Urban Law Annual ; Journal of Urban and Contemporary Law

Volume 46 *A Symposium on Health Care Reform—Perspectives in the 1990s*

January 1994

Health Care in America: In Perspective, in Reality

Leo van der Reis

Follow this and additional works at: https://openscholarship.wustl.edu/law_urbanlaw

Part of the Law Commons

Recommended Citation

Leo van der Reis, *Health Care in America: In Perspective, in Reality*, 46 Wash. U. J. Urb. & Contemp. L. 73 (1994)
Available at: https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

This Symposium is brought to you for free and open access by the Law School at Washington University Open Scholarship. It has been accepted for inclusion in Urban Law Annual ; Journal of Urban and Contemporary Law by an authorized administrator of Washington University Open Scholarship. For more information, please contact digital@wumail.wustl.edu.

ESSAY

HEALTH CARE IN AMERICA: IN PERSPECTIVE, IN REALITY

*LEO VAN DER REIS, M.D.**

INTRODUCTION

Health care reform in the United States is currently the subject of scrutiny and manipulation by various members of business, industry, and government.[1] Yet these efforts have merely formulated solutions that will not bring universal access and better

---

* M.D., University of Chicago. Director, Quincy Foundation for Medical Research Charitable Trust. In addition to being a practicing gastroenterologist, Dr. van der Reis has been engaged in research and has taught health care systems issues at various academic institutions.

1. *See, e.g.*, the Clinton health plan, H.R. 3600 & S. 1757, 103d Cong., 1st Sess. (1993); the Chafee/Thomas bill, H.R. 3704 & S. 1770, 103d Cong., 1st Sess. (1993) (requiring employers with less than 100 employees to participate in a purchasing cooperative, mandating individuals to have health insurance with a penalty for non-compliance, and eliminating pre-existing condition exclusions); the Cooper/Breaux bill, H.R. 3222 & S. 1579, 103d Cong., 1st Sess. (1993) (promoting a managed competition-type plan by encouraging the formation of health plan purchasing cooperatives to negotiate health plans for coverage on behalf of employers with fewer than 100 employees, establishing a basic benefits package, limiting the deductibility of health plans to the least expensive cost of the package, and encouraging the formation of accountable health plans); the Michel/Lott bill, H.R. 3080 & S. 1533, 103d Cong., 1st Sess. (1993) (implementing small group insurance reforms, expanding the Medicare program, and providing individuals with tax incentives to save for medical expenses through "medical IRAs"); the McDermott/Wellstone bill, H.R. 1200 & S. 491, 103d Cong., 1st Sess. (1993) (establishing a single-payer, Canadian-style government system of health care, replacing Medicare, Medicaid, and most private health insurance with a government-run system administered at the state level, and establishing a national health board to set a national health budget based on annual health costs); the Stark bill, H.R. 200, 103d Cong., 1st Sess. (1993) (establishing annual budgets based on prior year national health expenditures, rates for all personal health services, national standards for health insurance plans, a new federal program to provide health insurance to all children under age 19, and expanded benefits under Medicare and Medicaid); the Nickels/Stearns bill, H.R. 3698 & S. 1743, 103d Cong., 1st Sess. (1993) (establishing medical savings accounts).

Washington University Open Scholarship

health care to the American public. The solutions proposed retain those facets of the current system that are the cause of rapidly rising costs and reduced access to health care for those already insured. There is little or no provision for the members of our society who either are without coverage or whose coverage is limited. Good health care, like education, should be accessible to all. Much is at stake. Universal health care access is necessary for the United States to keep its economic and political leadership in an increasingly competitive world.[2]

Actors that have long controlled a myriad of health insurance programs in the United States, including employers, unions, physicians, and private insurance carriers, have elbowed into the political arena where a system for universal health care is being debated. Their interests are divergent and conflicting. Worse, none of the plans currently given priority realistically address the components which will produce a system of health care that is efficient and economically sound — a system in which medical practice retains the basic principles that have allowed it to excel, while simultaneously streamlining the administrative morass of redundant inefficiencies.

The present proposals under discussion in Washington, D.C. do not address genuine health care reform with all the necessary and attendant benefits. They are merely a mirage. As suggested in the French proverb, "the more things change the more they are the same." It is not changes in existing insurance programs that the American people need today, but rather complete reform that creates a system of health care accessible to all: a system that embodies the elements of *Egalité*, *Fraternité*, and *Liberté* — the slogan of a revolution that produced profound changes in France and a theory upon which we should base reform of the American health care system.

Reform of health care coverage in the United States must assure equality (*Egalité*) of access to all persons, without conditions or restrictions. Just as the United States provides its citizens military security, a national highway system, a postal service, and other essential components of a quality society, health care insurance should be provided. It should similarly be financed through income taxes. Access to a universal health plan, operated independently from the government, can be secured through an identification card, keyed into a computerized network designed to protect the individual.

---

2. *See* Carlo V. DiFlorio, Comment, *Access to Health Care: An Analysis of Legal Principle and Economic Feasibility*, 11 DICK. J. INT'L L., 139, 139 (1992) (noting that the United States is one of the only developed countries without universal health care).

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

To achieve *Fraternité*, a new system of health care coverage must include support from a nationwide group of health care providers. This system must become one in which more time and energy can be spent on the practice of medicine rather than on the administration of what by necessity is also a business. The system would also save billions of dollars through efficient administration. Programs such as Medicare[3] and Medicaid[4] would be rendered superfluous, and their elimination alone would result in tremendous savings.

