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SYMPOSIUM

SECURING HEALTH OR JUST HEALTH CARE? THE EFFECT OF THE HEALTH CARE SYSTEM ON THE HEALTH OF AMERICA

LAWRENCE O. GOSTIN*

If we just let the health care system continue to drift [in its present direction, Americans] will have less care, fewer choices and higher bills I want to make this very clear: If you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen, veto the legislation, and we'll come right back here and start all over again.

President Clinton's State of the Union Address, 1994¹

We know that America has the best health care system in the world; that people from every corner of the globe come here when they need the very best treatment; and that our goal should be to ensure that every American has access to this system. Of course, there are Americans with a sick child or sick

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1. President Bill Clinton, The State of the Union Address (Jan. 25, 1994), *in* WASH. POST, Jan. 26, 1994, at A12.

parent in real need, both in rural and urban America. Our country has health care problems, but no health care crisis.

Senator Robert Dole, Minority Leader²

INTRODUCTION

THE President's initiative on health care was expected to produce the most significant domestic social reform since the New Deal. As years of thinking and writing turned into a season of political debate, many believed the Congress would enact comprehensive health care reform. Yet, President Clinton's promise of universal coverage, like the promises of past presidents, was not to be realized.³

The media is replete with political explanations for the latest failure to enact comprehensive health care reform.⁴ Certainly, congressional bills proposing universal coverage, including the President's, were bedeviled by lobbying and political advertising motivated in substantial part by self-interest.⁵

2. Senate Minority Leader Robert J. Dole, Remarks Following President Clinton's State of the Union Address (Jan. 25, 1994), in WASH. POST, Jan. 26, 1994, at A13.

3. For a historical account of presidential proposals on health care reform see Ronald L. Numbers, *The Third Party: Health Insurance in America*, in SICKNESS AND HEALTH IN AMERICA: READINGS IN THE HISTORY OF MEDICINE AND PUBLIC HEALTH 233 (Judith Leavitt & Ronald Numbers eds., 2d ed. 1985); I.S. Falk, *Medical Care in the USA - 1932-1972*, 51 MILBANK QUART. 1 (1973); HOUSE COMM. ON ENERGY AND COMMERCE & SENATE SPECIAL COMM. ON AGING, 100TH CONG., 2D SESS., HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS 14-20 (Comm. Print 1988); COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, SUMMARY OF TESTIMONY AND QUESTIONS AND ANSWERS PRESENTED DURING NATIONAL HEALTH INSURANCE HEARINGS (1975); U.S. DEP'T OF HEALTH EDUCATION AND WELFARE, NATIONAL HEALTH INSURANCE PROPOSALS: PROVISIONS OF THE BILLS INTRODUCED IN THE 93RD CONGRESS AS OF JULY, 1974 (1974) (compiled by Saul Waldman).

4. See, e.g., Adam Clymer et al., *The Health Care Debate: What Went Wrong? How the Health Care Campaign Collapsed*, N.Y. TIMES, Aug. 29, 1994, at A1, A12; Karen Tumulty & Edwin Chen, *Blame for Health Plan's Collapse Falls Everywhere; Legislation: The Administration Task Force, Interest Groups, Congress and Public All Had a Hand in its Failure*, L.A. TIMES, Aug. 28, 1994, at A1.

5. The Center for Public Integrity estimated that health care interest groups spent over \$100 million from January 1993 to July 1994. *Health Reform Lobby Effort Called "Unprecedented"*, 20 HEALTH LEGIS. & REG. WKLY, July 27, 1994 [hereinafter *Unprecedented*], available in LEXIS, News Library, ZMH1 File. See Clifford Krauss, *Clinton's Health Plan: Interest Groups; Lobbyists of Every Stripe Turning to the Grass Roots on Health Care*, N.Y. TIMES, Sept. 24, 1993, at A20; Charles R. Babcock, *Health Interests and Lawmakers*, WASH. POST, Dec. 27, 1993, at A15; Ted Marmor & Jerry Mashaw, *Making Sense of the Health-Care Debate; Reform: The Promised Land May Be Out There, But the Vision is Distorted by Interests Who Do Not Want to Make the Journey*, L.A. TIMES, Feb. 10, 1994, at B7; James Risen, *Special Interests: Health Care Reform Sprouts Intense Grass-Roots Lobbying Outside the Beltway*, L.A. TIMES,

One illustration of self-interest was the Health Insurance Association of America's "Harry and Louise" commercials featuring a couple arguing over the "billion dollar bureaucracy" run by "tens of thousands of bureaucrats."⁶ However, in understanding the failure to enact health care reform, a dynamic exists that is more fundamental than private interest lobbying. The American people desire change as long as it does not cost them too much or affect them too much.⁷ One observer aptly concluded: "The problem wasn't Harry and Louise. The problem was us."⁸

Given the emphasis on financial costs and personal burdens, it is not surprising that political debate and academic discourse on health care reform focused so intensely on market structures and the economic effects on major segments of commercial society.⁹ Consequently, the linguistics of health care reform was market-oriented: managed competition, small and large insurance markets, employer mandates, tax credits and other market incentives. The overarching concern was the economic impact on the predominate players in the market: large employers, small businesses, insurers, and health care providers.

Manifestly, the effects of reform on the buying and selling of health care as a commodity, and its economic effects on American business (including the business of health care) are weighty concerns. It is not misguided, then, that so much focus was placed on the effects of health care reform on the economy. Yet, it is striking that so little attention was given to a still more fundamental value—the effect of the health care system on the health of individuals and populations.¹⁰ It is my thesis that promotion of the health

Aug. 1, 1994, at A5.

