someone from a particular action, it encourages particular ways of behaving and self-image. The ultimate goal is for the agents and clients to want to conform because they are doing the right thing instead of conforming out of fear of consequences. Agents and clients exert their power in one fashion or another because power is people doing things and what they do affecting others and what those others do (McFarlane & Prado, 2002). Agents and clients exert their power in this domino effect and it is up to the managers of an institution to ensure that the first domino is falling in the right direction (McFarlane & Prado, 2002).

McFarlane and Prado (2002), citing Foucault (1975), posit that health care is a different cultural institution because of its unpredictability. It has a large number of human and non-human components that are always changing and even the best managed institutions are prone to falling short of its objectives. Foucault describes a health care system as a chaotic system that is so complex that even a small change in its many variables results in unpredictable consequences. When something goes wrong within an institution, we must first look internally before looking externally to try and fix the intrinsic problems. When things go wrong in health care it is not always because someone made a mistake or the system is failing. It could very well be because the

components that make up the system are unpredictable and this unpredictability affects both agents and clients. The actions of those that make up a health care institution – the physicians, the patients, and the managers – are much more unpredictable and unmanageable than the system itself.

Harry Collins and Martin Kusch (1998) developed a term called *polymorphic* which means *many shaped* to describe how humans behave when “they draw on their understanding of their society” (p. 1). The actions of agents and clients are influenced by the actions of others and the power relations ultimately determine how they respond to these actions. Indeed, health care is unique because these polymorphic characteristics are true of not only the human subjects, but the non-human ones as well. In the health care system, not only is health care trying to change its agents and clients, but the agents and clients are trying to change themselves as well (self-image) which makes behavior exponentially unpredictable (McFarlane & Prado, 2002).

Foucault’s discussion on ethics, reflection and evolution of one’s self-image, is of particular interest because it helps us to appreciate the fact that the actions of agents and clients cannot be anticipated. It is this understanding that should help us better prepare for their unpredictability and be able to accommodate the day-to-day chaos in an institution. This unpredictability is expanded because of three things: (1) an institution’s expectations as to how they should behave; (2) their interactions with others; (3) and their own subjective influences of self-images. McFarlane and Prado (2002) demonstrate this with a simple example:

Compliance with a simple directive on informing patients about treatment side effects, for instance, may be conditioned by how things are done in a

particular ward. The effect is that perhaps patients are given too much detail in one ward, too little detail in another. In the one case, patients may be confused; in the other, patients may be inadvertently misinformed. The particular reasons why too little or too much information is given is very varied. (McFarlane & Prado, 2002, p. 57)

Age and gender of the patients can play a role in determining the amount of information given regarding treatment. Because agents have their own perceptions and historical perspectives of the problem and particular client, they will likely alter their behavior to accommodate these differences. Communication is very important concerning treatment information as Freire (1970) stated: “Without dialogue there is no communication, and without communication there can be no true education” (p. 81). Agents and clients must have an open communication in order to feel empowered to make decisions that are beneficial for both. Friere (1998) also emphasized the need to fight for change: “I struggle for a radical change in the way things are rather than simply wait for it to arrive because someone said it will arrive someday” (p. 122). That is, we can sit on our hands and wait for disaster or we can take control of our own destiny for a better health care system.

Data Collection Procedures and Descriptive Analysis

Using Foucault’s unique guiding deconstruction of social systems to reveal the relationship between agents and clients and to critically analyze the underlying ideologies, values, and purpose of medical care in the US, statistical data were collected showing the characteristics and forms of medical care delivery in the State of Georgia and in the US using two primary governmental web sites managed by the Department of

Health and Human Services – Center for Disease Control and Prevention and the Center for Medicare and Medicaid Services. The following state and national data were collected and analyzed: (1) the percentage of Georgia and US citizens without health insurance from 1993 to 2002; (2) the total health care costs of both the private (employers, employees, and patient payments) and public (government) sector in the US and the percentage of these payments between the private and public sector from 1993 to 2002; (3) the total health care costs (which includes hospital care, physician services, other professional services, dental services, home health care, prescription drugs, other non-durable medical products, durable medical products, nursing home care, and other personal health care) in both Georgia and the US from 1993 to 2002; (4) the breakdown of the total health care costs (which includes hospital care, physician services, other professional services, dental services, home health care, prescription drugs, other non-durable medical products, durable medical products, nursing home care, and other personal health care) in Georgia from 1993 to 2002; (5) the breakdown of the total health care costs (which includes hospital care, physician services, other professional services, dental services, home health care, prescription drugs, other non-durable medical products, durable medical products, nursing home care, and other personal health care) in the US from 1993 to 2002; and (6) the Medicare allowables for five random surgical CPT codes from 2001 to 2006.

I will use Foucault's hierarchical observation, normalizing judgement, and examination to show how both agents and clients affect and can have positive effects on the US health care system. As Foucault points out, there are two primary players in the health care system – agents and clients. Everyone plays a role in the downward-spiraling

health care system we have in the US. In order to change the path of destruction we are currently heading toward, we will have to change the culture in which we practice and receive medical services. It is important to observe and track patient and physician behavior as the costs of health care increase every year. As demonstrated by Table 3.2 and 3.6 below, the cost of medical services continues to decrease (on average) from year to year but we continue to spend more money.

Using Foucault's genealogy and ethical analysis tools, we can find a way to better govern and control subjects' behaviors if we can transform the health care system in the US. Table 3.1 shows the trends in the percentage of uninsured citizens in both the state of Georgia and the US. This table will be used to identify upward or downward trends in the uninsured population.

Table 3.1

Percentage of the Uninsured Population in Georgia and the United States from 1993 to 2002

<u>Year</u>	<u>% of Uninsured in Georgia</u>	<u>% of Uninsured in United States</u>
1993	13.20%	12.90%
1994	12.30%	12.60%
1995	10.20%	12.00%
1996	9.80%	12.90%
1997	12.00%	12.00%
1998	14.70%	13.00%
1999	13.60%	12.40%
2000	14.90%	11.80%
2001	13.80%	13.30%
2002	15.70%	14.10%

Source: Department of Health and Human Services – Centers for Disease Control and Prevention.

Table 3.2 demonstrates who is actually paying for all of the health care costs in the US. The private sector includes the contributions by employers to health insurance premiums, workers compensation premiums paid by employers, employee contributions

to insurance premiums, and individuals' out-of-pocket expense. The public sector includes the federal, state, and local government contributions to health care costs. Perhaps what is most intriguing about this table is the escalation of expenses more so than the actual percentage split. In 1989, the private and public sector shared expenses 70% and 30%, respectively, as compared to 62% and 38% in 2002, respectively.

