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America's heath care crisis

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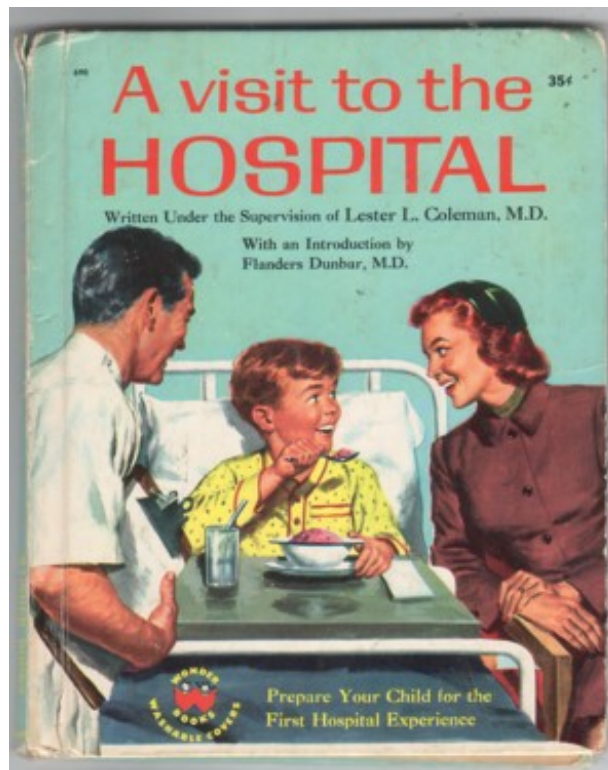
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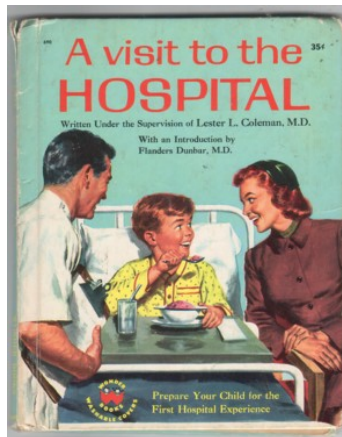
America's Health Care Crisis



Amy Krisch & Rachel Wall

Senior Capstone
Division of Humanities and Communication
Spring 2007

America's Health Care Crisis



Ken Rossi, "A Visit to the Hospital" New York: Wonder Books Inc., 1958.
<http://www.heritagebks.com/child/wb/c15623.htm>

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DEDICATIONS	4
ABSTRACT	5
INTRODUCTION	6
LITERATURE REVIEW	7
METHODOLOGY	11
<i>Introduction to Findings</i>	13
<i>The History of U.S. Health Care Systems</i>	13
<i>American’s “right” to Health Care</i>	17
<i>The Current Crisis</i>	18
<i>Understanding MCOs</i>	20
<i>Conclusion of U.S. Health Care</i>	21
<i>Examination of International Health Care Structures</i>	22
Argument to Critically Assess International Health Care.....	22
<i>Socialized Medical System: Germany</i>	22
<i>Canada’s Health Care System</i>	24
<i>Cuba’s Health Care System</i>	25
<i>Conclusion to the International systems</i>	26
<i>Suggested Models for the United States</i>	26
<i>Governor’s Mandate</i>	28
PREVENTION, HEALTH PROMOTION, WELLNESS	28
COVER ALL CALIFORNIANS	28
AFFORDABILITY AND COST CONTAINMENT	29
<i>Conclusion</i>	30
WORKS CITED	31
ENDNOTES	32
APPENDIX A: International Healthcare Comparison Chart	34
APPENDIX B: Lacking Health Coverage, Good Life Turns Fragile By Robert Pear, (5 March 2007) The New York Times, p. A1.	35
APPENDIX C: Putting The ‘We’ Back In Wellness By Joy Colangelo, (18 November 2006) The Monterey County Herald, p. F1.	36
APPENDIX D: Health Insurance Costs Outrun Wages Fourfold By Mark Schwanhausser (27 September2006) San Jose Mercury News, p. C1.	36
APPENDIX E: Interdisciplinary Reflection - Amy Krisch	37
APPENDIX F: Interdisciplinary Reflection - Rachel Wall	40
APPENDIX G: Annotated Bibliography	45
DIGITAL POSTER	49

Dedications

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Non scholae sed vitae discimus
"We learn not for school, but for life."

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Amy

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My parents and family, thank you for your love and support.

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Rachel

Abstract

Currently, in the United States health care is a matter of great moral, social and political significance. A rising number of uninsured and underinsured are excluded from medical services, charged more for medical services and die because they do not receive or cannot afford timely care. There is a growing movement to overturn the current health care system. Should every citizen have a right to health care? What type of health care system is best – single-payer, socialized or market-based? What type of health care system can we, as a country, afford? In this paper we analyzed the historical origins and influences, which led to the development of our current market-based system. Our paper also examines the way the current health care systems function and explores the systems of Germany, Canada and Cuba as a way of providing a basis for thinking about health care reform in the United States. We hope to provide our readers with information that informs their deliberations about health care.

Introduction

The purpose of this paper is to clarify the problems associated with the distribution of health care in the United States. For example, there are more than 46 million people without health care, costs for health services and goods continue to rise, the selling of sickness and managed care organizations that have become profit oriented.

In the United States there is an expressed right to universal health care, which is contradicted by the current system. The second half of this paper will look at health care from an international perspective; we will describe the health care systems of Germany, Canada and Cuba. We will analyze whether these countries might offer solutions to address the crisis in this country.

Health care availability and cost are growing concerns in this country and its constant appearance in newspaper headlines, cable news tickers and campaign speeches only reaffirm the fact that something must be done. There are 46.6 million people in the United States without basic health service. There are poor doctor patient ratios, the minimal funds spent on pre-natal and first five year care compared to the exorbitant amount spent on end-of-life care, the growing number of people declaring bankruptcy due to health related debt, etc.

This system is not working. So what options do we have and what system might address our current failures? We will offer a model, which addresses these problems.

Literature Review

In the 1920s health care was for the extraordinarily rich. In the 1950s much of the middle class began to enjoy the benefits of health insurance. In the 1980s health insurance was widely regarded as an automatic benefit for the employed public. In this day and age most of the working public has the minimum health insurance but cannot afford it. More and more of Americans are faced with the severe cost of health insurance for the individual buyer and the crippling cost of health insurance to businesses, which leaves them in an all too common bind.

Paul Starr, author of The Social Transformation of American Medicine, addresses the economic obstacles, emergence of different market types, the ecology of medical practices, the professional and market autonomy issues, and effectiveness of health care from the early 1800s till the mid 1990s. He addresses almost all issues related to the formation maintenance and practice of health care since the beginning of American history. From his piece several questions formulated: Is having sufficient health insurance worth half of your monthly income? Is going without coverage a risk you are willing to accept? Due to these questions being raised across the nation we have decided to critically examine the alternatives and arguments relative to our health care crisis. Lawrence Mitchell, the author of Stacked Deck: a Story of Selfishness in America, focuses on the question, how do we construct a society based on obligation that avoids domination? If health care is to be made a primary social good, what would you lose if you did not have healthcare? Where Mitchell feels vulnerability is what social complexity should be based on, John Rawls feels autonomy is the starting point. Rawls, author of A Theory of Justice, defines the structure and application of justice through maximized autonomy. He proclaims that laws and institutions of health care no matter how efficient and well arranged must be reformed or abolished if they are unjust.

In The Quest for Cosmic Justice, Thomas Sowell writes about the concepts and ideologies that have contributed to the idea of cosmic justice. Sowell asks these questions: What would a

just distribution of this scarce resource look like? What is our moral responsibility to do now? Sowell argues that Rawls and Mitchell will never be correct because healthcare should not be a primary social good but the means of attaining care should be fairer.

In recent years, and especially the last six months, health care has become a political and media focal point for many reasons. The financial impact that health care has on the average American individual has made the issue poignant. The text, Critical Condition: How Health Care in America Became Big Business and Bad Medicine, written by Donald Barlett and James Steele, discusses the amount in which the United States spends in health care. They argue that America's health care crisis can be cured without spending more money by redirecting resources and taking in to account the health needs of every American. It is widely accepted knowledge that: the cost of technology and medication has sky rocketed (leading to higher cost for services); the public has adopted a mindset of consumer mentality, the current system is not sustainable for the economy, business or the individual; most attempts to reform the system, state and federal level, have not addressed the contributing ideologies which shaped the system.

According to David Buchanan, the "ideology of the market based system is the primary contributing cause" of dysfunction in our current system. In his article, *An Ethic for Health Promotion: Rethinking the Sources of Human Well-being*, Buchanan points out the reasons why a market based approach works for almost every industry except health care. He offers points for the alternative approaches and their respective reform policies.