To assure *Liberté*, the long-standing freedom to choose a doctor and hospital should be a basic element in a new system of health care coverage.

In spite of its shortcomings, the United States provides one of the best, if not *the* best, health care services available today. Shortcomings are due to factors that have no place in any medical care delivery system. These factors are caused primarily by an orientation toward making financial profits.

This profit orientation has not always been dominant. During the Middle Ages, health care services were performed by individuals and institutions whose primary goal was not profit, but rather the delivery of care.[5] In the United States, hospitals sponsored by religious orders have always played a vital role in the delivery of health care services.[6] Today, many health care facilities are sponsored by religious organizations, as well as other foundations whose primary purpose is to provide medical services regardless of profit.

Institutions and individuals who are engaged in providing health care services must be appropriately compensated for their services; but these institutions and individuals should not expect to make excessive profits above and beyond their normal operating expenses. Similarly, institutions and individuals should be reimbursed for capital expenditures in a manner that allows them to pay for necessary services. These investments should not be considered a potential source of profit beyond the basic return on investment. The American health care system could be operated in a vastly different, and far less expensive manner,

3. Social Security Amendments of 1965, Pub. L. No. 89-97, tit. I, 79 Stat. 286, 290 (1965) (codified as amended at 42 U.S.C. §§ 1395-1395ccc (1988 & Supp. IV 1992)).

4. Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343 (1965) (codified as amended at 42 U.S.C. §§ 1396-1396u (1988 & Supp. IV 1992)).

5. Robert S. Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237, 238-40 (1970) (describing history of charitable hospitals).

6. *Id.*; Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 866-68 (1980) (describing history of U.S. charitable hospitals).

Washington University Open Scholarship

if the *basic* health care delivery system were a not-for-profit system. Universal access to health care can be accomplished only if eligibility and financing are divorced.

In summary, the conditions that must be satisfied in order to implement a system of universal health care for the people of the United States are: (1) access to a basic package of health care services for all Americans irrespective of their economic or social status; (2) administrative streamlining that would reduce costs and reallocate more resources to medical care giving, while maintaining total expenditures to the current fourteen percent of the gross domestic product (GDP);[7] and (3) free choice of physician and hospital.

I. Foreign Programs

Frequently, the advantages of health care programs in other developed countries are touted as examples for the United States to follow.[8] Given the status of many foreign programs, it seems more useful to examine their mistakes.

In countries operating a national health care delivery system, the national government is directly involved in its administration. This results in heavy overhead expenses for top-heavy management and a thick bureaucracy. As a result, many of these systems are "broke." The beneficiaries of these systems, all of whom are theoretically eligible to receive services, do not have ready access. Rationing of services is the order of the day.

Canada, for example, adopted a single-payer health care model.[9] It is facing crippling blows to its health care system because of rampant abuse by those who hold health care cards.[10]

---

7. In 1991, national health expenditures represented 13.2% of GDP. Suzanne W. Letsch et al., *National Health Expenditures, 1991*, 14:2 Health Care Fin. Rev. 1, 1 (1993). Expenditures are expected to rise to 18.2% of GDP by 2000. Sally T. Burner et al., *National Health Expenditures Projections Through 2030*, 14:1 Health Care Fin. Rev. 1, 2 (1992).

8. *See generally* Hans-Martin Sass & Robert U. Massey eds., Health Care Systems in European and American Public Policy (1988) (describing various European health care systems).

9. *See generally* Robert G. Evans et al., *Controlling Health Expenditures: The Canadian Reality*, 320 New Eng. J. Med. 571, 571-74 (1989) (comparing American and Canadian data on expenditures and describing processes of control); John Holahan et al., *An American Approach to Health System Reform*, 265 JAMA 2537, 2537-38 (1991) (providing brief description of Canadian health care system); Edward Neuschler, Canadian Health Care: The Implications of Public Health Insurance 37-52 (1990) (criticizing Canadian system as ineffective in cost containment and accessibility).

10. *See* Clyde Farnsworth, *Americans Filching Free Health Care in Canada*, N.Y. Times, Dec. 20, 1993, at A1; Philip Mathias, *This Patient Needs Strong Medicine: Health Care Costs Now Menacing Other Social Goals Such as Affordable Housing & Education*, Fin. Post, Apr. 6, 1992, at S22.

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

Canadian health care cards only state the name, gender, and birth date of the entitled individual.[11] Forgery is on the rise, along with abuse by Americans and illegal immigrants, who share cards to receive treatment.[12] Consequently, certain provinces are financially strapped.[13] The Canadian government is considering new laws to relieve physicians of liability for breach of confidentiality to encourage the reporting of cases of fraud.[14] Without a sophisticated computerized infrastructure, fraud is easy to accomplish and difficult to detect.

New Zealand has one of the oldest national health insurance programs in the world.[15] But New Zealanders can no longer avail themselves of medical care in an egalitarian way. Instead, the government has introduced a program of deductibles. The deductibles are linked to the individual's income level,[16] and therefore provide a barrier for some who cannot afford visits to primary care physicians or prescription drugs.[17] Equally damaging has been the introduction of waiting lists and prioritization.[18] A twenty-five-year-old woman who is now eligible for in vitro fertilization, for example, must wait at least eight years before she will advance on the list and receive treatment.[19] Bypass surgery for coronary artery disease is not allowed for individuals over sixty years of age under the national health care service.[20] The resulting options are either to pay yourself

11. Farnsworth, *supra* note 10, at A1.

12. *Id.* The Ontario Health Minister estimated that American citizens made 600,000 improper medical claims from August 1992 to February 1993. *Id. See also* Marina Jimenez & Corrina Schuler, *Illegal Immigrants, An Estimated 50,000 of them call Canada Home*, OTTAWA CITIZEN, July 25, 1992, at B4 (noting that Canadian health care benefits provide powerful incentives for illegal immigration).