Table 3.2

Total Health Care Costs of the Private and Public Sector in the United States and the Percentage of Payments from 1993 to 2002 (Amount in Billions)

Year	Total Private Expenditures	% of Total Health Care Costs	Total Public Expenditures	% of Total Health Care Costs
1993	\$546.90	64.00%	\$306.50	36.00%
1994	\$569.30	63.00%	\$331.20	37.00%
1995	\$604.50	63.00%	\$348.50	37.00%
1996	\$631.10	63.00%	\$371.80	37.00%
1997	\$667.90	63.00%	\$386.50	37.00%
1998	\$718.80	65.00%	\$392.90	35.00%
1999	\$766.40	65.00%	\$413.60	35.00%
2000	\$820.50	65.00%	\$444.00	35.00%
2001	\$867.70	63.00%	\$507.80	37.00%
2002	\$928.10	62.00%	\$571.10	38.00%

Source: Department of Health and Human Services – Centers for Disease Control and Prevention.

Table 3.3 represents the total number of dollars spent on health care services in Georgia and the US from 1993 to 2002. This table will help identify trends in the actual health care costs between the US and Georgia.

Table 3.3

Total Health Care Costs in Georgia and the United States from 1993 – 2002 (Amount in Millions)

Year	Total Health Care Costs in Georgia	Total Health Care Costs in United States
1993	\$20,270	\$773,646
1994	\$21,286	\$814,390
1995	\$22,945	\$863,709
1996	\$24,307	\$910,273
1997	\$25,660	\$959,805
1998	\$27,117	\$1,010,518
1999	\$28,357	\$1,068,349
2000	\$30,153	\$1,139,925
2001	\$32,465	\$1,239,071
2002	\$35,690	\$1,341,372

Source: Department of Health and Human Services – Centers for Disease Control and Prevention.

Table 3.4 shows a breakdown of all of the health care costs in Georgia from 1993 to 2002. This particular table will identify trends of the specific health care areas in which expenditures have risen at a greater level than others.

Table 3.5 shows these same costs for the entire US. This table will be used to compare trends against that of Georgia.

Table 3.4

Total Health Care Costs Break Down of Hospital Care (HC), Physician Services (PS), Other Professional Services (OPS), Dental Services (DS), Home Health Care (HHC), Prescription Drugs (PD), Other Non-Durable Medical Products (ONMP), Durable Medical Products (DMP), Nursing Home Care (NHC), and Other Personal Health Care (OPHC) in Georgia from 1993 to 2002 (Amount in Millions)

Year	HC	PS	OPS	DS	HHC	PD	ONMP	DMP	NHC	OPHC
1993	\$8,570	\$5,492	\$602	\$927	\$746	\$1,418	\$593	\$348	\$1,102	\$472
1994	\$8,891	\$5,595	\$653	\$1,008	\$862	\$1,530	\$599	\$372	\$1,178	\$600
1995	\$9,202	\$6,271	\$681	\$1,101	\$977	\$1,734	\$609	\$404	\$1,303	\$664
1996	\$9,624	\$6,597	\$739	\$1,163	\$974	\$1,973	\$620	\$445	\$1,442	\$730
1997	\$9,882	\$7,062	\$822	\$1,271	\$908	\$2,261	\$625	\$490	\$1,571	\$768
1998	\$10,270	\$7,579	\$822	\$1,375	\$912	\$2,568	\$647	\$510	\$1,650	\$783
1999	\$10,532	\$7,991	\$848	\$1,500	\$738	\$3,022	\$693	\$520	\$1,629	\$885
2000	\$11,273	\$8,173	\$899	\$1,678	\$658	\$3,471	\$712	\$532	\$1,729	\$1,027
2001	\$12,022	\$8,849	\$962	\$1,830	\$603	\$3,954	\$724	\$541	\$1,857	\$1,122
2002	\$12,848	\$10,031	\$1,057	\$2,051	\$658	\$4,468	\$744	\$573	\$1,941	\$1,320

Source: Department of Health and Human Services – Centers for Disease Control and Prevention.

Table 3.5

Total Health Care Costs Break Down of Hospital Care (HC), Physician Services (PS), Other Professional Services (OPS), Dental Services (DS), Home Health Care (HHC), Prescription Drugs (PD), Other Non-Durable Medical Products (ONMP), Durable Medical Products (DMP), Nursing Home Care (NHC), and Other Personal Health Care (OPHC) in the United States from 1993 to 2002 (Amount in Millions)

Year	HC	PS	OPS	DS	HHC	PD	ONMP	DMP	NHC	OPHC
1993	\$317,162	\$201,232	\$24,478	\$38,878	\$21,879	\$50,991	\$23,914	\$13,512	\$65,445	\$16,156
1994	\$329,797	\$210,488	\$25,669	\$41,432	\$26,066	\$54,301	\$24,663	\$14,248	\$67,922	\$19,805
1995	\$340,743	\$220,535	\$28,540	\$44,486	\$30,529	\$60,876	\$25,654	\$15,294	\$74,082	\$22,970
1996	\$352,240	\$229,385	\$30,866	\$46,818	\$33,602	\$68,535	\$26,774	\$16,634	\$79,587	\$25,832
1997	\$364,781	\$240,943	\$33,390	\$50,168	\$34,544	\$77,666	\$27,676	\$18,091	\$84,485	\$28,062
1998	\$376,317	\$256,361	\$35,742	\$53,490	\$33,239	\$88,595	\$28,210	\$18,738	\$89,547	\$30,279
1999	\$394,988	\$269,620	\$37,103	\$57,126	\$31,553	\$104,684	\$29,758	\$18,997	\$90,517	\$34,003
2000	\$417,049	\$288,587	\$39,111	\$61,975	\$30,560	\$120,803	\$30,165	\$19,330	\$95,269	\$37,076
2001	\$451,440	\$313,143	\$42,809	\$67,523	\$32,244	\$138,559	\$30,306	\$19,637	\$101,526	\$41,884
2002	\$488,604	\$337,854	\$45,658	\$73,341	\$34,299	\$157,941	\$30,857	\$20,752	\$105,730	\$46,337

Source: Department of Health and Human Services – Centers for Disease Control and Prevention.

As mentioned earlier, on the average, the reimbursement for health care services is continuing to decrease. The total health care expenses are on the rise, but the cost per service is constantly being lowered. How does this work? Even though Medicare only insures a portion of the nation's citizens, it is the single fee schedule that most everyone follows. Most all insurance companies base their reimbursement rates (fee schedule) on the Medicare fee schedule. As Medicare decreases its fee schedule, Blue Cross Blue Shield will decrease its fee schedule. This, of course, is always outlined in a contract and is legal, but Medicare sets the precedent in which insurance companies make decisions. Like insurance companies, Medicaid is always right behind Medicare in its particular reimbursement fee schedule. To demonstrate this, I have randomly selected 5 CPT codes and listed the Medicare allowable for years 2001 through 2006 as Table 3.6. CPT code 29860 is a hip arthroscopy with or without synovial biopsy; 29861 is a hip arthroscopy with removal of loose or foreign body; 29862 is a hip arthroscopy with shaving of articular cartilage, abrasion arthroplasty, and/or resection of the labrum; 29863 is a hip arthroscopy with synovectomy; and 29870 is a knee arthroscopy with or without synovial biopsy.