From our research, we have concluded only one consensus: the current system is not sustainable and must be reformed. In Tim Harford's The Undercover Economist, he asks, "If the health insurance market doesn't work well, the results will be excessively high premiums and a large number of uninsured people". Harford concludes that this is the exact situation in the United States where markets do not do a good job of providing medical insurance to the citizens.

Aside from that there are significant differences of opinion on issues such as: role of government, role of the individual, the role of insurance companies and government subsidized programs.

Kate Christensen focuses on defining multiple forms of managed care in her article *Ethically Important Distinctions among Managed Care Organizations*. She specifies the differences in financing, physician involvement and philosophy. In particular she discusses the difference between for-profit and nonprofit insurance organizations. She concludes that nonprofits currently work best to prevent under-treatment. There are various opinions as to the source of the dramatically increased cost of health care in recent years. Some sources identify insurance companies which are for-profit as the cause and other sources blame funding and demand for technological advancements. The 'selling of sickness' has also been pin pointed as a contributing factor to the cost.

Daniel Callahan, author of "The WHO Definition of Health", discusses how the WHO definition of health has affected the international community. He claims that the problem with the definition is the implication of various uses the concept of "health" can be put. He concludes that too much power and authority have been placed in the hands of medical professionals based in the WHO definition.

Yet another source of disagreement among scholars has been the comparison of the United States system to International health care systems. We called upon quite a few sources, which critically examined systems in Germany, Canada and Cuba. Biomedical Ethics provides a break down of each of these international systems beginning with a piece written by Pat Armstrong entitled, *Managing Care the Canadian Way*. In it he explains the focus on the Canadian single-payer health care plan currently utilized. The article clearly defines public

administration, nonprofit finances, cost evaluation, appeal verses U.S. models, and managed care practices.

Gerd Richter wrote a piece on the German system, *The German Health Care System*, in which he addresses the distinct system feature, “sickness funds.” These sources were quick to point out the differences between American health care and their particular systems. Nicholas Mays and Justin Keen focus on the overview of the British health care system in their article, *Will the Fudge on Equity Sustain the NHS into the Next Millennium?* They explain the NHS and the basis of its founding in 1946. They provide a timeline since the late 60s for issues such as spending, demand, drug and treatment costs, and other financially threatening scenarios.

Thus far, the most fruitful direction as a result of our research has been the international comparisons and the direction they provide. We have found that the critiques of the United States system offer alternatives for particular problems rather than an alternative ideology. The international systems are based on and adapted to other ways of seeing health care and the public. The international systems in question provide solutions for the current system and offer suggestions for sustainability, which can be utilized in the United States.

Methodology

The purpose of our paper is to identify the disparities in the United States health care system and address what can be done to ethically redistribute resources. Health care has become a top industry in this country despite ever increasing number of Americans without basic care. We have gathered our information from various media and we rely heavily on the research of scholars and professionals in multiple fields to discern the underlying causes.

Newspaper articles were chosen because of their concise definitions of health care legislation, explanation of social impact of the health care system and direction for sources. We have used both print and online newspaper articles, all of which are retained in our source library.

Our collection of books stem mostly from our research of the American medical system. We have four main texts: Critical Condition¹, The Social Transformation of American Medicine², The Undercover Economist³ and The Quest for Cosmic Justice⁴. These books were chosen for their thorough critique of the health care system and its contributing ideologies. By using these four texts in tandem it allowed us to compare and contrast scholarly perspectives on the health care system.

The CSUMB library article database, Voyager, was an essential source to obtain scholarly articles and older newspaper articles. It also allowed us to find vital medical policy and economic history of the American medical system. Another important part of our research was utilizing the inter-library loan program to obtain obscure articles and texts.

¹ Barlett, Donald L and James B Steele. Critical Condition: How Health Care In America Became Big Business And Bad Medicine. New York: Doubleday, 2004.

² Starr, Paul. The Social Transformation of American Medicine. New York: Basic Books, 1982.

³ Harford, Tim. The Undercover Economist. New York: Oxford University Press, 2006.

⁴ Sowell, Thomas. The Quest For Cosmic Justice. New York: Free Press, 1999

The information we gathered from the web was minimal but crucial. We used the web to solidify the perspective and stand point of various special interest groups and managed care organizations. The web also allowed us to gather official U.S. government census results, which we included as our primary source for statistics. Another source, which was only online, was the World Health Organization international health census statistics. Those statistics were important while comparing the advantages and disadvantages of international systems in question: Canada, Germany and Cuba.

The documentary we viewed about the history, social issues and ideologies of Cuba's health care system was our main source for the U.S. comparison. This documentary was on loan when we first viewed it and will be available again in late February. At that time we will gather our citations and review the film again.

Our research has been extensive and continually updated as our work perseveres. Information on the health care industry continues to clarify the problems with the current system and offer alternatives methods of reform. As the issue becomes more widely debated, our argument remains a plausible

Introduction to Findings

The healthcare system in the United States is in crisis. Currently there are more than 46 million people with out health care. The cost for health services and goods continues to rise. “Sickness” has become a major commodity that the health care industry sells. A managed care organization, whose sole purpose, when created, was to reduce the cost of healthcare are now focused on profit. The number of people declaring bankruptcy due to health related debt grows by the day. Large sums of money are being spent on end-of-life care leaving minimal funds for prenatal and preventative care. The purpose of this paper is to clarify the problems associated with the distribution of health care in the United States and explore options and schemes that might address the systems failures.

The History of U.S. Health Care Systems

Presently, in the United States we have a system that has endured since the late nineteenth century. The system is described by Daniel Beauchamp as market based or capitalist. Beauchamp describes market-based systems as those that are focused on “individual responsibility, minimal collective action and freedom from collective obligations.” This system encourages individuals to care for their own health needs. It does not concern itself with the needs of the emotionally, socially, physically, or economically disadvantaged. How did we get here?

The market justice that has accompanied our system has been the “preventative ideology protecting the most powerful or most numerous from the burden of collective action...which is fatally deficient in protecting the health of the public”¹. The market-based concept was beneficial for health care in theory because it encouraged the public to care for there own health matters and not be bogged down by the health problems of others. However, it did not include the needs

of the typically disadvantaged and only benefited those who were already successful in a capitalist market. Due to market morality, those who were successful were granted “fundamental freedom to all individuals to be left alone even if the individuals in question are giant producer groups with enormous capacities to create public harm through sheer inadvertence”². This disparity in producer and consumer market relations strained the already taxed health care system.

The highest quality of care had been until recently reserved for the wealthy. The current trends in United States health care seem to suggest that most people request and use the highest quality of care whenever possible. The cost of using such limited health care denies care to those without by diverting the funds to pay for highest quality, which should be paid for by the consumer³. This trend has also been attributed to the patient’s inability to see the detailed and exact cost of the treatment they receive, in order to promote conscience consumerism. However, the current system does allow the highest bidder to purchase whatever treatment or service they desire which can be seen as a benefit for those who have the ability to pay⁴. A market based health care system is not without benefits. Autonomy is fundamentally supported as the primary reason to adhere to a market based system. There is a common association with autonomy and the ability to choose your own doctor, pick and chose health care plans, receive referrals to the treatments of one’s choice, etc. The scenario as we see it paints a different picture. How autonomous is a system, which allows emergency medicine, among other flaws, and then passes the cost onto the patient? The system allows autonomy for the most prominent and denies it to the most numerous, the middle class, by forcing the costs of the uninsured onto them

In the early 1900s, unlike Europe, the American government was decentralized and engaged in little direct regulation of the economy or social welfare. Although a National Board of Health was created in 1879 matters of public health and service were mainly left up to the

state level. Hospitals were private and healthcare was sold on a fee-for-service basis. The success of the Progressive Party in early 1900s led to an increased awareness about public health insurance. Progressives wanted to ensure everyone was covered due to the need for stable and healthy industry workers to keep the economy viable. The American Medical Association was strongly opposed to overhauling the health care system. The physicians who were members of the AMA did not want to remove the power the practitioners had over cost and supply of goods and services.

In the United States, most health insurance funds of the early twentieth century went bankrupt because of their high overhead, high administrative costs and over 45 percent of premium income was disbursed to subscribers⁵. The rise of commercial insurance came soon after that time due to the social stigma of a “pauper’s burial”. The insurance sold during that time was mainly used to cover funerals and expenses of final illnesses. “Americans bought \$183 million of such insurance in 1911 – as much as Germany spent on its entire social insurance system”⁶.

During the time of the New Deal, Roosevelt set up the Committee on Economic Security to study many things, including medical care and health insurance. The confidential memo regarding the Committee findings was “the medical society’s opposition precluded any action on health insurance”⁷ for President Roosevelt. The AMA continued to reject all suggestions of compulsory insurance, therefore all mention of such insurance was removed from the Social Security bill for fear it would spell defeat for the entire bill⁸.