13. Mathias, *supra* note 10, at S22. The article reports Ontario Health Minister Frances Lankin as stating that Canada is "the highest per capita spender on health services in the world among jurisdictions with a national health service." *Id. See also* Peter Hadekel, *National Health Care System Suffering Death by a Thousand Cuts*, GAZETTE (Montreal), Mar. 26, 1993, at D6 (noting reductions in federal support to provinces as reducing health care standards).

14. *Id.*

15. *See generally* Heather Buchan, *New Zealand's Health Care Reforms*, 307 BRIT. MED. J. 635 (1993).

16. Lyndy Matthews, *Health Reforms in New Zealand*, 303 BRIT. MED. J. 327, 327 (1991).

17. Buchan, *supra* note 15, at 635.

18. *Id.*

19. Interview with Jill Nuthall, Public Health Association of New Zealand, Nov. 11, 1993.

20. *See generally* NAT'L ADVISORY COMM. ON CORE AND DISABILITY SUPPORT SERVICES, HOW WE DECIDE ON THE HEALTH AND DISABILITY SERVICES WE VALUE MOST 1 (1993); NAT'L ADVISORY COMM. ON CORE AND DISABILITY SUPPORT SERVICES, CORE SERVICES FOR 1994-1995, at 1 (1993).

Washington University Open Scholarship

or to forego treatment. This system creates a two-tier society.

American managed care gurus have long admired the system of the Netherlands,[21] but Dutch health care is also plagued by long waiting lists.[22] There are literally thousands of Dutch citizens waiting to undergo PCTA (angioplasty) or coronary bypass surgery.[23] In addition, the indications for such surgery have been "adjusted" so that no one who has had an acute myocardial infarction is eligible until at least three months after the heart attack.[24] The waiting period for an ophthalmology appointment averages six months.[25]

Some hospitals in Germany[26] and Sweden[27] close their operating rooms certain days of the week to all patients but those with dire emergencies. In France,[28] auxiliary hospital services such as personal laundry, television, and telephone services are often available only through private pay from outside sources. Hospitals often do not have the human and technical resources to deliver these services.

In the United Kingdom, the bureaucracy is bloated. A scandal erupted over the cost of providing automobiles for National Health Service (NHS) staff after the government revealed that the bill was £70 million in 1993.[29] This amount would have

---

21. *See generally* Paula Dwyer & Patrick Oster, *'We'll Need Hillary Clinton in Holland'*, BUS. WK., Nov. 11, 1993, at 72 (describing Dutch managed care health system).

22. Rene Steenhorst, *Vergoed operaties in buitenland ook*, DE TELEGRAAF, Mar. 23, 1994, at 6. *See generally* Bradford L. Kirkman-Leff & Wynand P.M.M. van de Ven, *Improving Efficiency in the Dutch Health Care System: Current Innovations and Future Options*, 13:1 HEALTH POL'Y 35 (1989).

23. *Wachtlijst hartpatienten groeit*, DE STEM, Mar. 11, 1994.

24. Personal communication with J. van Overveld, Dutch Health Association, Oct. 13, 1993.

25. Margot Poll, *Wachtlijsten: duur, verveland en gevaarlijk*, NRC-HANDELSBLAD, Mar. 28, 1994.

26. *See generally* Klaus-Dirk Henke, *Response*, 11 HEALTH CARE FIN. REV. 93 (1989 Supp.); John K. Iglehart, *Germany's Health Care System*, 324 NEW ENG. J. MED. 503, 503-08 (1991); Deborah A. Stone, *Health Care Cost Containment in West Germany*, 4 J. HEALTH POL., POL'Y & L. 176, 176-99 (1979).

27. *See generally* Bjorn Lindgren, *Response (The Swedish Health Care System)*, 11 HEALTH CARE FIN. REV. 66, 66-71 (Supp. 1989); MINISTRY OF HEALTH, MORE AND BETTER MEDICAL CARE FOR THE MONEY INVESTED 1 (1993); Richard B. Saltman & Casten von Otter, *Revitalizing Public Health Care Systems: A Proposal for Public Competition in Sweden*, 7 HEALTH POL'Y 21, 22-31 (1987).

28. Barbara Borst, *Doctors Struggle to Care for the Poor*, INTER PRESS SERV., Nov. 9, 1993. *See generally* Victor G. Rodwin & Simone Sandler, *Health Care Under French National Health Insurance*, 12 HEALTH AFF. 111, 120-125 (Supp. 1993).

29. Patrick Wintour, *NHS Care Spending a Scandal, Says Blunkett*, GUARDIAN, Dec. 8, 1993, at Home Page 2.

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

covered the cost of two new hospitals. In addition, government-owned hospitals throughout Britain are allowing patients of private general practitioners with separate budgets to obtain preferential treatment.[30] Cash pressures led to the preferential treatment because these practitioners have more money than health authorities.[31] This violates the government ban on a "two-speed" NHS, yet constitutes another major move toward a two-tier society.[32]

In countries such as Germany, the Netherlands, Norway, and Sweden, where programs are based on contractual relationships with physicians (and sometimes other providers), patients are limited in their choice of contracted physicians. In addition, certain geographic restraints may be placed on the subscribers and physicians resulting in limited access to medical resources.