Table 3.6

Medicare allowables for 5 random CPT codes from 2001 – 2006

Year	29860	29861	29862	29863	29870
2001	\$571.47	\$687.10	\$733.05	\$737.03	\$392.20
2002	\$571.82	\$635.93	\$698.15	\$716.08	\$396.53
2003	\$549.40	\$606.86	\$672.02	\$670.72	\$362.31
2004	\$535.77	\$592.25	\$659.00	\$657.56	\$352.49
2005	\$569.16	\$629.22	\$699.03	\$691.99	\$688.76
2006	\$566.92	\$627.67	\$696.06	\$688.76	\$373.09

Source: Center for Medicare and Medicaid Services.

US Health Care versus 23 Other Countries

As discussed earlier, Schoen, et. al., (2006) compared the health care system in the US with 23 other industrialized countries. The comparison was based upon such factors as long, healthy, and productive lives; quality of care; access and affordability; efficiency; and equity. The US spends 16% of its gross domestic product (GDP) on health care, which is double the median amount of the 23 countries used in the comparison (Schoen, et. al, 2006, p. 457). NOTE: some of the countries did not have adequate information in a few of the categories.

The US ranked 15 out of 19 countries for mortality from conditions amendable to health care (preventable or modifiable) in deaths before the age of 75 (Schoen, et. al,

2006, p. 460). In fact, the US was last in infant mortality rates out of the 23 countries (Schoen, et. al, 2006, p. 460). When looking at various states within the US, they found that the national average for vaccines and preventive medicine is well below the benchmark for the top 10 states (Schoen, et. al, 2006, p. 460). Quality health care means that all patients have a primary care physician (i.e. general practitioner or pediatrician) to coordinate the care of patients between specialists. However, one-third of adults and one-half of children do not have a consistent primary care physician to coordinate such efforts (Schoen, et. al, 2006, p. 461).

Summary

Foucault provides his readers with in-depth discussions of cultural studies, change theory, and philosophies of human behavior. He acknowledges that we must observe the behavior that we want to change and affect. We must find a model of behavior that is easily looked upon for normalizing judgement. Physicians, hospitals, insurance companies, and patients need to work together more effectively to make better medical decisions within the framework of our system.

The collected data show that our expenditure history is leading us into a health care system bankruptcy. Patients, employers, and the government cannot continue to pay 10% more every year for health care. While the percentage of uninsured patients remains steady, the percentage of *underinsured* patients continues to rise as insurance plans are altered every year to remain affordable. Chapter 4 will provide a critical analysis of the collected data and problems of health care using a combination of Foucault's lens and applicable processes in order to deconstruct the health care problems we face now and in the future.

CHAPTER 4

CRITICAL ANALYSIS

The purpose of this study was to debate and sort out the various ideological and political aspects of health care reform in the US, i.e., to critically analyze the underlying ideologies, values, and purpose of the health care system in a changing democratic society. The research was inspired by the cultural studies theoretical framework of Michel Foucault in which relationships between the health care crisis and the government's social responsibility to prevent the imminent bankruptcy of its health care system was examined.

Like others areas of life in the US, our health care system is defined by our culture and political history. As noted in the review of literature, the structure of our health care system has evolved over the years based upon the political and cultural climate of the time. In the early twentieth century, medicine was fairly simple, sophisticated technology was missing, and the need for expensive health care was not prevalent. The evolution of our nation's health insurance program was started as a way of luring employees from other businesses or industries, to take advantage of large pools of people, and to promote healthier, more productive employees. Employers in the first part of the twentieth century realized that healthy employees were productive employees.

Hospitals, many of which were started and owned by physicians, were largely responsible for the creation of health insurance. The hospitals realized that if they were going to keep their doors open, they needed a funding source. Prior to health insurance, patients would pay for services and the expenses were manageable. With the evolution and expansion of medical schools and residency programs, the need for funds was further

expanded. Hospitals found an incentive to host residents at their facilities because they were cheap medical labor, and they received government funding.

The creation and implementation of Medicare and Medicaid was a tremendous advancement in the political and cultural makeup of our country. The citizens of the US and, in turn, the government, realized that the elderly, disabled, and poor citizens of our country needed access to health care. By the mid-1960s, health care was still considered an affordable trade, and policy-makers unfortunately did not foresee the great increase in life expectancy and costs of health care over the next 40 years.

While the rest of the world was implementing socialized medicine, our politicians thought they were implementing a quasi-socialist program with the creation of Medicare and Medicaid. It was the standard in the employment world to receive employer-paid health insurance, the elderly would receive Medicare, and the poor and disabled would receive Medicaid. With the cost and utilization of health care still at reasonable levels, this was supposed to be the solution that would work for everyone. Now that most everyone was covered under some type of health insurance program (i.e. health insurance, Medicare, or Medicaid), the hospital sector expanded and new technology was added (Richmond & Fein, 2005). The hospitals and physicians who were in control of utilization had incentive to increase utilization of health care services. Patients, on the other hand, had very little out-of-pocket expenses for health care and were demanding better health care and more of it (Richmond & Fein, 2005). Even though there were a few prepaid group practices (PGPs) in which physicians practiced under a predetermined budget constraint, the concept did not catch on in the 1970s because they were difficult to

explain to employees and patients were afraid of the consequences (Richmond & Fein, 2005).

US Health Care through the Lens of Michel Foucault

Michel Foucault's cultural studies framework for this theoretical inquiry lends insight into some of the complexities of our health care system as he elaborated in *Discipline & Punish: The Birth of the Prison* (1975) and *The Birth of the Clinic* (1973). But what would his solution be to the unorganized, misaligned health care system we experience today? Both physicians and patients are ultimately in control of the utilization of health care services. Dramatic change is needed in order to reform a system that has developed. Foucault believed that it was necessary to reform the way we teach physicians:

Yet, in a very short time, this reform of the teaching system was to assume a much wider significance; it was recognized that it could reorganize the whole of medical knowledge and establish, in the knowledge of disease itself, unknown or forgotten, but more fundamental, more decisive forms of experience...a way of teaching and saying became a way of learning and seeing. (Foucault, 1973, p. 64)

Physicians have the ultimate power over utilization of health care, and if we are going to make positive change, we must teach these providers in training about the problems of health care and what they can do to help alleviate the problem.