In the 1940s socialized health care again resurfaced only to be shot down again. The Cold War brought fear of communism in the United States and the mainly European concept of socialized insurances were targeted. In order to further dissuade “communist influence” the general public wholly rejected the idea of federally socialized medicine⁹.

In 1944, Roosevelt asked Congress to affirm the “economic bill of rights” in which citizens had the right to adequate health care. Truman picked up where Roosevelt left off and proposed his own national program to Congress. Truman emphasized that his plan was not socialized medicine, rather a relief for the workingman from the fear of sickness. The National Physicians Committee picked up where the AMA had left off, writing the Truman plan would “make doctors slaves” due to the constraints on payment and wage to the doctor. In the late 1950s any attempt at Truman or Roosevelt’s plans had dissolved due to outrage by the community of doctors who had fought for things to remain as they were.

The health care schemes proposed over the years by Democrats, Socialists, Progressives, and labor unions have all been rejected by the medical community in the United States. People who lost out were “those without membership in groups, like the veterans and unions that had political influence or economic power. The poor, for whom health insurance was originally conceived, were precisely the ones who did not receive its protection”¹⁰.

While this was going on in the United States shortly before World War I, most European countries adopted some sort of national insurance program. European countries enacted compulsory insurance and cash benefit programs to combat the overall cost of sickness. Countries that did not enforce compulsory insurance still compensated individuals in other ways. Extensive state aid to voluntary funds was popular methods in countries such as Sweden, Denmark and Switzerland.

European countries were adopting compulsory insurance programs at the same time that other forms of social insurance were being normalized. These insurances were a response to “chief risks that interrupted continuity of income: industrial accidents, sickness, disability, old age and unemployment”¹¹. Prior to the industrialization of nations the primary means of assistance were community parishes. Free circulation of labor demanded a new means of support

for the working class hence the implementation of a government subsidized health care system. In order to maintain worker loyalty, it was necessary for the European governments to implement a social program that met the needs of everyone rather than just the wage earners, as it was originally intended. There were, of course other issues, which contributed to the introduction of greater social rights. In Germany for example, social rights were given out more freely to avoid giving more political rights to the masses¹².

Hence, there is a distinct difference between the way government, health care practitioners, and individuals in the United States and Europe think about health care. Daniel Beauchamp argues that in the United States the health care system encourages the public to focus on market relations. A market based health care system is not without benefits. In such a system, fundamentally individual autonomy is supported – it is primary. The problem, according to Beauchamp, is that the United States system affords autonomy to the most prominent and denies it to the most numerous. Given Beauchamp’s argument it appears that our current scheme denies American Citizens a right to healthcare. This raises a key question: Should we have a national health program?

American’s “right” to Health Care

As has been developed in the United States, the market-based system is incompatible with a right to health care. The free market system is based on competition, and in any competition there are winners and there are losers. The problem is this is inconsistent with this country’s health care needs, historically and currently. While the market based scheme appears to be incompatible with a right to health care that has not prevented the United State government from adopting and ratifying treaties that acknowledge such rights. In 1966 the United States adopted and ratified the International Covenant on Economic, Social and Cultural Rights

(ICESCR), which is often referred to as the “International Bill of Rights”. The right to health care “exists within this document, the care may be minimal, if a society is poor, but that right is protected for everyone, whether a citizen or an undocumented immigrant”¹³.

The right to health care is further supported in the Universal Declaration of Human Rights, which the United States affirmed. Article 25 of this document affirms the right to health care just as the right to housing. As the scholars Traer and Stelmach pointed out in their use of this document “it is reasonable to assert, as a moral presumption, that in the United States everyone should have a right to health care, and that those who oppose recognizing such right should bear the burden of proof necessary to overcome this presumption”¹⁴.

The international community supports a right for their citizens to have access to health care regardless of their ability to pay. For instance Canada, Germany, Cuba and many others continue to operate the systems in a universal manner. Similar legislation would drastically alter the way in which Americans receive health care and eliminate the current disparities that face this country today.

With these facts in mind it becomes even more pressing to alleviate the economic and social pressure our current system of “have and have nots”. The need for reform is evident and we argue it requires United States citizens to be given the expressed right to health care the nation has acknowledged internationally. In the following sections, we turn to this key concern.

The Current Crisis

Such rights, as mentioned above would resolve such an issue as the 46.6 million uninsured people in the United States¹⁵. Currently, the uninsured resort to emergency rooms for basic care¹⁶, which does not address preventative care, is more costly than basic insurance, and is not a sound utilization of our current resources. The cost of hospital use for all patients rises to

compensate for the unpaid bills for the uninsured people who were treated in the emergency rooms¹⁷. Emergency medicine is a catastrophic problem. Yes, there are more than 46 million people without health care in this country but in actuality they all have health care, the emergency room! The overall cost of health care for the insured rises dramatically each year because of the deficit caused by the over use of emergency rooms for basic medical needs¹⁸.

Therefore it is to be seen whether providing basic health services to the same number of people who enter the emergency rooms would be a fraction of the cost left unpaid by the uninsured. The insured public is already paying this cost in inflated hospital use rates, why not pay it ahead of time (in the form of socialized medicine) and lessen the cost of health care as a whole? Due to the fact that the cost of emergency medicine is so expensive, the negative impact health care costs have had on the American economy must be addressed with a solution that is ethically beneficial for the public as a whole. Market morality is detrimental to human well-being.

The middle class is hit the hardest when it comes to being under insured. When the average person cannot stay on top of their co-pays, prescriptions, and major health needs they fall under the category of under-insured. Their health insurance is simply not enough to offset the high cost of medical treatment. The middle class who cannot afford health insurance will sometimes cancel their policies to save money, which results in the insurance companies raising their premiums to compensate¹⁹. The severely ill are sometimes forced to pay for such costly insurance that they become indebted in the process of seeking better health²⁰.

In the United States, we have embraced a market-based system in which individuals are coerced through advertising and the “selling of sickness” to maximize their consumption of goods and services without concern for collective obligations. The consumer mentality is one of the core reasons health care and health insurance is so expensive²¹.

Understanding MCOs

Managed care in the United States has become one of the top grossing industries, specifically the for-profit sector. There are wide variations to the term “managed care” but there are two major distinctions: for profit and non-profit. Each individual managed care operation has its unique approach, financing, doctor involvement and philosophy.

For profit MCOs are notorious for their “extraordinarily high CEO salaries and bonuses, dividends to share holders, and cash reserves for acquisition of competitors”²². In comparison, a California survey reported the average administrative costs in a for-profit organization were 30.9 percent whereas a non-profit was as low as 3.1 percent of total revenue²³. Subscriber premiums are set by the market and direct competition between plans directs the cost. In order to create the surplus that for profit operations want, the funds spent on “doctors, tests, treatment and hospitalization”²⁴ are minimized. The pressure on doctors in a for profit MCO to spend less on patients and to please the stockholders will contribute to short changing the patients and negatively impacting the entire system.

There are many subcategories under a typical MCO, which define the relationship between the patient and the doctor. Some of the more common are independent practice associations (IPAs), preferred provider organizations (PPOs), and group model HMOs like Kaiser Permanente.

Physicians in PPOs are paid for services rendered and this can lead to an incentive to generate more health care costs per patient by ordering more tests and making more appointments. These physicians usually face the least amount of income security due to sudden contract termination with various MCOs. Physicians in IPAs also contract with more than one MCO but are given much more negotiating power. They are usually reimbursed on a “capitated

basis”²⁵. A capitated basis usually refers to a specified amount paid to a health provider for a group of specified services regardless of quantity rendered.

There are many financial incentives, which can and do influence the physician behavior. For instance, for profit MCOs have been known to use payment of bonuses from any unspent general funds as a means of encouraging physicians to lower the cost of doing business²⁶. An incentive such as this one has the potential to negatively affect the quality of treatment for the patient in order to promote a cost-effective business.

The harm financial incentives have may be greater than currently known, but what is known is that physicians have the pressure to withhold needed services or over prescribe unneeded services all for financial gain which contradicts their Hippocratic Oath “to do no harm”. The MCO structures that use financial incentives to the detriment of the patient do harm to the all involved parties as well as the health care system in this country.

A non-profit Managed Care Organization, such as Kaiser Permanente, does not face the same pressures as profit MCOs. However, non-profit MCOs are constantly challenged to compete with for-profit MCOs and the similarities between the two may increase.

Conclusion of U.S. Health Care

The United States health care system has been fraught with conflicting values and ideologies since the beginning. The belief that the “market alone will provide” is no longer an acceptable ideology, it has proved itself ultimately fallible. The current system must be reformed to alleviate the increasing crises.