The reasons for the breakdown of health care systems in other countries should be emphasized: (1) excessive and top-heavy administrative methods, including insurance agencies and health maintenance-type organizations (HMOs); (2) under-capitalization of technical resources; (3) limitations of human resources; and/or (4) elimination of the free choice of physician.

II. Eligibility

The only way to ensure universal access to medical care, irrespective of ability to pay, irrespective of employment, and irrespective of age, is the creation of a system in which eligibility rests solely on being part of American society.

Today there exist many impediments to access. Some are financial: the inability to pay the price of a policy, or a lack of employer-provided insurance. Other impediments are related to the refusal of insurance organizations to "cover" individuals because of family history, social behavior, environmental, or occupational factors. Whatever the reason, there are millions of "have-nots" in terms of health care insurance.[33]

Even within the "have-not" group there are major subgroups. It is not only those individuals with no medical insurance who

---

30. Craig R. Whitney, *British Health Service, Much Beloved But Inadequate, is Facing Changes*, N.Y. Times, June 9, 1991, at 16.

31. *Id.*

32. *Id.*

33. Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491, 2491 (1991) (citing estimate of 31-36 million uninsured Americans); *GAO Says Universal Access to Health Insurance "Achievable Goal"*, 93 Tax Notes Today 12-70 (Jan. 19, 1993) (estimating 34 million Americans without health insurance); Katharine R. Levit et al., *Americans' Health Insurance Coverage, 1980-91*, 14:1 Health Care Fin. Rev. 31, 33 (1992) (estimating 34.7 million uninsured Americans in 1991, or 14.4% of the U.S. population).

Washington University Open Scholarship

are denied access to prompt medical care. Major deductions (up to several thousand dollars) can be an effective block to medical services for many. Moreover, policy exclusions of treatment for mental illness, pregnancy, or pre-existing medical conditions are all too frequently effective barriers to gaining access to medical care.

Even individuals who have Medicare coverage may have limited access to health care if they cannot afford to pay the deductibles or other charges out of pocket. Physicians who routinely accept Medicare reimbursement for services as payment in full expose themselves to prosecution under the rules and regulations of Medicare.[34]

The right of the American people to have access to a basic package of health care insurance stands in stark contrast to the goal of making a profit from insurance. Access can be accomplished through the mechanism of "people's insurance." Coverage would be financed via the single channel of withholding on employee incomes and employer profits and administered via an independent organization. Congress would charter this organization and charge it with the responsibility to provide a basic package of health care to serve the American people. In this fashion, the economic, physical, and emotional well-being of the American people would be promoted while the impediments to access would be eliminated.

Just as all Americans have a right to a basic package of health care, those with excess disposable funds deserve the option to purchase extras. Insurers will be able to provide "excess" lines of coverage to accommodate this need.

III. The Role of Prevention

Citizens must not only have access to care, but access to preventive care. Measures for prevention are part of a properly functioning national health care system. These measures include vaccination against so-called childhood diseases such as German measles and mumps, as well as tetanus, influenza, and pneumococcal pneumonia. Other measures that have a preventive influence can be accomplished through social service programs and education; for example, the use of condoms, good personal hygiene, adequate housing, and sanitation.

Prevention also includes recognition and prompt treatment of diseases in their early stages rather than treatment for advanced diseases or the complications caused by delayed treatment. Un-

34. 42 U.S.C. § 1320a-7b (1988 & Supp. IV 1992) (defining criminal penalties). *See also* 42 U.S.C. § 1320a-7a (1988 & Supp. IV 1992) (defining civil monetary penalties).

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

fortunately, the current system does not recognize the importance of early diagnosis and treatment. Instead, most measures for health care reform have arisen under the guise of cost control and managed care, which in practice promote delay in diagnosis and treatment. Even among those who have health insurance, coverage may still require outlays of cash that cannot be met by the insured. The consequences of this policy are clear: prolonged illness and disability that subsequently result in high expenses that could be avoided with prompt diagnosis and treatment.

IV. Financing

Financing of American health care under the current system comes from a variety of sources. The federal government contributes through Medicare and other programs such as CHAMPUS.[35] State and local governments contribute in the form of services for the economically disadvantaged, disabled persons, and their own employees.[36] American business and industry support the health care delivery system by paying health insurance premiums for their employees, while additional contributions come from labor and fraternal organizations. The U.S. Department of Labor recently completed a federal survey on workers' health insurance spending: employers and employees spent $258.5 billion for workers' health insurance in 1992, and of this total amount, employers accounted for 86 percent.[37] Employers spent $221.4 billion for employee health benefits, or nearly six times as much as the $37.1 billion spent by employees.[38]

Except for those who receive medical insurance through a governmental agency, employees must purchase coverage either through employment benefits or personal funds. The unemployed and poor are left helpless. The current state of health care financing provides a sturdy foundation for the perpetuation of the two-tier system of "haves" and "have-nots."

35. Civilian Health and Medical Program of the Uniformed Services. CHAMPUS is a federally funded health insurance program for dependents of active duty and retired U.S. military personnel.

36. In 1991, state and local governments spent $86.5 billion on Medicaid, hospital subsidies, maternal and child health, vocational rehabilitation, public health activities, and other public and general assistance. They spent an additional $34.3 billion on employee insurance. In 1980, the expenditures were $26.3 billion and $8 billion, respectively. Cathy A. Cowan & Patricia A. McDonnell, *Business, Households, and Governments: Health Spending, 1991*, 14:3 Health Care Fin. Rev. 227, 228 (1993).