In medical school and residencies we are teaching our future physicians the science behind why they treat patients like they do. While good medical practice is important, it is only a piece of the solution for the future of our health care system.

Foucault believed that pupils of medicine should, “read little, see much, and do much” (Foucault, 1973, p. 70). It is the experience and correct training of the medical students and residents that will change the way we view medicine.

Foucault believed discipline was essential for conducting appropriate medical care and that an effective observatory was needed in order to observe and correct behavior for proper training. “The perfect disciplinary apparatus would make it possible for a single gaze to see everything constantly” (Foucault, 1975, p. 173). We have to develop a better system (i.e. information technology) in which all of the components (patients, physicians, and hospitals) are better organized and integrated. “By means of surveillance, disciplinary power became an integrated system, linked from the inside to the economy and to the aims of the mechanism in which it was practiced” (Foucault, 1975, p. 176).

Foucault recognized the effects of “normalizing judgement” in which there was a model to go by and a right way of doing something. In *Discipline and Punish: The Birth of the Prison*, he wrote, “The perpetual penalty that traverses all points and supervises every instant in the disciplinary institutions compares, differentiates, hierarchizes, homogenizes, excludes...in short, it normalizes” (Foucault, 1975, p. 183). Someone in our health care system (perhaps the government) has to take the lead to find the right way to align all of the incentives of the patients, physicians, and hospitals.

The examination, as Foucault puts it, “combines the techniques of observing hierarchy and those of a normalizing judgement...it establishes over individuals a visibility through which one differentiates them and judges them” (Foucault, 1975, p. 184). Physicians, patients, and hospitals have to be more accountable and have to be

more coordinated in their efforts. Profits, fees, and utilization reports need to be made public and any outliers should be explained. The norms of society should be adhered to, and those that do not conform should be punished.

Foucault states that, “All those who had taken up medicine during the previous five years were therefore subjected to examination by juries trained in the old school; doctors would once again be able to control their own recruitment; they would be reconstituted as a body capable of defining their own criteria of competence” (Foucault, 1973, pp. 76-77). Foucault would possibly propose more structure in the health profession if he was alive today. In the context of examining a medical provider he writes, “...physicians, surgeons, and pharmacists must be subject to stringent examination as to their knowledge, their abilities, and their moral habits...this does not mean that industry will be impeded or the liberty of the individual infringed” (Foucault, 1973, pp. 79-80). Foucault would likely be in favor of a national information technology system in which patients were easily streamlined and information was accessible to all relevant medical providers and facilities. This national system would be useful upon examination of the patient and to ensure that duplication of services was not permitted.

Data Analyses

As noted within the content of this research study, the US is on the verge of health care bankruptcy. When looking at relevant data, I felt that it was important to look at trends and historical data on the uninsured population, health care expenditures, and the funding source for the increased expenditures. The uninsured numbers in the US often look different depending on the source they come from. Some sources will count someone as uninsured if they did not have health insurance at any point during the year.

Other sources will only count the uninsured based upon the lack of insurance for the entire year. Data indicated that the percentage of citizens without health insurance has remained fairly stable – which is to say that it is stably treacherous.

Table 3.1 shows the percentage of uninsured citizens in the US wavered in between 12 and 14 percent of the total population. This indicates that far too many of our US citizens live without health insurance. However, many people do not see the real impact of the uninsured population.

The myth about the uninsured population is that they do not receive health care services because they do not have health insurance, and they cannot afford to pay for services. However, most local, non-profit hospitals have emergency rooms that are filled with uninsured patients that use these physicians and facilities as their primary care physicians. These facilities cannot turn patients away and, in turn, are partially subsidized by the federal and state government for their charity care and indigent write-offs. Therefore, everyone pays the price for the uninsured population – not just the uninsured themselves. Remember that close to half of the uninsured population is considered middle and upper class. Our health care system is set up for *payment after services* and we live in a culture that expects free or subsidized health care, so everyone is receiving health care at some level – even illegal immigrants.

The truth is that everyone has access to primary health care (emergency rooms physicians, internists, obstetricians/gynecologists, and general practitioners), but the main difference between an uninsured and insured patient is access to specialty care (i.e. orthopedics, gastrointestinal physicians, surgeons) and testing. These physicians and

services are often considered elective and are not always obligated to participate in free health care unless they have a special obligation at a local hospital.

Table 3.2 tells us who is paying for health care in the US. Again, over a 10 year period from 1993 to 2002, this table shows us that the public sector is paying between 35 and 38% of the health care bills while the private sector is responsible for 62 to 65%. Simply put, the public sector is government funding and the private sector is everyone else including employers, employees, self-pay patients, workers compensation companies, and health insurance companies.

While there is not a significant trend one way or another in this table, it is significant because one source (the government) pays over one-third of the medical bills in this country. The government has historically grouped these large numbers of patients to bring down the reimbursement it paid to hospitals and physicians. However, the government has done very little in terms of using data of this large mass to better our health care industry. Our country is far behind in information technology when compared to other nations (Schoen, Davis, How, & Schoenbaum, 2006). As mentioned earlier, all patients should be put on a standardized computer system in which their electronic chart goes with them wherever they go. This would do two things: 1) it would eliminate duplication of services and 2) it would provide better care with an integrated system of better communication.

Table 3.3 lists the total health care expenditures in the US from 1993 to 2002. During this 10 year period the total expenditures rose from \$773,646,000,000 to \$1,341,372,000,000 representing a 75% increase. This is an astronomical increase when you consider that statistically the number was already very high in 1993. In 2002,

hospital care and physician services accounted for 62% of the total expenditures with hospital care comprising over 36% itself. Most notably, while the total expenditures increased about 75% during the 10 year period, prescription drug expenditures increased over 300%. This statistics is very indicative of our curative culture in which we rely on a pill to cure most of our diseases instead of focusing on a wellness model to prevent disease. US culture does not want to pay a highly educated physician \$50 for 30 minutes of his time, but will pay enormous amounts for prescription drugs.

With the emergence of managed health care, the reimbursement (fees) per service of physicians and hospitals has decreased over the last 10 years along with Medicare and Medicaid fees. To be specific, the amount of money that Medicare and Medicaid pay per service has decreased (which does not necessarily mean that the total money has decreased). It is puzzling that the amount of money physicians and hospitals receive per service is consistently decreasing (on average) from year to year, but national expenditures for health care continue to increase. To demonstrate the decreased reimbursement, Table 3.6 shows a random selection of 5 surgeries and the Medicare reimbursement for each from 2001 to 2006.

On average, the Medicare reimbursement of the 5 random surgeries dropped 5% from year 1 to year 6. Yet, the expenses of a medical practice increase 6 to 9% every year in efforts to keep up with technological advances (i.e. sophisticated diagnostic equipment and practice management software) and soaring malpractice insurance premiums. That aside, the table shows that reimbursement is declining and expenditures are inclining as utilization of health care services is dramatically increasing.