6. A Center for Public Integrity report on inside lobbying for health care reform singled out the "Harry and Louise" advertisement campaign for special attention. "We have never seen such an audacious display of using millions of dollars in advertising as a blunt instrument to bludgeon public policy in a certain direction." *Unprecedented*, *supra* note 5. See Kathleen Hall Jamieson, *When Harry Met Louise*, WASH. POST, Aug. 15, 1994, at A19.

7. Public opinion polls show that the goal of universal coverage is the most popular aspect of health system reform plans, with support ranging from 73% to 86%. Yet, there is almost no public consensus on how to achieve this goal. See Robert J. Blendon et al., *The American Public and the Critical Choices for Health System Reform*, 271 JAMA 1539, 1540 (1994).

8. Clymer, *supra* note 4, at A12 (quoting Drew Altman, President of the Henry J. Kaiser Family Foundation).

9. See, e.g., Gail R. Wilensky, *Health Reform: What Will it Take to Pass*, 13 HEALTH AFF. 179 (Spring (I) 1994); Mark A. Hall, *The Political Economics of Health Insurance Market Reform*, 11 HEALTH AFF. 108 (Summer 1992); Thomas Bodenheimer, *Private Insurance Reform in the 1990s: Can it Solve the Health Care Crisis?* 22 INT'L J. HEALTH SERVS. 197, 198-99 (1992).

10. Too often, health care reform proposals were criticized, and ultimately defeated, not because they would fail to improve access to health care, but on subsidiary issues that triggered special interests: large employers who were self-insured complained that they would become subject to government regulation; small employers complained that they would have to cover the

of the population is the most important objective of health care reform; that reasonable levels of resource allocation are warranted to achieve this purpose; and that the adverse effects on the economy, American business, and citizens are as high, or higher, under the status quo than they would be if government assured universal coverage for health care.

First, I analyze why the prevention of illness and promotion of health provide the leading justification for the government to act for the welfare of the population.¹¹ This analysis focuses principally on the foundational importance of health for human happiness, the exercise of rights and privileges, and the formation of family and social relationships. I explain why health care, although critically important, is not the only, nor even the most important, determinant of health. Most morbidity and mortality in the United States is attributable to environmental conditions, pathogens, and human behavior, which are all more responsive to population-based interventions than to medical treatment.¹²

Second, I explore the importance of universal access to health care in achieving the health of populations.¹³ The number of persons in the United States without health insurance or with inadequate insurance is extraordinarily high and increasing. Fundamentally inadequate access to health care services results in unnecessary sickness and death among large sectors of the population. Universal access to health care is justified not only by greater vitality among the currently uninsured, but also by social and economic benefits for all of society.

Third, I examine the importance of equitable access to health care.¹⁴ The distribution of health care services is highly inequitable, with persons in lower

cost of mandated health benefits by reducing wages or jobs and increasing prices; health insurers and medical organizations complained that consumers would lose a certain amount of choice in selecting physicians. While these, and a host of other issues, are serious concerns, it is clear that universal coverage is not cost free. Providing health care for everyone will entail a financial cost, the loss of some consumer choice, and some additional governmental regulation. Ultimately, the question must be put—what is the overarching objective of health care reform? This article presents a reasoned argument for the preeminence of public health and, if this argument is accepted, some tradeoffs have to be tolerated. Those who criticize all proposals for achieving universal coverage have the burden of stating what other value should take precedence, and make a reasoned case for their position. It is the conspicuous absence of such a justification by critics that concerns me, and which motivates this article.

11. See *infra* Part I.

12. This article is concerned primarily with the beneficial effects on health of public health measures and the delivery of health care. It could be cogently argued that there is an even more fundamental reality in understanding the causes of morbidity and mortality. Several prominent scholars have drawn attention to the powerful contribution of social conditions such as poverty to ill-health. See e.g., Jonathan S. Feinstein, *The Relationship Between Socioeconomic Status and Health: A Review of the Literature*, 71 MILBANK Q. 279 (1993).

13. See *infra* Part II.

14. See *infra* Part III.

socio-economic classes and ethnic minorities receiving substantially inferior care. Inequity in the distribution of health care services not only lowers the quality of life among those receiving inferior services, but also renders them poorer and more dependent on society. Inequitable access to health care extends the already wide gap between rich and poor in the United States, with worrying social implications.

Fourth, I inquire into the applicability of market theory and competition to health care services.¹⁵ Market theorists have the burden of demonstrating why a theory developed for consumer goods and services generally is applicable to health services that are essential to human flourishing. This burden is particularly strong when the empirical evidence shows that increased cost and inaccessibility have occurred in spite, and perhaps because, of competition in health care.

I. THE PREEMINENCE OF THE VALUE OF HEALTH

The Nation has within its power the ability to save many lives lost prematurely and needlessly The health of a people is measured by more than death rates. Good health comes from reducing unnecessary suffering, illness, and disability. It comes as well from an improved quality of life. Health is thus best measured by citizens' sense of well-being. The health of a Nation is measured by the extent to which the gains are accomplished for all the people.¹⁶

In this article, I make no claim to a right to health. The government cannot be expected to take responsibility for assuring the health of each member of the population, and the concept of a right to health is too broad to have legal meaning.¹⁷ Nor do I claim a constitutional right to any level of health care that a person may want.¹⁸ An unfettered constitutional right to health

15. See *infra* Part IV.

16. U.S. PUBLIC HEALTH SERVICE, U.S. DEPT OF HEALTH AND HUMAN SERVICES, *HEALTHY PEOPLE 2000: NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES 6* (1991) [hereinafter *HEALTHY PEOPLE 2000*].