37. *Workers' Health Insurance Cost $258 Billion in '92, U.S. Says*, N.Y. Times, Aug. 10, 1993, at A8.

38. *Id.*

Washington University Open Scholarship

To eliminate this cleavage, health care financing must be revamped. If the government used existing channels to collect taxes on individual income and corporate profits, the financing mechanism would be in place. If the government eliminated the expensive and cumbersome multi-channel bureaucracies in existence today, major savings could be re-allocated for patient care. Together, these changes would provide the required financial support for universal coverage.

V. Administrative Infrastructure

The current administrative infrastructure of the United States' health care system is labyrinthine. There are thousands of organizations, each with their own bureaucratic structure. Currently, each insurance program, whether public or private, performs a multitude of steps to accumulate funds and disburse funds to providers. In the present era of sophisticated information systems, this is inefficient, unnecessary, and intensely expensive. The costs of collection, dispersing of funds, and other administrative steps are passed along to the policyholders along with a subsequent reduction of benefits. Approximately thirty percent of the health care dollar is spent on administration.[39] Consequently, only seventy percent of the health care dollar is directed to patient care. Approximately thirty-eight million Americans have no health care coverage whatsoever.[40]

The health care industry has attempted to contain costs under the guise of quality assurance, utilization review, and other schemes. Instead of containing costs, however, costs continue to rise. The continued increase in cost is due to an ever increasing medical bureaucracy exemplified by utilization review personnel; quality assurance clerks; administrative aides employed by managed care organizations; and physicians, nurses, and others in the employ of a multitude of health insurance organizations. All of these actors may involve cost control, but they do not

39. David U. Himmelstein & Steffie Woolhandler, *Cost Without Benefit: Administrative Waste in U.S. Health Care*, 314 New Eng. J. Med. 441, 442 (1986) (estimating that 1983 administrative costs totalled $77.7 billion, or 22% of all health care expenditures). *See generally* Robert G. Evans, *Tension, Compression & Shear: Directions, Stresses and Outcomes of Health Care Cost Control*, 15 J. Health Pol., Pol'y & L. 101, 112-14 (1990) (citing expenditures devoted to administration and bureaucracy in today's health care system).

40. *See supra* note 33. *See also* Lawrence D. Brown, *The Medically Uninsured: Problems, Policies and Politics*, 15 J. Health Pol., Pol'y & Law 413, 413-25 (1990) (providing analysis of uninsured demographics); Milt Freudenheim, *Insurance Premiums Rise 15% to 20%*, N.Y. Times, Sept. 15, 1993, at A9.

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

necessarily benefit the care and welfare of the patient. Instead, fees are cut, services are denied, and doctors are eliminated from various programs.

Furthermore, each service is subject to a number of expensive administrative gauntlets that must be cleared before services can be performed. This trend is increasing rapidly — and indeed has received a boost from the Clinton Administration proposals.

The damage that current attempts at cost control have done to the fabric of the American health care system is only beginning to show. Damage to the physical and environmental health of patients, and damage to established patient-doctor relationships, the basics for good medical care, can only be estimated. Due to the shifting emphasis toward the administrative, nonclinical side of health care, access to medical services decreases and quality of service is impaired. The shift toward a lower ratio of nurses to clerks must be reversed. The ratio of clinical versus nonclinical expenditures must increase.

In contrast to cost-control measures are various marketing initiatives, such as discounting[41] and disallowing,[42] that are prevalent in today's health care delivery system. Unlike many physicians, the administrators of health maintenance organizations (HMOs) and other insurance programs and alliances are keenly aware of discounting. HMOs make extensive use of discounting open to them in connection with contractual arrangements for medical services. In the course of discounting, payments for services often become so low that they do not even cover the provider's overhead expenses. Providers survive either by virtue of receipts from non-discounted services or by cutting services to a level below the standard to which the patient community has become accustomed. A number of providers have discontinued services because of extreme financial hardship caused by extensive discounting.

When viewed from the perspective of other countries where similar managed care measures have been enacted, the outlook is bleak. A much more efficient, ethically justifiable system must be put in place.

The implementation of a national computerized data system would alleviate these problems. Under this system, individuals

---

41. In the course of competitive bidding, and in order to absorb as many patients as possible, physicians, physicians' groups, and hospitals engage in reducing, or discounting, fees for services. This discounting is done in part in hopes that competition either will be absorbed or will disappear by going bankrupt.

42. Disallowing for services stems from the cost-oriented protocols of health insurers. By disallowing services or postponing approval of services, health insurers hope to cut expenses for clinical care. Disallowing, however, does not reduce administrative expenses.

Washington University Open Scholarship

would be identified by their Social Security numbers. Billing for services would become obsolete. In a system based on universal access, there would be no need to bill patients as done today.[43] Services would be tallied through the computer system and data would be accessible whenever appropriate or needed.

Another major benefit generated by a computerized national medical information system would be the veritable cornucopia of epidemiological data that would be available for research. The benefits that such a data bank would provide for the health of the nation in terms of better prevention, physical health, savings in lives and dollars, and reduction in the impact of environmental risks cannot be underestimated. The National Bureau for Health Statistics would receive such voluminous data that it would become an even more important part of the American health care system.