Summary

Foucault offers inspiring theories for better preparing practitioners during training and alleviating troublesome hospitals by creating a better culture within which to work. He shows how increased communication and better information technology would greatly reduce the cost associated with duplicating and unnecessary services. It is easy to see that we are heading for disaster in the administration of our health care delivery system. While we are spending well over a trillion dollars a year in health care and 16% of our gross domestic product, we are continuing to squeeze both physicians and hospitals in decreased reimbursement for services. We have to continue to motivate and provide incentive for cutting-edge medicine and the investment in new technology, but this is very difficult for facilities that receive cuts every year while major expenses continue to escalate.

Chapter 5 will bring the research study to a conclusion and will lend suggestions for similar and needed research in the future. We no doubt have a tremendous uphill battle to fight, but we can make some meaningful changes that will work for everyone. In order to do this, we have to change our culture and put our political views aside. There is a better way to provide health care to the citizens of the US. And in the near future, we will have no choice but to make those changes.

CHAPTER 5

SUMMATION, IMPLICATIONS, AND SUGGESTIONS

In this final chapter, I will summarize the findings that emerged from my critical analysis of contemporary US health care. In addition, I will discuss the implications of the study for educational, medical, and democratic reform of the US healthcare system, including specific suggestions for further research. Importantly, discovered within the US health care system are implications for solutions that can bring order to the chaos of crisis and provide adequate health care for US citizens.

Findings of this study indicate that the initial founders of the US health care system in the 1960s did not foresee the human needs nor the economic costs and/or medical crisis that we face today. Although the writers of the Medicare Bill of 1965 thought they were passing a bill that would insure everyone with health insurance and creating legislation that would ultimately provide a universal health care system, forty-two years later, millions of US citizens still have no health insurance, and sadly, millions of US citizens continue to suffer with inadequate health care.

Interestingly, every modern country in the world has faced a crossroads in history when the country was forced to decide whether or not to implement universal health care coverage. The US is presently at such a turning point. Utilization and costs of health care services is at an all-time high, health insurance coverage is at an all-time low, and health care consumers are being forced to assume greater responsibility for health and payment for services.

Implications of Study

Michel Foucault's theoretical frame assisted the analysis and discovery of the important systemic components, i.e., the *agents* and *clients*, which comprise and drive the US health care system. Discovered components include three major players in the US health care system—patients, physicians, and hospital administrators. Fortunately, all three players have potential for making positive changes in US society through the *education* of patients (and physicians), the regulation of *medical praxis*, and active participation in *democracy* in the ever evolving nature of democratic US society.

Findings of the study indicate that the health care system in the US is on the brink of bankruptcy, forcing major reforms in all areas. Clearly, key health care system players are being forced to do a better job of observing (Foucault's *hierarchical observation*) and predicting patient behavior, of demonstrating acceptable behavior (Foucault's *normalizing judgement*), and of examining (Foucault's *examination*) curriculum, culture, and competency of US medical praxis, as well as the effects of improper agent and client behavior within the health care community.

As is the case with most ailing social institutions, economic constraints, i.e., the lack of adequate funding, underlie the key problems. Demand for medical services is high; the willingness (or ability) to pay for services is low; and costs at all levels are up. Some believe health care is an individual's *right*; *others* believe health care is an individual's *privilege*; and social services institutions (physicians and/or hospitals) are caught in the middle between trying to do what is right for the client and trying to do what is necessary to stay in business. Staying in business is in the best interest of patients, but solutions to the dilemmas above could ultimately lead to very different

outcomes. Solutions to the above health care system dilemmas are elusive; however, findings of this critical analysis of the US health care system imply solutions through comprehensive democratic reforms in areas of education and medical praxis.

Education

Education through curriculum reform can change the perspectives of all US health care system players, i.e., all agents and clients who are stakeholders in the effectiveness and efficiency of the US health care system. Thus, education and curriculum reforms can provide solutions to the health care crisis in the following ways:

(1) All players must be educated to *the individual's responsibility* for personal health and welfare in general.

(2) All players must shift their views about health and health care from the *cure of illness* to the *prevention of illness*, i.e., to *the wellness of health*. All stakeholders, i.e., all health care system players, need to be educated to view health and health care in terms of *wellness rather than illness*. The health insurance industry has done a poor job at properly motivating their covered members through the years. The structure of insurance policies has not given patients the motivation to seek wellness and/or alternative means to expensive treatment. Likewise, the medical schools in the US have done a poor job of educating physicians in the business and management side of medicine. Medicare's historical *un-managed* approach to medicine and unshared financial arrangement with its members has given patients no incentive to alter their behavior.

Patients (Foucault's *clients*), physicians and hospital administrators (Foucault's *agents*) are accustomed to a curative model of medicine - one in which surgery and prescription drugs will solve all health care problems. Education can change this

perspective to thinking in terms of *wellness*, instead of *illness* for better use and discretion when adhering to the advice of physicians and administrators.

(3) Physicians and hospital administrators must become more *knowledgeable concerning patient needs*, and patients must become *more savvy and knowledgeable about personal health and health insurance plans*.

(4) All players must develop *cautious and conservative perspectives* toward the utilization of medical services.

(5) All players must become aware that *cost-sharing* is a necessary part of the solution to the US health care crisis. Patients do not always need an MRI, a CT scan, and an ultrasound to diagnose shoulder soreness. Cost-sharing methods can be implemented in which patients carry more of the burden and risk of health care. This is not a popular notion, but patients must be educated to understand that cost-sharing is vital to the future of the US health care system. Patients are far more likely to access appropriate levels of health care when they are paying for part of it.

(6) All players must be educated to *understand the need for health insurance*. Individuals must carry health insurance policies to insure themselves and their families against catastrophic medical expenses. Catastrophic health insurance may provide a solution for covering those individuals who contend that they cannot afford health insurance. Most Americans are used to health insurance in which they pay little when seeing a physician or going to a hospital. This type of insurance is very expensive and is not really insurance as we typically think of it when describing other types of insurances.

Car, house, and life insurance are considered catastrophic insurance plans in which the policy holder receives large amounts of money in case of a catastrophe. These

policies usually have sizeable deductibles and most policy holders do not even file small claims in order to keep the cost of the insurance down. Many US citizens can receive catastrophic insurance for less than \$100 a month. This type of insurance usually carries a \$2,500 deductible or higher and will not be utilized until the policy holder has paid \$2,500 out of pocket. However, it is very handy insurance in catastrophic circumstances such as heart conditions, cancer, and/or other costly diseases and calamities. Many more of these types of policies are becoming popular. These types of health insurance policies are cost-effective and very useful.