The system of managed care, in this country, has continued to climb to a top grossing industry, regardless of the decreasing number of people who are being underserved. The pharmaceutical companies and medical providers in this country continue to target the healthy

and the impoverished for unnecessary services. The established market-based mind set in the United States provides the ultimate consumerism of goods, leading to an even more off balance system. More than 46 million people cannot attain basic care while the majority indulges in frivolous goods and costly services.

We have established that Americans have a right to health care, which entails a federal obligation to ensure that right. In the following we will offer international solutions, which have fulfilled that obligation,

Examination of International Health Care Structures

Argument to Critically Assess International Health Care

By examining international alternatives to a market based system we underscore a collective obligation to public health that is lacking in the United States. The disadvantages of America's market based system are:

- Expenditure per capita is drastically less in countries with socialized medicine. The U.S. has the highest expenditure per capita and the greatest percentage of uninsured citizens²⁷.
- Countries such as Germany and Canada, which have universal pre-natal care, have seen a drastic drop in the infant mortality rate. The United States is ranked third in infant mortality internationally²⁸.
- The United States spends more on end-of-life care than any other nation in the world²⁹.
- Life Expectancy is highest for men and women in Canada. The United States, the largest consumer of health care with the largest number of uninsured, has the same life expectancy as Costa Rica and Cuba.
- The United States has less than three doctors available per every 1000 insured citizens but the country of Cuba has one doctor per every 200 residents³⁰.

Socialized Medical System: Germany

Germany has had a socialized medicine system in place since the Health Insurance Act of 1883. Their form of socialized health care, in which premiums are based on the person's ability to pay, covers 90 percent of the German population. For profit private insurance companies

cover 8 percent of the population. There is another 2 percent who are civil servants and are covered by government specific insurance³¹. The German health care system is based on the following principles:

- **Self-Governance:** implies that the insured and the providers operate as self-managing private organizations under public law, with as little interference from the government as possible.
- **Social Partnership:** suggests that both employers and employees share the financial burdens of health care.
- **Social Security:** reflects the attitude that the economically stronger members of a society should support the weaker members to ensure equality of access to health care³².

The German health care system is based on the belief that younger and healthier members of society should subsidize the older and less healthy members of society; those with higher incomes should subsidize those with lower incomes; the single and childless should subsidize families and those with children; and the employed should subsidize those who are unemployed. The system finances itself through employees and employers in a government-mandated way. Care is provided in the following four ways: sickness funds, associations of office-based ambulatory care physicians, hospitals, and the pharmaceutical sector³³.

A key element of the German health care system was the creation of sickness funds. The program was put in to effect under the Health Insurance Act of 1883. Sickness funds were developed in order to allow all citizens to benefit from the goods of the state. Sickness funds also provide citizens with accident insurance, retirement funds, and unemployment insurance, which have continued to be the basis of the German system. The system is highly decentralized and consists of more than one thousand insurance or sickness funds. These are non-profit organizations and membership is compulsory. They are required to accept all persons who qualify. Premiums are not permitted to reflect differences on the basis of age, gender or risk factors. They have a mandatory acceptance of difference, which distributes the risk evenly³⁴.

Canada's Health Care System

Canada is a working model of a capitalist economy which balances the needs of the market with the health care needs of their population. Universal health care for all citizens is considered *the* advantage of a socialized health care system. The Canadian central agency responsible for collection and payment is able to immediately and efficiently handle the burden of its large population.³⁵

Canada retains a mainly non-profit health care system, which represents an approach to managed care contrary to that of the United States. Canada implemented this system in 1957 under the Hospital Insurance and Diagnostic Services Act. This system of managed care has been attempted in many countries, including the United States, but in Canada they have effectively produced the model of managed care. Their goals for managed care are: (a) reduce unnecessary utilization of services, and (b) contain costs and measure performance while providing accessible quality and effective health care³⁶.

Preventative care lowers overall cost by redirecting spending for disease prevention and routine basic care visits to health professionals³⁷. Compromised autonomy is provided in socialized medicine systems patients are allowed to choose their doctor and hospital, rather than insurers limiting the selection³⁸.

As in most systems socialized health care comes with certain disadvantages. In the past, increased waiting times have been complaints of socialized medicine systems – Canada is no exception. Socialized medicine has been criticized because patients are not allowed to seek out procedures and prescriptions outside the system unless they use personal funds. Patients are not allowed to seek treatment outside the Canadian system. Of ten these restrictions are seen as attacking patient autonomy³⁹.

Cuba's Health Care System

In a country where a forty year economic embargo has strained a struggling economy, Cuba's health care system is a shining model of socialized medicine. Appendix 1 provides an example of several statistics. When looking at infant mortality rate, under-five mortality, maternal morbidity, mortality rate, and life expectancy, Cuba's statistical data ranks better than any country monitored by the World Health Organization. Cuba values the health of its citizens and prioritizes it accordingly, health care is more than just a privilege, in Cuba it is a birthright.

Statistics do not provide a complete picture of Cuba's successes in the area of health care. Cuban physicians provide neighborhood clinics and make house calls as part of their everyday work. An aspect of the Cuban system exceeds other countries with equal to or greater populations. "Neighborhood and family practice doctors contribute to Cuba's first line of medical defense"⁴⁰. There is a medical clinic in most neighborhoods, which help expedite the time for house calls. This feature of the Cuban model is drastically different than the United States method of handling patients. In the United States patients more easily travel to their local doctor. Due to Cuban medical professionals offering in-home services, unique relationships develop between doctor and patient. These relationships lend to the success of the system. They create a trust of the care providers, like physicians, nurses, and aids. Cuban resident, Francisco Rodriguez Mena Cartaya said, "the in-home services provided by Cuban medical professionals are excellent". "I called her this morning and now you see they are here. They always come very fast. There is no delay. They give the best attention"⁴¹.

Cuba's health care system demonstrates how much can be done with very few resources. The United States focuses on technology, especially in regards to advanced procedures, ensuring proper diagnosis and seeking new advancements in the field. Cuban medical professionals do not have such a privilege. The inability to acquire the proper resources as a result of the United

States embargo prevents medical professionals from acquiring equipment. As a result Cuban medical professionals and trainees turn to traditional practices of medicine and gain experience in an environment with little to no technology⁴². “The kind of medicine we practice, which is not high tech helps us to use more traditional procedures and trains us to practice medicine better...the experience in a low-tech environment allows you to be better prepared to treat people in a high tech world” Dr. Vivian Revilla Rodriguez, General Surgeon, on the use of technology in Cuba’s medical system⁴³.

Conclusion to the International systems

International models should be considered in any attempt to reform the United States system. It is clear Germany embodies a socialized medical system that bases premiums on one’s ability to pay, Canada values preventative care and cost management, and Cuba focuses on the traditional medical practice and universal care. By incorporating the values of each of these systems the United States could develop a system beneficial to all Americans. Due to the global recognition of the above systems many Europeans now go to Cuba for specialized procedures, and many Americans now go to Canada for medications. Hence of the globalization of health care is but one more way of highlighting the problems of our market-based system. Our own citizens are going to other countries because the United States is too expensive.

Suggested Models for the United States

In recent years there have been many suggested models to address our problematic health care system. With the number of citizens without health care rising each day, developing a new model has become an essential. The following models provide us with insight on how some states sought after change. In April of 2006, Massachusetts became the first state to develop a “first-in-nation,” program to allow universal health coverage to all citizens. According to

Governor Mitt Romney “instead of facing health care cuts, we’re well on our way to achieving out longstanding goal of health care for all”⁴⁴. People will be encouraged to buy the universal health care package because the program will use a combination of subsidies and penalties in order for coverage to be more affordable. In order for the health reform to be successful participation is required from both individuals and employers.

The plan would also include a mandate for all residents requiring them to have acquired health insurance by July 1, 2007. Those residents who do not purchase the plan by July would be fined a 50 percent penalty taken from income tax filings. The plan offers what is called a “Connector,” with the intention to “connect” individuals with quality insurance products that are affordable to state residents. Individuals and small businesses then purchase insurance through the Connector program. The program recognizes residents between ages 19-26 and offers low-cost products to their disposal.

Mayor Gavin Newsom has also just recently proposed a universal health plan for San Francisco residents. "Rather than lamenting about the fact that we live in a country with 45.8 million Americans that don't have health insurance ... San Francisco is doing something about it."⁴⁵. The incentive for the health plan is not to take over private insurance companies but to provide the uninsured with access to health insurance with out relying on hospital emergency rooms for medical attention. The health plan would make available: preventive and catastrophic health care, covering everything from checkups, prescription drugs and X-rays to ambulance rides, blood tests and surgeries⁴⁶. The plan would allow participants to choose between approximately 400 doctors affiliated with the health program. An expense paid by taxpayers, businesses that do not insure all their workers, and program participants⁴⁷.