17. Article 12 of the International Covenant of Economic, Social and Cultural Rights recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." International Covenant on Civil and Political Rights, Dec. 16, 1966, art. 12, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976), in RICHARD B. LILICH, *INTERNATIONAL HUMAN RIGHTS INSTRUMENTS: A COMPILATION OF TREATIES, AGREEMENTS AND DECLARATIONS OF ESPECIAL INTEREST TO THE UNITED STATES* (2d ed. 1990). However, even if the United States were to sign this covenant, there is no clear understanding of when the right to health is abrogated or how it would be enforced. See generally Audrey R. Chapman, *EXPLORING A HUMAN RIGHTS APPROACH TO HEALTH CARE REFORM* (1993).

18. For a thoughtful discussion of the ambiguity of "rights rhetoric" in health care, see Mark Kelman, *Health Care Rights: Distinct Claims, Distinct Justifications*, 3 *STAN. L. & POL'Y REV.* 90 (1991); Charles Fried, *Equality and Rights in Medical Care*, *THE HASTINGS CENTER REPORT*, Feb. 1976, at 6. See also Mary Ann Glendon, *RIGHTS TALK: THE IMPOVERISHMENT OF POLITI-*

care is not currently tenable.¹⁹ Further, the government could not be expected to respond to all demands and preferences for health care, irrespective of the cost or effectiveness.

My claim is simply that the prevention of disease or disability and the promotion of health, within reasonable resource constraints, provides the preeminent justification for the government to act for the welfare of society. In determining the allocation of resources in society, the transcending public value must be based upon improved health outcomes for the population, based upon objective measures of morbidity and mortality.²⁰ Despite marked increases in spending for personal medical services and advances in bio-medical technology, the decade 1980-90 showed little improvement in numerous objective health indicators such as maternal and child health, nutrition, sexually transmitted diseases, and occupational health and safety.²¹ Health promotion is measured not only by increased longevity or life extension. Rather, health promotion is measured by improvement in the quality of life, "compression" of morbidity and suffering, and extension of *active* or well-functioning life expectancy.²²

The very purpose of government is to attain through collective action human goods that individuals acting alone could not realistically achieve.²³ Chief among those human goods is the assurance of the conditions under which people can be healthy.²⁴ While the government cannot assure health, it can, within the reasonable limits of its resources, organize its activities in ways that best prevents illness and disability, and promotes health among its population.

CAL DISCOURSE (1991).

19. Some insightful commentators, however, do argue for a rights-based approach to health and welfare services. See Rand E. Rosenblatt, *The Courts, Health Care Reform, and the Reconstruction of American Social Legislation*, 18 J. HEALTH POL., POL'Y & L. 439 (1993); Kenneth R. Wing, *The Right to Health Care in the United States*, 2 ANNALS HEALTH L. 161 (1993).

20. See David C. Hadorn, *The Role of Public Values in Setting Health Care Priorities*, 32 SOC. SCI. & MED. 773 (1991).

21. HEALTHY PEOPLE 2000, *supra* note 16, at 4. The U.S. Department of Health, Education and Welfare set out 226 measurable objectives in 1980. See U.S. PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, PROMOTING HEALTH/PREVENTING DISEASE: OBJECTIVES FOR THE NATION (1980) [hereinafter PROMOTING HEALTH/PREVENTING DISEASE].

22. James F. Fries et al., *Health Promotion and the Compression of Morbidity*, THE LANCET, March 4, 1989, at 481, 481.

23. See generally MICHAEL WALZER, SPHERES OF JUSTICE: A DEFENSE OF PLURALISM AND EQUALITY 64-91 (1983).

24. "Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy." COMM. FOR THE STUDY OF THE FUTURE OF PUBLIC HEALTH, INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 19, 19 (1988) [hereinafter THE FUTURE OF PUBLIC HEALTH]. See *id.* at 36-38.

Health is basic to all human endeavor and, therefore, may be regarded as a foundational justification for government action.²⁵ Health is a necessary condition for just about all aspects of human endeavor. First, health is necessary for the pursuit of livelihood. Without a certain level of health, a person cannot train, develop skills, or employ existing qualifications and skills in income-producing activities. This not only impedes individuals in obtaining the basic necessities of life such as food, shelter and clothing, but reduces their capacity to contribute to the production of goods and services in society generally.

Second, a certain level of health is a necessary condition for the exercise of fundamental rights and privileges. Persons with severe physical or mental disabilities, as well as acute and chronic diseases, may not be able to exercise their rights to liberty (e.g., travel), autonomy (e.g., decision-making in personal and financial affairs), or the franchise.

Third, health is of overriding importance in achieving personal satisfaction, happiness, and better personal relationships. Human fulfillment is much more difficult to achieve when human beings experience unremitting pain and suffering, when they cannot meet their basic self-care needs, or when they lose mental and physical functioning. Nor can people as easily form close relationships with family and the community when they are dependent and have less physical and mental capacity to interact. Indeed, health is one of the more important aspects of personhood. A person's self dignity, self-identification, and status in society are often connected with that person's vitality and ability to function.²⁶

When illness or disease are preventable, or when pain and disability can be alleviated, the government's failure to act is conspicuous. Persons whose morbidity and suffering could have been prevented or lessened through reasonable government interventions may understandably claim that they count less, that their dignity is undermined by governmental inaction.