(7) The federal government must extend the *tax-deductible status for health insurance premiums to private individuals*. Another economic solution for the lack of health insurance for US citizens is hidden in the benefits package that employers often offer employees—in the tax deductible, employer and employee jointly-paid health insurance premium. Tax-deductible health insurance premiums provide relief to employers and employees, alike. However, individually-paid premiums (by individuals not associated with an employer) are not tax deductible. The government should allow these premiums to be tax deductible as an incentive for individuals to buy more health insurance. This, by itself, would alleviate some of the problems of the uninsured. Unfortunately, although the government requires car drivers to have car insurance, citizens are not required to have health insurance.

(8) Employers must provide medical savings accounts for employees. A new tax-deductible solution for employer-paid health insurance is medical savings accounts (MSAs). Employees are able to defer a pre-set, tax deductible amount of money every month into an escrow account to pay for health-related costs. This provides pre-taxed

health benefits for these individuals and can save a family considerable dollars. The tax-deductible money rolls over from year to year and the employees can take the money with them if they switch jobs. There is no risk involved in setting these funds aside. However, like the tax-deductions for health insurance premiums, these benefits are only offered to those who receive health insurance from an employer. The government should extend this offer to those who buy health insurance on an individual basis outside of an *employer-employee* context.

(9) The federal government should subsidize health care for the poor. Another possible solution to the need for universal health care is evident through the federal government's assistance to the poor—and working poor. Individuals who do not qualify for Medicaid should be allowed to buy into the Medicaid network. In the State of Georgia (US), the State Medicaid program is outsourced to commercial insurance companies. The State of Georgia pays insurance companies approximately \$120/month per member, per month, to provide health insurance to those who qualify for Medicaid. The benefits are good, and the physician and hospital networks are efficient. This helps provide health benefits to those who could not otherwise afford health insurance.

Many states have trouble funding their child health insurance programs designed especially for those children without health insurance and who are from low-income families who do not qualify for traditional Medicaid because their income exceeds the Medicaid limits. Federal funding can assist in overcoming these shortfalls.

Medical Praxis

Discovered implications for reform of US medical praxis appear in areas of patient observation (Foucault's hierarchial observation) in the following ways:

(1) A more efficient health care system can be fostered through the implementation of a more efficient medical record system. The federal government could require that physicians and hospitals utilize a standardized *electronic medical record system for all patients*. Every patient can have an electronic chart that is transportable and easy to understand. This would eliminate duplication of services and doctor-shopping, the phrase commonly referred to when patients see different physicians for the same problem.

(2) A more efficient health care system can be fostered through *standardized billing* for patient services. The federal government could make policies that standardize billing; thereby lowering the expenses of a physician's practice and/or hospital administrative operations. There are too many different sets of rules that physicians and hospitals have to conform to. This is very costly and the patients end up getting caught in the middle of a game of tug-of-war. There are many costly and unwarranted gray areas in the field of medical billing, such as unbundling, denying not-medically-necessary services, and non-covered denials. If every insurance company, including government-run programs, played by the same set of rules, the expense of running a physician practice or hospital would dramatically decrease.

(3) A more efficient health care system can be fostered through tort reform. As Michel Foucault aptly pointed out, the medical field has many unexplained events, and it is sometimes more like an art and less like a science. Artful trial lawyers, specializing in

medical malpractice suits, are very well coordinated in their lobbying efforts and very well funded. Trial lawyers have done a tremendous job in marketing their services to those who are looking for a quick buck. For example, in efforts to sue for malpractice, patients have been observed making efforts to deceive their physicians into operating on opposite limbs (for shoulder replacement), spouses have been known to interfere in patient care (resulting in infectious death), and/or some patients have even sued for blisters. Most lawmakers are lawyers who have a connection to other lawyers; thus, legal policies are made that promote special interest groups.

Physicians and hospitals (who have traditionally under-funded their efforts in combating the malpractice problem) are now forced to carry expensive malpractice insurance. As a result, many states have passed tort reform (which limits punitive damages). Tort reform has been a tremendous help in freezing malpractice premiums in the short term. But the problem is that they are frozen at a rate this is still unaffordable for many physicians. As a deleterious consequence of malpractice lawsuits, the cost of malpractice insurance is driving some physicians to early retirement and creating doctor shortages in some areas.

Malpractice is a controversial and troubling topic because there ARE physicians who should not be practicing medicine and hospitals that should be closed down. But the abuse of the US legal system with malpractice suits has greatly escalated the US healthcare crisis, increasing medical costs that are passed on to consumers.

(4) A more efficient health care system can be fostered through extensive reform within the context of medical praxis involving pharmaceutical pricing regulations. The relationships are complex among and between the pharmaceutical industry, hospitals,

physicians, and patients. As reported earlier, the amount of money spent in the US on prescription drugs is outrageously high. Although the research and development of new drugs does cost, the amount of money in producing pills is nominal. Yet citizens will pay exorbitant prices for prescription drugs.

The government has used its power in numbers to lower the cost of health care through low, negotiated rates with physicians and hospitals but has done very little when it comes to lowering the prices on prescription drugs. One solution might be that the federal government establishes a network of pharmaceutical companies in which it negotiates the costs of medications, i.e., prescription rates, for anyone who wants to subscribe to the *pharmaceutical network*. The penalty for pharmaceutical companies would be that if they do not want to sign up for the reduced rates, they will lose the patronage of millions of covered prescription-cost-regulated policyholders. NOTE: Selling prescription drugs on the street (through the black market) is also a big business; thus, lowering the costs of prescription drugs would help reduce the drug-dealing problem.

(5) A more efficient health care system can be fostered through cultural and curriculum reforms. There is additional strong evidence that the medical training curriculum that is widely utilized in the training of physicians - in medical school and residency training - must undergo significant reform. Since novice physicians have been taught only to cure patients by means of diagnosing, treating, running tests, and fixing problems, they lack the preparation and competence to assist patients to prevent illnesses and disabilities. Consequently, their training curriculum needs to be reformed to shift their medical perspectives from *cure* to *prevention*. Yet US medical culture resists such a

paradigm shift of perspective. There are no classes or programs for physicians to change the culture in which they practice. This dilemma is worsened by increasing expenses involved in practicing medicine and decreasing reimbursement from funding sources; thus, physicians are compelled to see more patients, do more surgeries, and run more tests. Medical school curriculum teaches that the only way to make up for the relatively uncontrollable costs of running the business of health care is to increase the utilization of patient services. Patients, however, typically have very little decision-making control over their utilization of health care services.