Governor's Mandate

On January 8, 2007 Governor Schwarzenegger of California proposed an elaborate plan for California's health care system reform⁴⁸. The Governor's health care mandate is divided in to three sections, with each section covering the most valued aspects of the proposed universal system.

Prevention, Health Promotion, Wellness

Preventable disease and disability play a large role in the first section of the Governor's proposal. Each has a deep impact on the health of California residents and communities. Placing more emphasis on disease prevention, health promotion, and healthy lifestyles allows for improvement in containing health care outcomes and costs. The Governor hopes to achieve a healthier California by implementing following procedures:

- Structuring benefits and providing incentives/rewards to promote prevention, wellness and healthy lifestyles through the implementation of "Healthy Actions Incentives/Rewards" programs in both the public and private sector
- Establishing a national model for the prevention and treatment of diabetes
- Preventing medical errors and health care acquired infections
- Reversing obesity trends through nation-leading innovative and comprehensive strategies
- Continuing the battle against tobacco use⁴⁹.

Cover All Californians

A UCLA California Health Interview Survey found that were 6.5 million uninsured at some point in 2006; 4.8 million Californians were uninsured at any given time. The Governor's proposal identifies adequate funds to cover all Californians. The proposal emphasizes the importance for each individual to have a minimum level of health coverage. This would ensure that all citizens to have equal access to care. The following have been proposed for the Governor's *Cover All Californians* plan:

- Addressing the "hidden tax" benefits everyone
- Ensuring availability of emergency rooms and trauma centers is essential

- Availability of insurance affects not only the physical but the financial health of the community
- To achieve coverage for all of California's uninsured, the Governor's action steps include:
 - Requiring all individuals to have a minimum level of coverage (individual mandate)
 - Providing low-income individuals affordable coverage
 - Requiring insurers to issue health insurance
 - Increasing Medi-Cal rates significantly
 - Facilitating and enforcing the individual mandate

Currently there are 750,000 uninsured children in California. The Cover All Californians plan would take care of the health needs of these children. There are 4.1 million uninsured adults in California. The plan would take care of the health needs of these adults by requiring them to maintain a minimum level of insurance. Finance for public programs, increased Medi-Cal rates, programs to promote prevention, and health and wellness will all be achieved through a shared responsibility finance strategy.

Affordability and Cost Containment

Health care costs have been rising faster than general inflation, with employers and employees unable to keep up with the quick moving pace. This forces suspended coverage and dependence on state health care programs. Affordability and Cost Containment is designed to create individual mandates to make it possible for individuals to afford, purchase and maintain comprehensive benefits. The following steps are the break down of the Governor's action plan towards the last principle of his proposal:

- Reduction of the "Hidden Tax"
- Enhanced tax breaks for individuals and employers for the purchase of insurance
- Enhance insurer and hospital efficiency
- Reduce regulatory barriers to more efficient health care delivery
- Reduce cost for delivering HMO products to employers and individuals
- Prevention, health promotion and wellness represent critical long-term cost containment strategies, as described above. Other key components for achieving long-term affordability include
- Health Information Technology (HIT)

- Leverage state purchasing power through Medi-Cal
- Enhance health care quality and efficiency⁵⁰

According to the mandate, health care reform is necessary to bring back a healthy, productive and economically competitive California. The Governor's plan is to develop a health care system to contain costs with shared responsibility. The shared benefits of universal coverage and affordability should expand to include a secure individual coverage and controlled costs. The Governor and his administration hope that by working with health care insurers and providers, California will establish a national model for health care.

Conclusion

The best system is a system in which every person matters and their health needs are addressed. The purpose of this paper is to inform our readers of the current crisis, the system that created it and the possible alternatives. We would like to implore our readers to make their own educated and informed decision for America's health care system.

We realize there are many other sources of disparities in the American health care system. Some of those include racism, sexuality bias, ageism, etc. The scope of our research limited our ability to address these issues in reference to health care disparities.

If health care reform is to be successful in the United States we must acknowledge the right to basic health care for all, the costs for goods and services must be controlled, prevention and wellness must be prioritized and that there is a social obligation to fund basic care. There have been many steps in the right direction recently, which only reaffirm the urgency of this matter. The next step is to look beyond state budgetary obstructions or partisanship. In order to nationally acknowledge the need for reform, we argue that as a society, we must look outside our system. We must look at international models, which address similar disparities for guidance and implementation.

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⁵⁰Office of the Governor of California

Appendix A: International Healthcare Comparison Chart

	CANADA ¹	CUBA ²	GERMANY ³	USA ⁴
# of People w/o medical insurance	Zero	Zero	< 0.2% ⁵	46.6 million ⁶
Cost of health care	5:1000	Zero	5:1000	
Infant mortality rate	5:1000	8:1000	5:1000	8:1000
Patient doctor ratio	2.14:1000	1 to 200 ⁷ 5.14:1000	3.37:1000	2.56:1000
Level of technology use	High	Low ⁸	High	High
Average annual cost of pharmaceuticals		Free ⁹		
Life expectancy	78 M 83 F	75 M 80 F	76 M 82 F	75 M 80 F
Health expenditure per capita (US\$)	2989	251	3001	5711

This article has been included to provide our readers the opportunity to see the affects of the failing health care system on average, middle class Americans.

Appendix B: Lacking Health Coverage, Good Life Turns Fragile By Robert Pear, (5 March 2007) The New York Times, p. A1.

Salisbury, N.C. - Vicki H. Readling vividly remembers the start of 2006. "Everybody was saying, 'Happy New Year,' "Ms Readling recalled. " But I remember going straight to bed and lying down scared to death because I knew that at that very minute, I was without insurance. I was kissing away a bad year of cancer. But I was getting ready to open up to a door of hell." Ms. Readling, a 50 year-old real estate agent, is one of nearly 47 million Americans with no health insurance. Increasingly, the problem affects middle-class people like Ms. Readling, who said she made about \$60,000 last year. As an independent contractor, like many real estate agents, Ms. Readling does not receive health benefits from her employer. She tried to buy a policy in the individual insurance market, but –having had cancer- could not obtain coverage, except at a price exceeding \$27,000 a year, which was more than she could pay.

"I don't know which was worse, being told that I had cancer or finding that I could not get insurance," Ms. Readling (pronounced Red-ling) said in an interview in her office, near the tree-lined streets and stately old homes of this city in Piedmont region of North Carolina.

It is well known that the ranks of the uninsured have been swelling; federal figures show an increase of 6.8 million since 2000. But the surprise is that the uninsured are not necessarily the poor, the unemployed and the undocumented. Solidly middle-class people like Ms. Readling are one of the fastest growing subgroups among the uninsured.

And that is one reason, according to a recent New York Times/ CBS News poll, that the problems of the uninsured have jumped to the top of the domestic political agenda in Washington and on the campaign trail.

Today, more than one-third of the uninsured- 17 million of the nearly 47 million- have family incomes of \$40,000 or more, according to the Employee Benefit Research Institution, a nonpartisan organization. More than two-thirds of the uninsured are households with at least one full-time worker.

Ms. Reading's experience is typical; people have had serious illnesses often have difficulty obtaining insurance. If coverage is available, the premiums are often more than they can afford.

While the government does not have an official definition of "middle-class" one commonly used point of reference is the median household income, which was \$46,326 in 2005.

...

The idea of universal coverage, in the form proposed by President Bill Clinton, proved politically untenable. Since the Clinton plan collapsed in 1994, the politics of health care have changed because of the steady rise in health costs, the increase in the number of uninsured and the erosion of the employer-sponsored insurance. Politicians are once again speaking about universal coverage as a goal, though opinion polls show that many voters still oppose the idea of a government run health care system. Ms. Readling said it was stressful enough visiting doctors every few months for her cancer follow-ups. Without coverage, she said, the experience is even more stressful.

...

"Anything that goes wrong with my health could destroy me financially," Ms. Readling said. "I could be ruined". She said she had never voluntarily allowed her insurance to lapse and could not understand why she was being blackballed. "What did I do wrong?" Ms. Readling asked.

Barbara Morales Burke, the chief deputy insurance commissioner of North Carolina, said state law did not guarantee the availability of health insurance for individual. "Most insurers decline to issue policies to those individuals whom they deem to be too risky because of their medical history" Ms. Morales Burke said.

Blue Cross and Blue Shield of North Carolina will sell to anyone, regardless of the person's medical condition, she added, but the premiums may be very high for people who have had serious illness.

Heidi Deja, a spokeswoman for Blue Cross and Blue Shield of North Carolina, said, "Rates are based on the anticipated cost of providing care". For people who have had serious illnesses, she said monthly premiums "can run into the thousands of dollars".