VI. Human Resources, Physician Services, & Allied Health Care Professionals

Most physicians prefer to practice medicine rather than spend their time on administrative matters.[44] Indeed, most physicians love to practice medicine.[45] The majority of nurses also enjoy their livelihood, as do other individuals involved in the delivery of health care services. Health care professionals should not be burdened by noxious problems such as excessive malpractice premiums and costly administrative procedures. These diversions lower medical care productivity and raise costs.[46]

---

43. Elimination of the accounting bureaucracy that bills patients would produce enormous savings. Canadian politicians have suggested implementing "user fees" to offset large health care deficits, but have been rebuffed: "The user-payer U.S. system is much more expensive than Canada's, mainly because of the big bureaucracy that is necessary to send out bills." Mathias, *supra* note 10, at S22.

44. Sara Fritz, *A Profession on the Edge: New Doctors Face a New Day*, L.A. TIMES, May 24, 1993, at A1 (interviewing medical school student professing a loathing for paperwork which interferes with practice of medicine). *See, e.g.*, Larry Lipman, *Survey: Doctors for Reform But Most Predict Bad Results*, ATLANTA CONST., Apr. 14, 1993, at A5; Elisabeth Rosenthal, *Clinton's Health Plan: Some Doctors See Peril, Others are Unworried*, N.Y. TIMES, Sept. 28, 1993, at B11.

45. Laurence C. Baker & Joel C. Cantor, *Physician Satisfaction Under Managed Care*, 12 HEALTH AFF. 258, 265-68 (1993) (citing survey results indicating physician satisfaction with their current practice ranging from 72% to 91% depending on employment category).

46. *See* Fritz, *supra* note 44, at A1 (citing *New England Journal of Medicine* poll in which 78% of physicians questioned had problems obtaining insurance reimbursement, and 53% complained that "insurers were reviewing their clinical decisions").

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

American physicians are well trained, having spent years of hard study and work to prepare themselves for the task at hand. They expect and should receive income commensurate with their abilities. Surveys have shown that today's physicians are inclined to accept a reasonable salary or compensation in full for professional services.[47]

Congress can implement a group practice system in which a national group of physicians attend to the medical services available under a basic health care package. Such a scheme would also make it possible to provide educational support for medical students who graduate with a significant debt burden.[48] A national group practice system would support these medical students (undoubtedly the vast majority) who would subsequently sign up with the group practice. This would allow for reallocation of physicians, both in terms of geography and specialization, and would rectify some of the maldistributions that exist today.

Allied health professionals are often employed and compensated by other health care professionals or other health care facilities on a for-profit basis. This applies, for example, to physical and occupational therapists, psychologists, and technicians. Allied health professionals who become part of a national group practice system would be compensated based on their expertise, training, and experience. But their compensation, if part of another health care facility, would only be reflected in the health care facility's reimbursement. As such, there would be no fee for services charged by these facilities for services rendered by allied health professionals. Budgetary allocations to health care facilities, whether they be hospitals, clinics, or private practices, would allow these facilities to continue performing the necessary functions of allied health professionals.

In a national health care group system, compensation of human resources and allocation of payment to health care facilities should take into consideration both qualitative and quantitative factors. Qualitative factors, such as health outcomes, would determine which physicians and which facilities will be most eagerly sought after by patients. In the current health care system, and even more so in the Clinton proposals and other managed care proposals, however, qualitative factors no longer play the typical role in selection for services. Rather, it is a price-driven race that determines who gets the largest piece of the health care pie.

---

47. *See* Rosenthal, *supra* note 44, at B11.

48. Fritz, *supra* note 44, at A1 (reporting that the Association of American Medical Colleges estimates that one-third of medical students will graduate owing more than $75,000).

Washington University Open Scholarship

VII. The Health Care System and Industry

Assuming that adequate health care is a right and not a privilege for every citizen of this nation, the multiple and divergent interests involved in health care reform must be confronted. These interests have fed at the trough of health care benefits to such an extent that employer costs have risen beyond reason. Benefits to employees have correspondingly decreased.

The current health care delivery system benefits a number of links in the chain of health care related organizations, all of which take a percentage of the total pie without providing any concrete benefits to the clinical care of the patient. In spite of the tremendous expenditures, there has been an overall decrease in health care services for those individuals who were the intended beneficiaries of costly expenditures. In effect, these funds have been deposited in the coffers of intermediaries whose primary interest is not the delivery of health care services.

This state of affairs has made American business and industry less profitable and competitive. The proposals currently before Congress will only compound and aggravate an already dismal situation.

The Quincy Model for Universal Health Care (Quincy Model)[49] prescribes an entirely different scenario, one which would benefit American industry and business. It would provide the American worker with more dollars for clinical services while concurrently reducing total costs. More importantly, it would eliminate the rapidly increasing costs of middlemen in the health care environment.

The Quincy Model adheres to the principle of simplicity. It would collect and disburse all funds via a single channel.[50] Instead of burdening businesses with major premium payments for health care services (thus raising the cost of the final product and decreasing competitiveness), the premium would be derived from a tax on corporate profits.[51] At present, American businesses pay health care premiums for employees and retirees as a production expense. For example, the Ford Motor Company's cost to build a single automobile includes $800 for health care

49. Quincy Found. for Medical Research Charitable Trust, Universal Health Care for the U.S.: A Model (1992) [hereinafter Quincy Model].