Democracy

Discovered in the present critical analysis of the US health care system was the sad fact that many US citizens are left without health insurance, causing these poorest among us to look to the US government to provide and administer universal health care. Although the reforms described above are grounded in democratic governance and principles of equity and justice, one specific democratic solution to the US health care crisis might be for the US government to assist those who cannot truly afford medical insurance. In a socioeconomic democracy such as the US, where taxes are utilized to distribute wealth in efforts to aid the weakest and neediest among us, governmental subsidies might be implemented through a quasi-socialistic system to provide care for all citizens. In such a system, Medicare and Medicaid would continue to cover the elderly, disabled, and those who truly cannot afford insurance, while state and federal governments would implement separate systems and assist those who don't qualify for these programs. Through a quasi-socialistic health care model, the US health care system

could be controlled by the government through its numbers of insured constituents and enforced through state and federal law.

Michel Foucault's Tools for Critical Analysis

To view US health care problems through the lens of Michel Foucault's historical perspectives is to discover the need for reforming the health care system from its foundation, i.e., to feel the need to reform US health care from its underlying cultural curriculum upward and outward to the revitalizing effects of curriculum reforms on those who have the most impact on the system – the physicians. Clearly, to reform the way physicians are trained is to consider the comprehensive experiences of physicians with their patients, as well as their residency training. Foucault was aware of these critically important issues as he noted... "there is only one language: the hospital, in which the series of patients examined is itself a school." (Foucault, 1973, p. 68) Especially helpful in the critical analysis of the US health care system were the use of the following Foucault tools of analysis:

(1) *Discipline*. Foucault insisted that *discipline* is essential for conducting appropriate medical care, and that effective observatories are needed in order to observe and correct behavior for proper training, stating that, "The perfect disciplinary apparatus would make it possible for a single gaze to see everything constantly" (Foucault, 1975, p. 173). Applying Foucault's discipline can reform the health care system and develop a better system in which all of the system players (patients, physicians, and hospital administrators) are better organized and integrated. Physicians and administrators could use surveillance and disciplinary power within an integrated system, "linked from the

inside to the economy and to the aims of the mechanism in which it was practiced” (Foucault, 1975, p. 176).

(2) *Normalizing Judgement*. Foucault’s principle of normalizing judgement is also an applicable reform strategy. For exemplary models are needed to show the right ways of doing things. In *Discipline and Punish: The Birth of the Prison*, Foucault wrote, “The perpetual penalty that traverses all points and supervises every instant in the disciplinary institutions compares, differentiates, hierarchizes, homogenizes, excludes...in short, it normalizes” (Foucault, 1975, p. 183). It is important to align everyone’s incentives in health care. Physicians and hospitals need to model shorter hospital stays, less-invasive surgeries, and better disease management that will ultimately result in health care savings; and health insurance companies need to normalize lower insurance rates for lower utilization of services.

(3) *Examination*. Foucault’s examination, as he states it, “combines the techniques of *observing* hierarchy and those of a normalizing judgement...it establishes over individuals a visibility through which one differentiates them and judges them” (Foucault, 1975, p. 184). Examination implies accountability. Physicians, patients, and hospitals must become more accountable and more coordinated in their efforts. Profits, fees, and utilization reports need to be made public and any outliers should be explained. The norms of society should be adhered to, and those that do not conform should be punished. As Foucault recommended, there should be regular juried examinations for physicians administered by its own governing body that defines its own *criteria of competence* (Foucault, 1973). The medical profession should become its own policing board with stringent examinations for physicians, surgeons, and pharmacists to examine

their knowledge, their abilities, and their moral habits (without impeding the liberty of the institution or infringing on individual rights (Foucault, 1973). In addition, the national information technology system mentioned earlier in which patients are easily streamlined and information is accessible to all relevant medical providers and facilities would be useful upon examination of the patient and ensure that duplication of services is not permitted.

In summary, health care, or a lack thereof, dramatically impacts a nation and its citizens throughout its history, contemporary, and future existence. The problem is two-fold: 1) some people do not have appropriate access to health care services and truly cannot afford it; and 2) many people who can currently afford health care will soon be unable to afford it. The amount of money citizens are paying every year on health care is rising twice as fast as their wages. If something does not change, bankruptcy will ensue.

As previously discussed, there are three predominate players in the US health care industry – patients, physicians, and hospital administrators. All three players can make positive change in our society through the education of individuals, the regulation of medical praxis, and participation in the ever-evolving nature of democratic society.

For those who are employed in health care, it is a rapidly changing industry in which employees are increasingly required to be more sophisticated and educated.

Receptionists are no longer greeters who check-in patients and smile; they are now sophisticated individuals who must be knowledgeable about the changing governmental and managed care insurance plans. Radiological technologists now must be technology experts in order to keep up with the digital imaging world that continually recreates medical culture. And physicians as practitioners are continually challenged by the

changing rules that govern billing/coding and reimbursement in addition to the information technology that is changing at every hospital and physician office. Physician billing is complex and changing rapidly, and administrators are forced to provide free health care to those who do not want to pay while a billing collector has the job of collecting unpaid debts.

Data analysis of economic trends indicates that the US spends a tremendous amount of money on health care – 16% of its gross domestic product. Nevertheless, as Jonathan Cohn (2006) pointed out, this may not be a bad thing. Noticing those who are left out of health care and those who should be *contributing* to the cost of health care are more important statistics than GNP percentages. Economic priorities are important, and countries usually spend money on what is important to them.

Clearly, the present research, a critical analysis of the US health care system, and the data reports included within indicate a health care system spiraling out of control. Fortunately, such research can assist the discovery, reform, and efficient utilization of the US health care system. Michel Foucault's cultural tools of analysis, i.e., hierarchial observation, normalizing judgements, and examination can be utilized to re-create a more democratic implementation and utilization of the structure and processes of the US healthcare system. As Foucault argued for cultural and curriculum changes, so reform of the US health care system should begin at the beginning of life (for learning health and wellness) and at the beginning of a physician's education (for learning health and prevention). The US is dominated by a culture of entitlements and handouts. Yet dramatic changes are taking place in health insurance and patient utilization of services. Unless we make a dramatic change in the way we view our health care in the US, the

problems of financing and access will worsen. As the health care delivery system in the US evolves, all system players must contribute to making positive reforms. Finally, there is hope for reform. The US health care system can survive and will prosper if all system players will heed the calls for reform discussed herein.

Suggestions for Further Research

In this critical analysis of the US healthcare system, I sought to identify the problems of the contemporary US health care system, to analyze contributing, underlying causes of its spiraling demise, and to seek possible solutions to circumvent the collapse of the system. Further research on state Medicaid programs is needed. The founders of Medicaid intended for these state-run programs to provide health insurance for all those who could not afford to buy it on their own. As it has evolved, however, more and more citizens are being left out, and relevant research is needed to find out who specifically is falling between the health care cracks of US society. Moreover, there is a need for further research to compare hospital data. Hospital expense is the largest segment of the health care dollar. Some hospitals make millions of dollars every year while others struggle to keep their doors open. Further research could lead to many opportunities for savings through more efficient use of health care facilities and services.