...

Though satisfied with her car, Ms. Readling continually wonder if doctors and nurses treat her different because she is uninsured. "Are they going to turn their nose up at you because you don't have insurance?" Ms Readling asked, "Will they take care of other people first?" They can make more money on patients with insurance. What am I? I am just a financial loss to them".

This article has been included to provide further reform insight and an alternative viewpoint on the current crisis.

Appendix C: Putting The ‘We’ Back In Wellness By Joy Colangelo, (18 November 2006) The Monterey County Herald, p. F1.

A monk was asked the difference between wellness and illness. He wrote the words on a chalkboard and circled the “WE” in wellness and the “I” in illness.

Unfortunately, health care in the United States focuses on the “I” with its emphasis on private payer health insurance. Such a system leaves us ranked lower than 71 other industrialized countries in overall health while we spend twice as much on health care than country ranked No. 1.

Every country in the developed world except the United States has a tax supported public health care system.

Canada, which shares a very similar lifestyle and risk factors, has the 23rd best infant mortality rate. The United States ranks 43rd, tied with Croatia.

It gets worse. The United States has nearly 50 million citizens without health insurance and their lack of benefits affects the rates of those with insurance. The uninsured resort to the most expensive health care: emergency rooms.

...

It all comes down to the type of society we want. Do we want to spend a quarter of every health care dollar on paperwork? No? Well, we do, like it or not. Do we want to work mundane jobs we hate just to get the health insurance? Too many do. Do we enjoy living with the fear of getting ill; losing our benefits and working until we are in our 70s in case Medicare isn’t available? Well, we are.

It is the cost of doing nothing. Doing nothing about universal health care coverage is our national strategy.

Luckily, some enlightened states and cities are making their own reforms. Maine passed the Dirigio Health Reform Act, a bill to achieve overall health care for its residents. Illinois has the Health Care for All Children law and Maryland the Fair Share Health Care Act. Vermont passed its Health Care Affordability Act this year, and San Francisco has done the same. They are putting the “WE” into wellness, and the rest of us should be following their example.

This article provides statistical data concerning health care costs, from the perspective of the consumer mentality present in our society.

Appendix D: Health Insurance Costs Outrun Wages Fourfold By Mark Schwanhauser (27 September 2006) San Jose Mercury News, p. C1.

If you think paying \$2.75 for gas is a bargain, here’s more news you can use as companies prepared to let workers sign up for health care plans: The average cost of health insurance premiums climbed *just* 7.7 percent over the past year

That was the slowest rate of increase since 2000 – down from 9 percent the previous year and a far cry from the nearly 14 percent jump three years ago, according to the annual benchmark survey by the Kaiser Family Foundation.

The flip side: Premiums to cover a family have vaulted 87 percent since 2000 – more than four times the rate of inflation and the growth of wages – a trend that is forcing millions of Americans to go without insurance coverage.

“We get excited when gas goes below \$3 a gallon,” said Helen Darling, president of the National Business Group on Health. “Some of us would say that’s crazy, but you do look for the tiny signs of hope, and you could say that’s one of them.” Experts say premiums would be rising even faster if employers, workers and insurers weren’t making health care trade-offs. Many employers are restricting which family members are covered and are forcing workers to pay more before their insurance kicks in. Workers are paying more for checkups, to buy drugs or visit the emergency room. Insurers are limiting the choices that patients have by dropping the priciest hospitals, doctors and labs.

“No doubt about it: You’re paying more for less,” said Edward A. Kaplan, who heads the health consulting arm for Segal in New York. “There are lots of different ways where we are rationing the health care dollar”.

...

A survey of 18,000 workers by the consulting company Hewitt Associates released last week found that just 34 percent track their health care bills, and less than half bother to estimate how much they’re likely to spend in the coming year. And of those enrolled in high-deductible plans, 40 percent said wouldn’t re-enroll.

“They had 30 years of being desensitized to the costs because most people had insurance, and they knew very little if anything about the true costs,” Melnick said, “Now they’re being asked to get involved in the decision-making process about spending money. It’s a very difficult adjustment period.”

Appendix E: Interdisciplinary Reflection- Amy Krisch

It was clear at the beginning of Human Communication that it would focus on a neglected area of today's society; an area many other majors have a tendency to overlook. Communication is one of the most important aspects one must have in order to find your place in today's world. And at the same time, it is the very thing most individuals lack. When beginning this major it was clear many viewed it as an easy way to achieve a bachelor's degree. As I delve deeper in to the specifics of what the major would cover, I found it concentrated on the exact thing most individuals are afraid of self-reflection and the ability to evaluate situations in the most ethical way. Now that I have approached the last month of school the impact of my major, human communication with a concentration in practical and professional ethics, has lead me to the process of self discovery much earlier than expected.

Practical and Professional Ethics has provided a powerful impact on the mold of my future. It has taken me in to a field that is unknown by much of the outside world. The idea of an ethical society is truly hard to grasp, but when you reach that point of understanding it is amazing to see the whole picture come together.

My classroom experience has truly helped me develop in to a more confident individual. I was an extremely introverted person, one who questioned each and every more, and when it came to classroom participation I only contributed when I knew I had the right answer. But after my first semester of classes that quality soon began to diminish. By participating in classroom activities I realized I was discovering an entirely new personality; a personality I have grown to love. Embarrassment no longer became an issue, and saying what was on my mind became such

a satisfying characteristic. I contribute much of my turning point to the concentrations ability intertwine each course so that you were able to expand personal growth with course material.

I can honestly say, throughout each course I have absorbed the material offered with much enthusiasm. I am privileged enough to have the opportunity to achieve a high leveler education, and wasting what has been offered by the outcome based educational format would have prevented knowing what I know now. This major has had a giant impact on many areas in my life. Months before graduating it has already opened many doors that have to potential to lead my future to great success. But more importantly the qualities I have gained from my professional and relational ethics courses have allowed me to fully evaluate each and every situation and decision I have and will eventually encounter.

I will always remember the first time I told someone my intended major was Human Communications. Their response was a roll with their eyes, and even now 4 years later, many people still do. But now, having completed 4 semesters of that major many roll their eyes, I know I have successfully completed the one thing those people are unable to do; communicate.

You can never fully prepare yourself for the obstacles that arise during Capstone. Even the most prepared projects come across challenges that have powerful setbacks. My Capstone partner, Rachel Wall, and I were well aware of the struggle students in the past have had with their projects, and were determined to not let those difficulties effect the outcome of our project. In order to prepare ourselves for the abundant amount of work we knew lay ahead we felt the best decision was to begin our research as soon as possible, and to find a that one professor we trusted most to guide us with his powerful expertise. This move was essential if we had any hope of developing the project we had envisioned.

Our method was strong, and we produced a great deal of research in a minimal amount of time. The most difficult area of research surfaced when we choose to take a deeper look in to the health care crisis at home and focus on individuals who found themselves directly affected. The material found in various newspaper articles was overwhelming, and we discovered that we were letting ourselves become too connected with the personal stories we were reading. Rachel and I realized we needed to create a new way to approach content we had the potential to become attached to. Our decision was to take out the story lines and focus directly on the matter at hand. What were health care companies doing? How did that impact individuals without coverage? And what did they intend to do about it? Taking out the story lines allowed us to focus only on the loopholes many insurance companies pulled thousands upon thousands of individuals and families through. This provided us with more concrete examples of how the U.S. health care system is flawed.

Due to the early start on our research and even the writing of our paper it became apparent that we ended up knowing too much information about our topic. It was then essential for us to teach ourselves how to “unlearn” much of the material in order to allow the significant material to resurface. Although this process was not difficult, it took a great deal of time to determine which material had stronger content over others. Dr. John Berteaux had a strong influence on many of the decisions Rachel and I chose to make. Without his guidance, confidence and encouragement I do not think Rachel and I would have found it within ourselves to step outside our abilities and reach for something more.

The challenge of research quickly shifted and the writing soon became the critical issue. We knew we had more than enough content, but getting it on paper, and keeping up with the fast

approaching deadlines was far more difficult than we could have ever imagined. In the end however, the outcome of our work proved to collectively be one of our greatest accomplishments. This feeling of success will continue to out way the stresses of the project as a whole each time it is discusses. What Rachel and I were able to achieve is something many felt was impossible. Although CSUMB greatly supports the concept of group work it was not recommended when it came to Capstone. But the confidence Rachel and I had in one another was every reason why we knew we would succeed in completing this project. If we would have done this work separately the material would be nowhere near as strong as it is now. We found ways to feed off of each other, even in times when we were more than willing to give up. Finding strength in one another is the greatest accomplishment Rachel and I have learned from this experience. This project has left me with an experience I can not imagine having at any other university and it has highlighted capabilities within myself I never knew I had.