This is not to suggest that the government is solely or even predominantly responsible for the health of all individuals. Morbidity and mortality are caused by many factors that the government cannot control such as genetic predispositions to disease, high risk behavior such as driving recklessly, smoking, poor diet or a sedentary lifestyle.²⁷ Individuals bear a significant re-

25. See generally Dan W. Brock & Norman Daniels, *Ethical Foundations of the Clinton Administration's Proposed Health Care System*, 271 JAMA 1189 (1994); 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *SECURING ACCESS TO HEALTH CARE* 11-47 (1983); Charles J. Dougherty, *Ethical Values at Stake in Health Care Reform*, 268 JAMA 2409 (1992); NORMAN DANIELS, *JUST HEALTH CARE* (1985).

26. See Reinhard Priester, *A Values Framework for Health System Reform*, 11 HEALTH AFF. 84 (Spring 1992).

27. See J. Michael McGinnis & William H. Foege, *Actual Causes of Death in the United*

sponsibility for their own health. However, illness, injury and disease have become societal, as well as personal problems, and their solution is a collective as well as an individual responsibility. Through government, society can act collectively to help assure that individuals do not live in manifestly unhealthy environments; they are not knowingly exposed to pathogens; do not consume contaminated water or food; have the knowledge necessary to make informed health choices; and receive clinical prevention services such as health screenings and vaccinations and personal medical services when necessary to prevent or ameliorate pain, suffering, or physical and mental impairments.

A. *The Deterioration of the Public Health Infrastructure*

From this broad description of the role of government in the prevention and alleviation of morbidity and the promotion of health, it ought to be obvious that personal medical care, while critically important, is not the sole, nor necessarily even the most significant, determinant of the health of the population.²⁸ The United States records the principal causes of death in biological and clinical terms such as heart disease, cancer, cerebrovascular disease, and pulmonary disease.²⁹ However, approximately half of all deaths in the United States are attributable to social, environmental, and behavioral risks which are, in part, preventable.³⁰ The major external (non-genetic) causes of death are tobacco, diet and activity patterns, alcohol, microbial agents, toxic agents, and firearms.³¹

Prevention programs aimed at these major causes of morbidity and mortality are fraught with complexity and are not wholly effective. For example, behavioral change is not achieved solely by knowledge, but also by providing the means for altering behavior and motivating healthier choices.³² Yet, well designed prevention programs, rather than clinical treatment, are widely regar-

States, 270 JAMA 2207 (1993).

28. See ECONOMIC REPORT OF THE PRESIDENT, TRANSMITTED TO THE CONGRESS (Jan. 1993):

Americans buy health care to improve their health, but recent research suggests that the connection between health care and health is not a simple one. In fact, increases in life expectancy in developed countries are not strongly related to increases in the number of physicians or hospital beds per capita, nor are they primarily a consequence of increasing utilization of these services.

Id. at 120.

29. See McGinnis & Foegen, *supra* note 27, at 2207.

30. *Id.*

31. McGinnis & Foegen, *supra* note 27.

32. See Larry Gostin, *The Interconnected Epidemics of Drug Dependency and AIDS*, 26 HARV. C.R.-C.L. L. REV. 113, 121-31 (1991).

ded as more effective in achieving aggregate benefits for the population.³³ Most of the major achievements in the health of American people have been accomplished through broad public health campaigns.³⁴ Control of diseases, safe food and water, maternal and child health, reduction in smoking and other behavioral risks represent only some of the benefits of population-based public health programs.³⁵

Core public health functions that are, for the most part, undertaken by government outside of the traditional personal health care system include:³⁶ (i) public information and education campaigns to change risk behaviors such as tobacco use, abuse of alcohol and drugs, sexual activity that increases the risk of HIV infection and other sexually transmitted diseases, inadequate nutrition, and physical inactivity; (ii) protection of the environment, food, and water such as enforcement of standards related to air pollution, water contamination, exposure to high lead levels, handling and preparation of food, sewage and solid waste disposal, and radiation or radon exposure; (iii) disease surveillance and control, such as the identification, containment and treatment for community-wide health problems such as communicable and infectious diseases, and emerging health threats; and (iv) accountability and quality assurance, such as through regulation and certification of providers, clinics, and laboratories.³⁷

Public health prevention programs are also more cost effective than personal medical services.³⁸ Each dollar spent on prevention services is estimated to save several dollars in personal medical services and lost productivity.³⁹

33. See generally U.S. PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *HEALTHY PEOPLE: SURGEON GENERAL'S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION* (1979); *PROMOTING HEALTH/PREVENTING DISEASE*, *supra* note 21; *HEALTHY PEOPLE 2000*, *supra* note 16.

34. See *THE FUTURE OF PUBLIC HEALTH*, *supra* note 24, at 1.

35. *THE FUTURE OF PUBLIC HEALTH*, *supra* note 24, at 19-31.

36. THE WHITE HOUSE DOMESTIC POLICY COUNCIL, *THE PRESIDENT'S HEALTH SECURITY PLAN 162-65* (1993) [hereinafter *PRESIDENT'S HEALTH SECURITY PLAN*].

37. *Id.* Certainly, personal health care services contribute substantially to prevention such as through clinical testing (e.g. pap smears and mammograms) and individual counselling (e.g., HIV risk behavior). Other prevention responsibilities are undertaken jointly by the personal health care and the public health systems, such as childhood vaccinations and treatment for sexually transmitted disease, tuberculosis, or drug dependency.