REFERENCES

- Alan F. Holmer on National Public Radio (2001), *Talk of the Nation*, hosted by Juan Williams
- Angell, M. (2004). *The truth about the drug companies*. New York: Random House.
- Becker, H. (1955). *Prepayment and the community*. New York: McGraw-Hill.
- Beidermann, R. E. (2002). *The health care cure* (2nd ed.). Tucson, AZ: Hats Off Books.
- Blumenthal, D., Schlesinger, M., & Drumheller, P. B. (1988). *Renewing the promise: Medicare and its reform*. New York: Oxford University Press.
- Centers for Medicare and Medicaid Services (2006, March). Retrieved March 22, 2006, from www.cms.hhs.gov.
- Cohen, W. (1985). Reflections on the enactment of Medicare and Medicaid. *Health Care Financing Review*, 3, 3-11.
- Cohn, J. (2006, September 29, 2006). Can we afford to spend so much on health care? *The New Republic Online*. Retrieved October 2, 2006, from www.tnr.com
- Colins, S. D., & Tibbets, C. (1972). *Research memorandum on social aspects of health in the depression*. New York: Social Science Research Council.
- Collins, H., & Kusch, M. (1998). *The shape of action: What humans and machines can do*. Cambridge, MA: MIT Press.
- Corning, P. A. (1969). The evolution of Medicare...from idea to law. *US Department of Health, Education and Welfare*. Retrieved October 2, 2006 from www.hhs.gov
- Davis, K., & Rowland, D. (1986). *Medicare policy: New directions for health and long term care*. Baltimore: Johns Hopkins University Press.

Department of Health and Human Services - Center for Disease Control (2006, March).

Retrieved March 23, 2006, from www.cdc.gov

Dwornik, I. A. (Spring 2003). *A comparison of educational theory: Alfred Adler and*

John Dewey. Retrieved October 14, 2005, from

<http://search.epnet.com/login.aspx?direct=true&db=aph&an=9975091>

Eve, S. B., Havens, B., & Ingman, S. R. (1995). *The Canadian health care system:*

Lessons for the United States. Lanham, Maryland: University Press of America.

Fein, R. (1967). *The doctor shortage: An economic diagnosis*. Washington, D.C.:

Brookings Institution.

Fishbein, M. (1932, December 3). The committee on the costs of medical care. *Journal of*

the American Medical Association, 99, 1950-52.

Flexner, A. (1910). *Medical education in the United States and Canada*. New York:

Carnegie Foundation for the Advancement of Teaching.

Foley, J. D. (1993). Uninsured in the United States: The nonelderly population without

health insurance. (Ed.), *Analysis of the March 1990 current population survey*

Washington, D.C.: Employee Benefit Research Institute.

Foucault, M. (1973). *The birth of the clinic*. New York: Vintage Books.

Foucault, M. (1975). *Discipline and punish: The birth of the prison*. New York:

Vintage Books.

Freire, P. (1970). *Pedagogy of the oppressed*. New York: Herder and Herder.

Freire, P. (1998). *Pedagogy of freedom: Ethics, democracy, and civic courage*. Lanham,

MD: Rowman & Littlefield Publishers.

- Gay, G. (2000). *Culturally responsive teaching: Theory, research, and practice*. Teachers College Press, New York.
- Gornick, M., Greenberg, J. N., & Eggers, P. W. (1985). Twenty years of Medicare and Medicaid: Covered populations, use of benefits, and program expenditures. *Health Care Financing Review, 4*, 13-59.
- Gratzer, D. (2002). *Better medicine: Reforming Canadian health care*. Toronto: ECW Press.
- Grossberg, L. Nelson, C. & Treichler, P. (Eds.). (1992). *Cultural Studies*. New York: Routledge.
- Hanft, R. (1967, February). National health expenditures, 1950-1965. *Social Security Bulletin 30, 3*, 30-31.
- Harris, R. (1969). *A sacred trust*. Baltimore: Penguin Books.
- Hester, M. D. (1998, July 1998). *The place of community in medical encounters*. Retrieved October 15, 2005, from <http://search.epnet.com/login.aspx?direct=true&db=aph&an=7513092>
- Higginson, L. A., Cairns, J. A., Keon, W. I., & Smith, E. R. (1992). Rates of cardiac catheterization, coronary angioplasty, and open-heart surgery in adults. *Canadian Medical Association Journal, 146*, 921-5.
- Lueck, S. (2003, July 10, 2003). Drug Prices Far Outpace Inflation. *Wall Street Journal*, (D2).
- McFarlane, L., & Prado, C. (2002). *The best-laid plans: Health care's problems and prospects*. Montreal: McGill-Queen's University Press.

- Miller, I. (1996). *American health care blues*. New Brunswick, NJ: Transaction Publishers.
- Needleman, J., Arnold, J., Sheila, J., & Lewin, L. S. (1990). *The health care financing system and the uninsured*. Washington, D.C.: Lewin.
- Richmond, J. B., & Fein, R. (2005). *The health care mess: How we got into it and what it will take to get out*. Cambridge, MA: Harvard University Press.
- Rx R & D myths: The case against the drug industry's R & D scare card*. (2001, July)
Retrieved July 2001, from www.citizen.org
- Scheiber, G. J. (1992). US health expenditure performance: An international comparison and data update. *Health Care Financing Review*, 13(4), 1-17.
- Schoen, C., Davis, K., How, S. K., & Schoenbaum, S. C. (2006). US Health System Performance: A National Scorecard. *Health Affairs*, 25, 457-475.
- Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.
- Styring, W., III, & Jonas, D. K. (1999). *Health care 2020: The coming collapse of employer-provided health care*. Indianapolis: Hudson Institute.
- United States Department of Health and Human Services - Agency for Healthcare Research and Quality - Medical Expenditure Panel Survey (March, 2006).
Retrieved March 26, 2006, from www.meps.ahrq.gov.
- Vogel, R. J. (1999). *Medicare: Issues in political economy*. Ann Arbor, MI: The University of Michigan Press.
- Weissman, J. S., & Epstein, A. M. (1994). *Falling through the safety net*. Washington, D.C.: Beard Books.

Widmaier, W. W. (Fall 2004). *Theory as a factor and the theorist as an actor: The*

"pragmatist constructivist" lessons of John Dewey and John Kenneth Galbraith.

Retrieved October 15, 2005, from

<http://search.epnet.com/login.aspx?direct=true&db=aph&an=15020957>

Wolkstein, I. (1970). Medicare 1971: Changing attitudes and changing legislation. *Law and Contemporary Problems*, 35, 697-715.