Appendix F: Interdisciplinary Reflection – Rachel Wall

The Human Communication major has been a wonderful and supportive learning environment. I had initially intended to transfer from CSUMB after my second year, in order to attend a more prestigious university. My first HCOM courses were with professors Adler, Swanson and Watson. They were the most interesting, knowledgeable and intellectually demanding instructors I had ever met. Their curriculum demanded that I critically examine the world around me and find the unanswered ethical questions. I was inspired by the challenge of the information I had learned at previous schools. I came to the point during my sophomore year that professional, ethical and compassionate communication and decision-making was a field I wanted to take part in and master.

My first semester in upper division HCOM classes was the most challenging semester

academically for me. That semester I was enrolled in Ways of Knowing and Ethics for the Professions with Dr. Berteaux, Proseminar and Gender Communication with Dr. Marty. I was overwhelmed with the radically different perspectives of ethical communication I was being asked to understand and examine. Although, the most challenging, it was by far the most rewarding semester for my understanding of the major. I felt I finally knew what I didn't know and I knew what I needed to still learn.

That was also the first semester I realized what wasn't for me in HCOM. Only to be reaffirmed each semester, I found that I did not want to pursue creative writing or journalism. I am incredibly grateful there are students and professionals who enjoy those avenues but I am not yet one of them. Personally, I have found analytical philosophy and relational ethics to be the most inspiring disciplines in HCOM.

My primary concentration is Practical and Professional Ethics and my secondary concentration is Pre-Law. My time in HCOM has only reassured me of my choice for my primary concentration. I am enthused by the moral and interpersonal questions in the world and I feel inspired by the conversations these topics provoke. My primary concentration paved the way of the classes I chose to take in HCOM but due to a financial aid mishap I was forced to choose a pre-law focus as well. I was not excited about adding more classes to my schedule but those classes have given me another avenue to apply and deepen my understanding of ethics. The course work in both fields has had an enormous impact on my learning future and is the primary reason I wish to continue my education in graduate school. I feel that my graduation from CSUMB leaves so many unanswered questions from the curriculum I have studied. I want to pursue answers to those questions in graduate school and make an impact on the social topic of ethics. Thankfully the capstone process was an excellent practice round for graduate school

preparation.

Capstone is an intimidating process. At the point that I decided I wanted to take on a topic of great detail, I became wary of going it alone. I knew that a topic such as health care reform was too large for a HCOM capstone. Picking it apart and narrowing the subject down seemed an injustice for the readers and my passion. Shortly after deciding that I was going to write about health care reform no matter what, I found exactly what I needed: a capstone partner.

In retrospect, I can see the intention of the capstone process. At first, I was consumed with envy for the students at other CSUs who “only had to write a research paper”. As my search for graduate programs began during pre-capstone, I saw the similarity between graduate work and our capstones. My partner and I began our research in June of 2006, the summer before pre-capstone. We were deeply concerned that our summary of the current condition would be seriously lacking if we did not begin to research and absorb all the available information. We were correct. Learning new things about United States health care and various international models have been daily events. The experiential process of seeking out new material from every possible media was well worth the consumption of our last summer vacation. Without the data we had gained during the break, our paper would not have come together satisfactorily.

The beginning of the pre-capstone process was incredibly beneficial for our confidence going into such a large project. We were prepared and knowledgeable for the creation of the foundation of our paper. The organization of our prospectus allowed us to become engrossed and complete the proposal with all the findings we wanted to include. Although it was discouraging at first, the elimination of unnecessary data and the narrowing of our thesis was an invaluable tool for capstone.

Both of us knew that our winter break would not be a logical time to produce great

volumes for our capstone but surprisingly we were able to write our literature review at that time. It was nice to form the habit of writing early, getting thoughts, however unorganized, onto paper and then revisiting. The revisal of our literature review and early capstone drafts were also habits that I have been grateful for; the revised drafts were always better. Academically, the capstone project has also encouraged us to rely on as many sources of constructive criticism as possible. I had been previously opposed to in class group reviews due to their ineffectiveness and lack of depth. I found that to be true in our pre-capstone course but things had changed in capstone dynamic. Our peers began to see the importance of the review process and review our drafts as critically as we had viewed theirs.

The capstone class itself was a challenge to keep on top of our deadlines while juggling other classes and graduation preparation. The first month of capstone included many, many 6-hour writing sessions and 8-hour revision sessions. I can honestly write that I was completely burned out by the middle of March. Spring break could not have had better timing for our paper. That break gave us time to step back from the paper we had been so engrossed in and to see our near finished product for the first time. It allowed us a sigh of relief but a newfound sense of urgency as the deadline painfully approached. We have been hard at work to add the revision suggestions from each of the advisors we draw upon. Although tempting to accept each suggestion that comes our way, we have had to discuss the impact a small or simple change may have on the tone of our paper. The final product must remain true to our own writing and our intention.

The success of our capstone project could not have been obtained without the faculty expertise we drew upon since early 2006, Dr. John Berteaux. He has been an invaluable source of advising and direction for our specific topic. Both our pre-capstone and capstone instructors

were incredibly supportive and helpful with the organization and preliminary drafts of our project; they spoke with understanding and experience. But the asset of the Directed Reading/Special Topic course was the key to our capstone. Without the special time Dr. Berteaux dedicated for us, we would have been competing with his other students, his incredible busy schedule or unable to continue with the project altogether. We were able to communicate regularly about capstone goals that incorporated our topic and the challenge to expand and contract portions of our subject matter. He made time for us via conference call, email and office hours no matter the limitations of his academic calendar. His dedication to the success of our paper inspired us to exceed his expectations and to produce quality work. The ability to draw upon expert advising should be a staple in every applicable capstone for HCOM students.

My partner, Amy, and I have accomplished a work that we are proud of but we know it will be unfinished. I am sure this topic will remain of great social importance and we hope to include pertinent information when it becomes available in the future. We have established our own foundation for this subject, and we are proud that it will never be complete. This topic will never be so simple as to be encapsulated in a capstone paper, new information inspires us to continue our research. I know I will use this project in the future to apply for graduate school, employment and civic responsibility. I am personally happy that we were able to work together in a partnership to write a paper that matters. Health care affects every person in this country and if I can contribute to the dialogue to remedy the crisis in any way possible, I will feel honored.

Appendix G: Annotated Bibliography

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Secondary Sources

Armstrong, Pat. "Managing Care the Canadian Way." Biomedical Ethics. Eds. Thomas A Mappes and David DeGrazia. Boston: McGraw Hill, 2001. 666 – 669.

This article focuses on the Canadian single-pay health care plan currently utilized. The article clearly defines public administration, nonprofit finances, cost evaluation, appeal verses U.S. models, and managed care practices. The author also includes a note concerning the future plans to expand on preventative in Canada.

Barlett, Donald L and James B Steele. Critical Condition: How Health Care In America Became Big Business And Bad Medicine. New York: Doubleday, 2004.

According to the authors the United States spends more on health care than any other nation, yet we have the highest rate of uninsured. They compare this appalling statistic to other countries such as Germany, France, Japan, Italy and Canada. These countries all employ systems of universal coverage. They feel that this system of health care in the United States is a national breakdown that will require a national solution. The authors argue that our system of government is wedded to the concept of market-based medicine even though it wastes billions of dollars, is

inefficient, and riddled with fraud and profits companies who deny care. They argue that America's health care crisis can be cured with out spending more money by redirecting resources and taking in to account the health needs of every American. This text will supply case studies, statistics and research from other countries in support of our argument.

Berteaux, John A. Lecture: "Bridging the Racial Divide In Healthcare". Loyola University Chicago Stritch School of Medicine, Chicago. 8 Oct. 2005.

This transcribed lecture reviews the different approaches and needs for cultural competency in the health care profession. This lecture reviews the inequalities and suggestions to eliminate them through education and awareness. We will incorporate the above-mentioned inequalities in our attempt to prove disparities in health care.

Buchanan, David R. An Ethic For Health Promotion: Rethinking The Sources Of Human Well-being. New York: Oxford University Press, 2000.

The purpose of this book is to advocate a new way of thinking about promoting individual and community well-being. The author critiques the current market based system as "the wrong approach both ethically and epistemology." He remarks that the current framework is exacerbating the very condition that give rise to them in the first place. The author argues for different, more meaningful means, to affect the quality of outcomes. He concludes that well-being is just such a normative value, where means and ends are inseparable. The book lays the foundation "for a sound, cogent and urgently needed alternative philosophy and practice to succeed the quest for a science of health."

Callahan, Daniel. "The WHO Definition of Health." Bioethics, Justice, and Health Care. Eds. Teas, Wanda and Laura M Purdy. New York: Thomson/Wadsworth, 2001. 7 – 11.