38. See COMMISSION ON MONITORING ACCESS TO PERSONAL HEALTH CARE SERVICES, INSTITUTE OF MEDICINE, *ACCESS TO HEALTH CARE IN AMERICA 2* (Michael Millman ed., 1993) [hereinafter *ACCESS TO HEALTH CARE*] (noting that population-based strategies in such areas as the environment, pollutants, health education, occupational health, and injury control could potentially "save more lives and have a greater impact on quality of life than programs to extend health services.").

39. See REPORT OF THE U.S. PREVENTIVE SERVICES TASK FORCE, *GUIDE TO CLINICAL PREVENTIVE SERVICES: AN ASSESSMENT OF THE EFFECTIVENESS OF 169 INTERVENTIONS* xix (1989); Joycelyn Elders, *The Future of U.S. Public Health*, 269 *JAMA* 2293, 2293 (1993).

Many expensive injuries and diseases such as smoking-related lung cancer (\$29,000), spinal cord injury-induced quadriplegia (\$570,000), congenital rubella syndrome (\$354,000), liver transplant for alcoholic cirrhosis (\$250,000), and low birth weight babies (\$10,000) are preventable.⁴⁰ Expansion of public health prevention programs, then, are not only justified by personal and social benefits to the population, but also economic savings.

Despite the evidence of the beneficial effects of public health measures in preventing disease and disability, American society has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray. The public health infrastructure has deteriorated seriously.⁴¹ Federal, state, and local government public health activities are disorganized with no clear lines of responsibility and accountability, and little coordination of services have weak and unstable leadership with the best training and development of leaders reserved to medical specialties which offer far higher compensation and status; and are under-valued and misunderstood by politicians and the public.⁴² More importantly, health departments have deteriorating capacity to accomplish their goals. Surveillance, health statistics, health information networks, laboratories, and epidemiologic services are often fragmented and insufficient.⁴³

Society has similarly failed to allocate adequate resources to public health services.⁴⁴ Approximately \$900 billion dollars were spent on health care in 1993.⁴⁵ The preponderance of this expenditure was devoted to personal medical services for biological disease, with only a small fraction going to prevention of the root determinants of illness, disability and death.⁴⁶ The national investment in public health prevention is estimated at three percent of total health care spending.⁴⁷

40. HEALTHY PEOPLE 2000, *supra* note 16, at 5-6.

41. The public health infrastructure is broadly defined as the capacity of public health agencies to carry out their mission to promote and protect the public health and to perform their core functions with respect to this mission. William L. Roper et al., *Strengthening the Public Health System*, 107 PUB. HEALTH REPS. 609, 610 (1992); Josephine Gittler, *Controlling Resurgent Tuberculosis: Public Health Agencies, Public Policy and Law*, 19 J. HEALTH POL., POL'Y & L. 106, 132 (1994).

42. THE FUTURE OF PUBLIC HEALTH, *supra* note 24, at 31-32, 139; COMM. ON EMERGING MICROBIAL THREATS, INSTITUTE OF MEDICINE, MICROBIAL THREATS AND HEALTH IN THE UNITED STATES 138 (Joshua Lederberg & Robert E. Shope eds., 1992).

43. PRESIDENT'S HEALTH SECURITY PLAN, *supra* note 36, at 168-69 (1993); THE FUTURE OF PUBLIC HEALTH, *supra* note 24, at 19, 31-32.

44. See Elders, *supra* note 39, at 2293.

45. Sally T. Burner et al., *National Health Expenditures Projections Through 2030*, 11 HEALTH CARE FINANCE REV. 1, 1, 14, 20 (1992) (estimates).

46. McGinnis & Foege, *supra* note 27, at 2211.

47. Centers for Disease Control and Prevention, *Estimated National Spending on Prevention: United States, 1988*, 41 MORBID. & MORTAL. WKLY. REP. 529, 531 (1992).

The disconnect between the benefits of public health and attention to the problem is most evident in the voluminous academic discourse on health care reform. At a time when the nation is engaged in a great debate about the health of the public, there is a dearth of literature about deteriorating capacity to undertake effective population-based prevention services or the need to reinvent public health.⁴⁸

The public perception is that advancing biotechnology can dramatically reduce morbidity and premature mortality. Because of the belief in the efficacy of medical interventions and the obvious importance of treating existing disease, there is little commitment to public health prevention and even resistance to a reordering of national priorities.⁴⁹ Yet, if the value of achieving more favorable health outcomes for the greatest number of people is accepted, and if the strong evidence relating to cost effectiveness is understood, it will be necessary to focus more political and scholarly attention, and devote greater resources, to public health prevention.

II. THE IMPORTANCE OF UNIVERSAL ACCESS TO HEALTH CARE SERVICES

It is not necessary to demonstrate which is the more fundamental governmental activity—public health or personal medical services. What is important is that both are essential to the health of individuals and populations, and both systems are functioning badly. Consequently, an assessment of the inadequacies in the personal health care system shows many people receiving insufficient and inequitable access to medical services.

Most countries with advanced economies in the world concentrate their resources in one health insurance system that provides universal coverage to their populations.⁵⁰ The United States, however, provides a fragmented array of private and public programs that results in a substantial portion of the population without health insurance coverage or with highly inadequate coverage. The American public, while purporting to support universal coverage,⁵¹ appears highly ambivalent about whether health insurance is a social good, of which the costs should be borne collectively, or an economic enterprise that effectively should be governed by market forces.⁵²

48. But see Scott Burris, *Thoughts on the Law and the Public's Health*, 22 J. L., MED. & ETHICS 141 (1994) for such a discussion.