50. *Id.* at 6. The Quincy Model proposes the establishment of the American Health Care Trust (AHCT), a Congressionally-chartered autonomous corporation "responsible for disbursing funds for services and for allocating funds for capital investments." *Id.*

51. *Id.* at 7. The argument that cheating would adversely affect taxing corporate profits is moot. Any organization or individual can try to cheat in a variety of ways and it is ludicrous to suggest that this would be particularly applicable to the collection of taxes on profits.

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

premiums.[52] This expense is reflected in the price of the product, whether it be an automobile, loaf of bread, or any other product or service.

By using a single channel tax on profits, the provision of health care services is no longer a component of pre-sale cost. Because the production expenses are lower, the price of the product or service can be lower, leading to a more competitive product line, greater sales, and higher pre-tax profits. A percentage of the taxes on these increased profits will be allocated to the health care system. By spreading the burden throughout the American business community, the funding of the health care system becomes more egalitarian and more equitable.

Health insurers would also operate in an easier environment under the Quincy Model. At present, health insurers continue to be criticized because of their various discriminatory practices. If, on the other hand, health insurers are limited to low-risk "excess" coverage above and beyond the basic health care package provided through the universal health program, insurers will no longer have to resort to discriminatory practices.[53] Health insurers may well find that by covering a small number of low-risk individuals with the "excess" package, their net profit will be greater than the current profits of which they complain are too small.

The Quincy Model would also offer the information systems industry an opportunity to play a paramount role in the development of a computerized infrastructure for the American health care system.[54] A national single-payer system will provide major benefits to that industry. A joint venture between the American information technology and health care industries will require the production of large numbers of computers. The financing of this joint venture can be arranged so that the cost of implementation is spread over a number of years, precluding a vast initial outlay of capital. The development of a national system is currently technologically feasible.

VIII. Technical Resources

The American health care system is fortunate to have a wealth of sophisticated diagnostic and therapeutic resources. In some

---

52. Harold A. Poling, Ford Motor Company's Chief Executive Officer, Statement at the Clinton Economic Summit, Little Rock, Arkansas (Dec. 13, 1993); *see also* Robert Dodge, *Deficit Could Change Clinton's Economic Plans*, Dallas Morning News, Jan. 11, 1993, at 1A (citing Poling's estimate that $1000 of the cost of each new Ford vehicle is due to employee health care costs).

53. Quincy Model, *supra* note 49, at 11.

54. *Id.* at 7-8.

Washington University Open Scholarship

regions, there are far too many facilities for the given populations. Consequently, there is a tendency to over-utilize existing facilities because they must recover the investment costs.

Developing a system that cannot absorb the needs of the population is inappropriate. A comparison of European and American facilities is particularly telling: they don't have enough; we have too many. The maldistribution of technical resources has to be corrected on the basis of demographic and geographic need. A reallocation of these technical resources is feasible and can be accomplished with relative ease.

Furthermore, a health care system should allocate spending on additional technical resources based on well considered design rather than political agendas. This method would not interfere with private ownership of health care facilities.

The United States also enjoys a wealth of pharmaceutical resources. The free market approach produces a marvelous treasury of medications, but these compounds are often developed at a high cost. Meanwhile, politicians, reporters, and others decry the high cost of medications.[55] Pharmaceutical companies should receive a fair return on their investment, which in part is used to conduct further developmental pharmaceutical research.

The system must, however, take steps to make it possible for everyone who needs medication to receive it without undue hardship. This would be possible if a program for universal health care was in place. Medications would be available as required based on a computerized pharmaceutical infrastructure, which would contain all the necessary data reflecting up-to-date, medically accepted standards in therapy. The health care authority could also permit competitive bidding for those medications that have more than one manufacturer or equivalent.

If our colleagues in pharmacology could guarantee that a generic equivalent of a given medication provides the same therapeutic effect as the trade name, the generic drug could be dispensed under the basic health care package. If some patients prefer the trade name equivalent, they can pay the difference out of their own pocket. The savings generated from a generic dispensing system are significant by themselves, but they are insignificant when compared with the savings that would be derived from the transformation of the current maze-like infrastructure to the grid infrastructure of a national computerized administrative network.

55. *See, e.g.*, Milt Freudenheim, *Clinton's Health Plan — Drug Companies Feeling Pressure of Clinton's Plan to Keep Their Prices Down*, N.Y. TIMES, Sept. 30, 1993, at A22.

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

IX. Managed Care and Protocols

Insurance protocols restrict what can and cannot be done for a patient "insured" with a given insurance plan. In addition, the insurance programs are placing an increasingly heavy burden on physicians (primary care physicians, or so-called gate-keepers, as well as specialists) to "toe the 'party' line."[56] For example, one surgeon requested the insurer's permission to remove pancreatic gallstones (a cholecystectomy) from a morbidly obese patient at the same time the patient was undergoing a major gastric operation. The insurer denied coverage for the cholecystectomy because the patient was not presently symptomatic from the gallstones. The surgeon found that

> All my arguing with [the insurer] about the potential risks of leaving gallstones in a patient who was to undergo a major surgical procedure and the likelihood that the patient would come back on another occasion for a full hospitalization when the gallstones played up, was to no avail.[57]

Physicians failing to capitulate to insurer directives face expulsion from participation in reimbursement programs.[58]

These measures totally disregard differences in practice. Some physicians, for example, by virtue of reputation and expertise, may attract patients with complicated or more serious problems than the average physician. This factor cannot be considered in the current protocols produced by the insurance entities.