The author focuses on the World Health Organizations definition of health and how that has affected the international community. He points out that the problem with the definition is the implication of the various uses to which the concept of "health" can be put. Another implication is the absence of mental health in the WHO definition. He concludes that too much power and authority have been placed in the hands of medical professionals based in the WHO definition.

Christensen, Kate T. "Ethically Important Distinctions Among Managed Care Organizations." Eds. Thomas A Mappes and David DeGrazia. Biomedical Ethics. Boston: McGraw Hill, 2001. 650 – 658.

The author begins the article by defining multiple forms of managed care. She specifies the differences in financing, physician involvement and philosophy. In particular she discusses the difference between for-profit and nonprofit insurance organizations. She concludes that nonprofit currently works best to prevent under treatment.

Goodwin, James S. "Culture and Medicine: The Influence of Puritanism On American Medical Practice." Bioethics, Justice, and Health Care. Eds. Teas, Wanda and Laura M Purdy. New York: Thomson/Wadsworth, 2001. 12 – 18.

The author addresses the prevailing ideology in the formation of the current American Health System, American Puritanism. The author points out that no where in American public health literature is there the concept of pleasure, contentment, or happiness. These concepts have been circumscribed as "quality of life." He compares this to systems and therapies in European countries. The article includes an analysis of the U.S. preoccupation with pills, programs, and disreputable diagnosis that are not matched in European countries. There is also a focus on 4 areas where American medical practice clearly differs from European countries: alcohol use, pain control, pregnancy, and preventative medicine. The author concludes that a thorough

understanding of American cultural traits will allow insight in to our current practices and open a national debate on the future of our system.

Harford, Tim. The Undercover Economist. New York: Oxford University Press, 2006.

Harford describes the current health insurance crisis in detail. He asks “if the health insurance market doesn’t work well, the results will be excessively high premiums and a large number of uninsured people”. Harford concludes that this is the exact situation in the United States where markets do not do a good job of providing medical insurance to the citizens. A unique point in this chapter was the predicament of middle class health insurance clients: people of middle class who find insurance too expensive and cancel it, force the insurance companies to raise premiums even higher to stay in business. Harford also points out that insurance policies depend on mutual ignorance. If customers could predict the future insurance would be meaningless, the more we know the less we can insure. This information will help us critique the insurance system.

Mays, Nicholas and Justin Keen. “Will The Fudge On Equity Sustain The NHS Into The Next Millennium?” Biomedical Ethics. Eds. Thomas A Mappes and David DeGrazia. Boston: McGraw Hill, 2001. 673 – 677.

The authors focus on an overview of the British health care system that is both historical and forward looking. They explain the NHS and the basis of its founding in 1946. They provide a timeline since the late 60’s for issues such as spending, demand, drug and treatment costs, and other financially threatening scenarios. The authors conclude that there is a high level of British satisfaction with the NHS and changes should be approached cautiously.

Mitchell, Lawrence E. “Stacked Deck: A Story Of Selfishness In America.” America In Transition: Radical Perspectives. Ed. Gary L Francine. Philadelphia: Temple University Press, 1998.

Mitchell focuses on the question, how do we construct a society based on obligation that avoids domination? If health care is to be made a primary social good, what would you lose if you did not have healthcare? Mitchell feels that social complexity is based on vulnerability and not autonomy as previously stated by Rawls. Mitchell starts with vulnerability as the key issue. We are all vulnerable; he has an assumption of vulnerability applied nationally. We have a myth of individuality in this country but in actuality we live in communities but have responsibilities according to Mitchell.

Rawls, John. A Theory of Justice. Cambridge, MA: Belknap Press of Harvard University Press, 1971.

The purpose of this text is to define the structure and application of justice. Rawls proclaims that laws and institutions of health care no matter how efficient and well arranged must be reformed or abolished if they are unjust. Rawls defines justice as the maximization of autonomy. We will use this text to support the reform of our current health care system.

Richter, Gerd. “The German Health Care System.” Biomedical Ethics. Eds. Thomas A Mappes and David DeGrazia. Boston: McGraw Hill, 2001. 669 – 672.

This article addresses a descriptive overview of the German Health care system. The most distinctive features are the “sickness funds” and defects of the German system. The author provides detailed structure of the nonprofit organizations known as “sickness funds.” The defects of the system are at the forefront of the socialized medicine debate.

Sowell, Thomas. The Quest For Cosmic Justice. New York: Free Press, 1999

Sowell focuses on the juxtaposition of the principles of justice and equality. Sowell writes about the concepts and ideologies that have contributed to the idea of cosmic justice. Sowell asks these questions: What would a just distribution of this scarce resource look like? What is our moral

responsibility to do now? Sowell argues that Rawls and Mitchell will never be correct because healthcare should not be a primary social good but the means of attaining care should be fairer.

Starr, Paul. The Social Transformation of American Medicine. New York: Basic Books, 1982.

Starr addresses the economic obstacles, emergence of different market types, the ecology of medical practices, the professional and market autonomy issues, and effectiveness of health care from the early 1800s till the mid 1990s. He addresses almost all issues related to the formation maintenance and practice of health care since the beginning of American history. Starr clearly separates the contributing philosophies, which shaped the health care systems. He lends expertise to differentiate ideologies in historical context.

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⁷ O'Brien

⁸ O'Brien

⁹ O'Brien

HCOM Senior Capstone Digital Poster Spring 2007

Name:
Project Title:

Amy Krisch and Rachel Wall
America's Health Care Crisis

Concentration:

Practical and Professional Ethics and Pre Law

Abstract

Currently, in the United States, health care is a matter of great moral, social and political significance. A rising number of uninsured and underinsured are excluded from medical services, charged more for medical services and die because they do not receive or cannot afford timely care. There is a growing movement to overturn the current health care system. Should every citizen have a right to health care? What type of health care system is best- single-payer, socialized or market-based? What type of health care system can we, as a country, afford? In this paper we analyzed the historical origins and influences, which led to the development of our current market-based system. Our paper also examines the way the current health care systems function and explores the systems of Germany, Canada and Cuba as a way of providing a basis for thinking about health care reform in the United States. We hope to provide our readers with information that informs their deliberations about health care.

Project Context & Contribution

Our project is an attempt to provide new insight on the failures of the United States health care system. Our research does not just claim there are problems; we explore the historical basis for the development of the current system. Our paper aims to contribute a new approach the issue of reform with a guideline of ethical redistribution based on international models.

Relevant Links

<http://www.who.int/countries> - The World Health Organizations website gathers and tracks specific statistics on all recognized countries in order to promote education, awareness and for the medical community.

<http://www.canadian-healthcare.org/> - Created and managed by the Canadian Department of Health. Provides first hand information on the policies, laws, and regulations for the Canadian socialized health system.

<http://www.pnhp.org/> - The Physicians for National Health Program website provides feedback, support and publications by practicing and retired physicians in the United States about the Single Payer National Insurance proposal and progress.



“Single Payer”

Deutsch, B. "Single-Payer". Cartoon, Jan. 2004.

<http://www.cuivienien.org/blog/images/singlepayer10.jpg>

Research Questions

How many United States citizens lack health care? Why?

How is the money currently designated for health care actually used?

How do market based and universal health care plans compare? How do these two approaches shape the structure?

In what ways would a market-based reform of the system in the United States impact the distribution of health care?

Is it possible to ethically re-distribute health care?

Is it possible to integrate health care models such as market based and single payer? What are the advantages and disadvantages of such a compromise?

Key Findings

The best system is a system in which every person matters and their health needs are addressed. The purpose of this paper is to inform our readers of the current crisis, the system that created it and the possible alternatives. If health care reform is to be successful in the United States we must acknowledge the right to basic health care for all, the costs for goods and services must be controlled, prevention and wellness must be prioritized and that there is a social obligation to fund basic care

Our conclusion does not address issues such as racial disparities, gender bias, fraud, waste, abuse and corruption within the system, the public's expectation of services, the funding intended for the advancement of medical science or the number of other issues such as stem cell research, contraceptives, end of life issues, elective procedures, etc.

Evidence

Our research consists of:
Primary newspaper articles collected since January 2006. -- Textbooks and scholarly articles used in the curriculum for HCOM Ethics in the Professions SL: Biomedical Ethics. -- Voyager search engine from the CSUMB Library database to obtain books through normal check-out and inter-library loan. -- We have reviewed the medical policy, medical economics and medical care subject references available at the CSUMB Library. -- U.S. Government census results and statistics from official websites used as primary sources. -- Documentaries on various health care systems. -- Dr. John A. Berteaux, a scholar and professional expert on U.S. health care reform.

Project Format

Our Capstone Project is a 45-55 page in-depth research paper. We believe this form will allow us to fully examine all aspects of the issue. We have been researching and writing this paper for fourteen months.

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