49. John B. McKinlay et al., *A Review of the Evidence Concerning the Impact of Medical Measures on Recent Mortality and Morbidity in the United States*, INT'L. J. HEALTH SERVS. 181, 181 (1989).

50. John K. Iglehart, *The American Health Care System*, 326 NEW ENG. J. MED. 962, 962 (1992).

51. See, e.g., Blendon, *supra* note 7, at 1540.

52. Iglehart, *supra* note 50, at 962.

Whatever vision of health care that the public may prefer, the system itself has become market-oriented.⁵³ By the nature of markets those who are unable or unwilling to pay the price of the commodity are left out. Not being included in a commodities market that trades in durable goods and services may be justified on economic grounds, but exclusion from the market in health care presents profoundly different considerations.

The number and profile of those who have been left out of the health insurance market, juxtaposed with current national health expenditures, is illuminating.⁵⁴ The United States spent approximately \$900 billion dollars on health care in 1993.⁵⁵ This represented approximately 14% of the nation's gross domestic product.⁵⁶ Health care expenditures are expected to reach \$1.7 trillion, between 16% and 18% of the gross domestic product, by the end of the decade if effective controls are not instituted.⁵⁷

Despite the inordinate national expenditures on health care, many Americans lack health insurance. At any given time during the last year, approximately 37 to 40 million people were without health insurance,⁵⁸ about 15-18% of all children and adults.⁵⁹ While different methods of counting the uninsured have allowed critics of health care reform to obfuscate its true dimensions, any dispassionate assessment reveals a considerable and enduring national problem.⁶⁰ Thus, while the census reported 33.5 million uninsured

53. See *supra* note 9 and accompanying text.

54. See generally Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857 (1986).

55. See Burner, *supra* note 45, at 1, 14, 20 (estimates).

56. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, UNDERSTANDING ESTIMATES OF NATIONAL HEALTH EXPENDITURES UNDER HEALTH REFORM I (1994) [hereinafter UNDERSTANDING ESTIMATES].

57. See *id.* at 1-3 (figures 1-2); Sally T. Sonnenfeld et al., *Projections of National Health Expenditures Through the Year 2000*, HEALTH CARE FINANCE REV., Fall 1991, at 1, 4, 22. See also CONGRESSIONAL BUDGET OFFICE, PROJECTIONS OF NATIONAL HEALTH EXPENDITURES 14 (1992) [hereinafter HEALTH EXPENDITURES] (table).

58. Sarah C. Snyder, *Who Are the Medically Uninsured in the United States?*, STAT. BULL. 20, 21 (1994) (38.9 million had no private or public health insurance during 1992); BNA, *Number of Uninsured Persons Increases to 36.6 million in 1991*, DAILY LABOR REP., Jan. 12, 1993, available in LEXIS, BNA Library, DLABRT File.

59. Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491, 2491 (1991).

60. See *How Many Americans Are Uninsured?*, 111 ARCHIVES OF OPHTHALMOLOGY 309, 309 (1993) (number of uninsured Americans varies with the method of surveying, giving a variety of numbers).

in 1992 based on monthly averages,⁶¹ others calculated that 50⁶² to 58 million⁶³ lacked health insurance for at least one month in that year.

It is suggested by market-oriented analysts that the alleged 37 million uninsured is a "big lie"⁶⁴ that "wilts under analysis."⁶⁵ These analysts claim that the chronically uninsured amount to fewer than 10 million, and that the number of uninsured persons could be reduced dramatically by introducing medical savings accounts.⁶⁶ These claims are based on data suggesting that the median spell length of persons without insurance is six months, and that 70% of all spells end within nine months.⁶⁷ However, a deeper examination of the pool of uninsured persons demonstrates the intransigence and severity of the problem. At least 28% of all uninsured spells last for more than one year, and 15-18% last more than two years. For over 20 million people in 1993, being without health insurance was not a temporary or transient phase in their lives.⁶⁸ Professor Swartz, the scholar who originally reported these insurance data, concludes that the point-in-time estimate of 37 million uninsured actually refers to at least 21 million long-term uninsured plus nearly 16 million with spells lasting less than one year.⁶⁹

61. Census figures on health insurance coverage status are based on monthly averages during the first quarter of the year. These data show that 37.4 million people were not covered by health insurance in 1992. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, 1993 STATISTICAL ABSTRACT OF THE UNITED STATES (113th ed. 1994) (table 165). See M. Eugene Moyer, *A Revised Look at the Number of Uninsured Americans*, 8 HEALTH AFF. 102 (Summer 1989) (number of uninsured dropped from 37 million to 31.1 million because of different questions asked on the 1988 census).

62. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, HEALTH INSURANCE COVERAGE: 1987-1990: SELECTED DATA FROM THE SURVEY OF INCOME AND PROGRAM PARTICIPATION 3 (1992); Friedman, *supra* note 59, at 2491 (noting that 63.6 million lacked insurance for at least one month from 1986 to 1988).

63. FAMILIES USA FOUNDATION, HALF OF US: FAMILIES PRICED OUT OF HEALTH PROTECTION 3 (1993).

64. Alan Reynolds, *Another Big Lie*, FORBES, June 22, 1992, at 241, 241 ("This year's big lie, echoed in numerous political speeches, is that 37 million Americans are completely uncovered by health insurance Instead of 37 million who were continuously without insurance, the long-term uninsured amounted to fewer than 10 million.").