For a national health care system to operate appropriately, conditions such as protocols must be eliminated. Efficient operation of a national health care system can be accomplished if the system provides: (1) universal access; (2) free choice of physician; and (3) protocols which also include outcomes rather than simply being (ab)used for the purpose of rationing medical care.

Managed care[59] is widely touted as the health care cure in Congress,[60] and is the theoretical foundation for President Clinton's proposal.[61] Managed care is an invention of individuals

---

56. Basil R. Meyerowitz, *Nixing Denials*, BULL. 8 (San Mateo County Medical Association ed., Apr. 1994).

57. *Id.*

58. *Id.*

59. *See generally* Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24 (Supp. 1993); ALAIN C. ENTHOVEN, THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE (1988).

60. *See supra* note 1.

61. *See generally* JACKSON HOLE GROUP, THE 21ST CENTURY AMERICAN HEALTH SYSTEM (1991).

Washington University Open Scholarship

who have no interest in actual patient care. It is a system whereby insurance companies can control access to medical services and keep premiums as low as possible. This allows insurance companies to sell policies at competitive prices with ever-decreasing benefits.

Managed care is analogous to practicing medicine through remote control. Individuals without any responsibility for the outcome of the case decide what is and is not allowed through the use of protocols. Further, the expensive control mechanisms currently executed by physicians, nurses, and others who rely on very narrowly defined protocols are not designed to examine outcomes. In spite of protocols (the design of which can be faulty), not all human beings fall within the "norm;" rather, patients present a continual challenge to physicians to recognize the minute but telling signs and symptoms that lead physicians to decide on a certain course of action.

However, the use of protocols in a national computerized system would allow for consideration of indications in terms of diagnoses and therapy. It would also allow physicians to take outcomes into consideration. The computerized system would show interrelated data that would provide a much better perspective on the performance of physicians and other health care professionals. The outcome of the entire management of a patient's illness should determine whether or not the physician's judgment was correct.

A system using protocols that would not take away the physician's freedom to exercise judgment, such as a national computerized system, would be desirable. If the purpose of protocols is primarily cost reduction to benefit insurance company investors, as is the case today, protocols are not acceptable.

The cost-containment objectives of diagnosis-related groups (DRGs)[62] for the reimbursement to hospitals for services rendered also tends to skew the system. There is a tendency to pass the lost revenues under DRGs onto other programs.[63] American hospitals should be allowed to compete, but on the basis of

---

62. *See generally* James A. Morone & Andrew B. Dunham, *Slouching Towards National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263 (1985). The authors stated:

> [A] DRG system classifies each patient by his or her diagnosis into one of more than 400 categories, or diagnosis-related groups. Payment is based on a price set in advance for each group (DRG) rather than on the nature of the services provided or on the cost of treatment.

Id. at 263 n.3.

63. *Id.* at 267-69, 277-80 (describing the New Jersey and Medicare experiences with DRGs and the resulting cost-shifting phenomenon).

quality rather than the basis of cost alone. It is possible to allocate funds to hospitals based on past performance. Thereafter, based on further performance and innovative policies, some hospitals will flourish while others will wither on the vine. Such a system, however, will allow for a sufficient number of diagnostic and hospital facilities to provide all the services that the American people require.

CONCLUSION

President Clinton is sincere in trying to bring about equitable health care reform without widening the gap in a two-tier society. Unfortunately, the Clinton proposal emphasizes a managed care system that would aggravate and accelerate the decline of the American health care delivery system. Clinton's proposal accentuates control measures that in turn result in the growth of a costly, nonclinically productive bureaucracy. The trend toward a managed, restrictive, limited health care delivery system is already too evident in America today, and must be reversed. The focus should be on the delivery of services and a shift from nonproductive to clinically productive funding.

The American health care system should provide universal health care for the American people and should be operated on a not-for-profit principle. All funds should be devoted to the health care system, and there should be no payments of dividends to investors in various health insurance organizations. The system would operate properly, with an appropriate focus on service to the community.

The Quincy Model for Universal Health Care would result in a productive shift of priorities. It would accomplishes *egalité* through universal access to a basic package of health care services, including preventive care. Eligibility would be divorced from the ability to pay. The American people's right to medical care would be fulfilled, and prevents the two-tiered societies endemic to other nations' systems.

The Quincy Model also achieves *fraternité* through administrative streamlining by encompassing the entirety of the health care delivery system. It absorbs Medicare, Medicaid, and workers' compensation into the mainstream system.[64] It establishes a national group practice system to encourage proper distribution of human resources, and a computerized network to analyze outcomes. The model also provides an opportunity for health insurance companies to operate in an easier environment by limiting their participation to excess coverage.

64. QUINCY MODEL, *supra* note 49, at 11.

Washington University Open Scholarship

Finally, *liberté* is secured by ensuring patients the freedom to choose physicians and hospitals.[65] Both are important traditional assets of American medicine, assets that have already been damaged by, *inter alia*, managed care programs.

Fifty years have passed since President Harry Truman asked Congress for genuine health care reform.[66] Now is the time to present the American people with a health care reform program that guarantees equal and universal access for all.

---

65. *Id.* at 8.

66. In his January 1948 State of the Union address, President Truman supported pending legislation in Congress for health care reform. David Blumenthal, *Medicare: the Beginnings, in* DAVID BLUMENTHAL ET AL. EDS., RENEWING THE PROMISE: MEDICARE AND ITS REFORM 5 (1988).

https://openscholarship.wustl.edu/law_urbanlaw/vol46/iss1/7

ARTICLES

Washington University Open Scholarship