65. *Medical Reform Simplified*, WALL ST. J., Oct. 18, 1993, at A16.

66. See *id.*

67. Katherine Swartz & Timothy McBride, *Spells with Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured*, 27 INQUIRY 281, 283 (1990).

68. Katherine Swartz, *Dynamics of People Without Health Insurance: Don't Let the Numbers Fool You*, 271 JAMA 64, 65 (1994) (estimating that at least 21 million people were uninsured all of 1992).

69. *Id.* Professor Timothy McBride presents new estimates of the chronically uninsured suggesting that of the 37 million uninsured at a point-in-time, between 20-28 million persons are chronically uninsured. Moreover, an analysis of the chronically uninsured shows that they are not much different than those who are uninsured for short periods. Timothy D. McBride, *Esti-*

Moreover, the trend in the number of uninsured persons, moreover, is rising.⁷⁰ The Pepper Commission expressed concern that the proportion of non-elderly persons without health insurance grew from 14.6% in 1979 to 17.5% in 1984, despite the economic recovery from the 1982 recession.⁷¹ Since the Pepper Commission reports, there has been a steady growth of the uninsured population. The three major surveys that have regularly monitored the size of the uninsured population have all shown an upward trend of about 24% over the past decade.⁷² Currently, nearly a quarter of the non-elderly population is estimated to be without health insurance.⁷³ Primary reasons for the rising number of the non-elderly uninsured persons are the decline in health coverage among individuals (and their families) working for small firms,⁷⁴ the increase in the overall poverty rate,⁷⁵ and the increase in the costs of medical services.⁷⁶

The uninsured are not the only persons in the population with difficulties in obtaining access to health care. An additional 20 million people are thought to be underinsured.⁷⁷ Under-insurance is a concept that is hard to define or quantify.⁷⁸ Persons may have inadequate access to health care because of insufficient overall insurance coverage (e.g., capitations on coverage based on limits on cost or hospital stays); exemptions for certain conditions (e.g., pre-existing coverage, waiting periods, mental health or childbirth services); or low reimbursement schedules for the payment of physicians, which results in denials of service (e.g., Medicaid patients in certain geographic areas or seeking certain kinds of services).⁷⁹

mating the Real Number of Chronically Uninsured, J. AM. HEALTH POL'Y, July-Aug. 1994, at 16.

70. See Katharine R. Levit et al., *Americans' Health Insurance Coverage, 1980-91*, HEALTH CARE FINANCE REV., Fall 1992, at 31.

71. THE PEPPER COMMISSION, U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE: A CALL FOR ACTION 1, 22 (1990) [hereinafter PEPPER COMMISSION].

72. See ACCESS TO HEALTH CARE, *supra* note 38, at 41.

73. Snyder, *supra* note 58, at 22.

74. Snyder, *supra* note 58, at 22.

75. See BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, 1991 STATISTICAL ABSTRACT OF THE UNITED STATES 462-66 (112th ed. 1991) (tables indicating that 13.5% poverty rate in 1990 is higher than at any time in the 1970's).

76. See 1993 STATISTICAL ABSTRACT OF THE UNITED STATES, *supra* note 61, at 114 (table 163) (index of medical prices from 1970 to 1992 showed an increase of over 145% in medical care).

77. A commonly accepted measure of inadequate coverage is health insurance that leaves the person covered at risk of spending more than 10% of income on health care in the event of a costly illness. See PEPPER COMMISSION, *supra* note 71, at 23.

78. See Pamela J. Farley, *Who Are the Underinsured?*, 63 MILBANK Q. 476, 477 (1985).

79. See Beth K. Yudkowsky et al., *Pediatrician Participation in Medicaid: 1978 to 1989*, 85 PEDIATRICS 567, 568 (1990); Friedman, *supra* note 59, at 2491; ACCESS TO HEALTH CARE, *supra* note 38, at 41-42; THE MEDICAID ACCESS STUDY GROUP, *Access of Medicaid Recipients*

The demographics of the uninsured population reveal the deep interconnections between the absence of health insurance and socio-economic status, race, and age. The uninsured population is disproportionately poor or near-poor, African-American or Hispanic, young, and unemployed.⁸⁰ In 1991, some 36% of the uninsured population were African-American (17%) or Hispanic (greater than 18%), representing approximately 30% of the African-American population, and over 40% of the Hispanic population; 24% of the uninsured population were under the age of 16 years, representing nearly 25% of the children and adolescents in America; 38% of the uninsured population were unemployed, and 55% had family incomes below \$10,000.⁸¹

While estimates of the number of persons who are uninsured vary, virtually every study on the use of medical services reports that lack of health insurance represents a major barrier to medical care. Compared with the insured, they have significantly fewer ambulatory visits, are less likely to have contact with a medical provider, and are more likely to receive their care in a hospital outpatient clinic or emergency department.⁸² The under-utilization of health services among the uninsured is particularly pronounced among those with chronic and serious illness, precisely those individuals who most need health care.⁸³ Children without health insurance are particularly at risk of not receiving care.⁸⁴ Further, the uninsured are significantly more likely to report needing but not receiving medical care, primarily for economic reasons.⁸⁵ Although poorer, the uninsured have higher out-of-pocket medical expenses than the rest of the population.⁸⁶

to *Outpatient Care*, 330 NEW ENG. J. MED. 1426 (1994) [hereinafter MEDICAID ACCESS STUDY GROUP].

80. Howard E. Freeman et al., Abstract, *Uninsured Working-age Adults: Characteristics and Consequences*, 265 JAMA 2474, 2474 (1991) (noting that "the uninsured are most likely to be poor or near poor, Hispanic, young, unmarried, and unemployed.").

81. The percentages of individuals with the stated personal characteristics who were uninsured in 1992 are calculated from data provided in the 1993 STATISTICAL ABSTRACT OF THE UNITED STATES, *supra* note 61, at 118 (tables 165, 167). Percentages of individuals who are uninsured within their own racial, age, or economic group are contained in Friedman, *supra* note 59, at 2491-92.

82. See Freeman, *supra* note 80, at 2475 (differences in health status do not account for these findings); Stephen H. Long & M. Susan Marquis, *The Uninsured 'Access Gap' and the Cost of Universal Coverage*, 13 HEALTH AFF. 211, 214-16 (Spring (II) 1994). See also ACCESS TO HEALTH CARE, *supra* note 38, at 40-42 (1993).

83. See Chris Hafner-Eaton, *Physician Utilization Disparities Between the Uninsured and Insured Comparisons of the Chronically Ill, Acutely Ill, and Well Nonelderly Populations*, 260 JAMA 787, 791 (1993).

84. See Jeffrey J. Stoddard et al., *Health Insurance Status and Ambulatory Care for Children*, 330 NEW ENG. J. MED. 1421, 1422-24 (1994).

85. *Id.*

86. See generally JOSEPH P. NEWHOUSE & THE INSURANCE EXPERIMENT GROUP, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 183-243 (1993).

Financial barriers to health care, then, may restrict access either by impeding the person's ability to pay for services or by discouraging health care providers from treating patients with limited means. Lack of health insurance and other financial barriers certainly are not the only reason for inadequate access to health care. Nor would the issuance of health insurance to every American assure full access to services.

Many non-financial barriers are also present, and include structural, personal, and cultural impediments.⁸⁷ Structural barriers are impediments to access related to the number, type, concentration, location, or organization of health care providers. Access to health care can be significantly impeded by geographic isolation (e.g., the person in need lives in an area with few general practitioners or particular specialists such as obstetricians);⁸⁸ an insufficient number of practitioners willing or able to treat certain sub-groups in the population (e.g., unwillingness to treat immigrants or Medicaid patients in inner cities or migrant workers in farming areas);⁸⁹ and inadequate coordination of services (e.g., little cooperation between the health and public health system in the treatment of tuberculosis, drug abuse, or sexually transmitted disease).

Personal and cultural barriers may inhibit people who need medical attention from seeking it or, once they obtain care, from completing a course of prescribed treatment. Women and minority racial, religious, or ethnic groups may be impeded in their access to health care by real or perceived discrimination, antipathy, or insensitivity of providers. Patients who speak different languages or have different cultural expectations of health care may similarly be discouraged from seeking or continuing medical services.

87. The classification of financial, structural, personal and cultural barriers to health care is taken from ACCESS TO HEALTH CARE, *supra* note 38, at 39-44. See Eli Ginzberg & Miriam Ostow, *Beyond Universal Health Insurance to Effective Health Care*, 265 JAMA 2559 (1991). See also PEPPER COMMISSION, *supra* note 71, at 42-44.

88. One study found a ten-fold or greater differential in the proportion of physicians to population between more affluent areas and low-income, minority neighborhoods. Eli Ginzberg, *Parallels, Differences, and Prospects*, in CHANGING U.S. HEALTH CARE: A STUDY OF FOUR METROPOLITAN AREAS 200, 200 (Eli Ginzberg et al. eds., 1992). Recently, the General Accounting Office found that federal government programs designed to improve the supply and distribution of health care providers in under-served areas had not affected significantly the supply, distribution, or minority distribution of health professionals during the last ten years. BNA, *Programs Have Not Improved Access, Numbers of Minorities*, GAO Reports, BNA HEALTH CARE DAILY, July 15, 1994 (citing GENERAL ACCOUNTING OFFICE, HEALTH PROFESSIONS EDUCATION (GAO/HEHS No. 94-164, 1994)), available in LEXIS, BNA Library, BNAHCD File.

89. Faced with rising Medicaid costs, many states have limited the number of physician visits, days of hospitalization, and the number of prescriptions for which they provide reimbursement. Reimbursement rates for physician visits and payment for hospital care are set low so that a significant number of health care providers avoid accepting Medicaid patients or limit the number of Medicaid recipients treated. See Ginzberg & Ostow, *supra* note 87, at 2559.

There is certainly an inter-connectedness to each of the primary barriers to access—financial, structural, personal and cultural. It is clear, however, that without dismantling financial barriers, access to health care will continue to be highly inadequate; the Institute of Medicine recently “reaffirmed that lack of health care coverage is, to a great extent, a good proxy for access.”⁹⁰

It is commonly believed that patients without health insurance are not so much denied access, but are diverted to emergency rooms and other public clinics for their care. It is, therefore, important to inquire whether the absence of insurance leads to delayed or insufficient access of such seriousness that it actually affects health outcomes. The data show that lack of access is closely associated not only with under-utilization of services but, more importantly, with poorer health outcomes.⁹¹ Although health insurance coverage is not the sole determinant of health status, it is a key factor. Persons without health insurance typically present an emergency room or clinic with disease of greater severity and duration,⁹² and the uninsured have significantly higher morbidity and mortality than insured persons of similar socio-economic status.⁹³ Along a wide continuum of health measures ranging from physical health, mental health and dental health to the risk of dying, persons without insurance fare worst.⁹⁴ Further, obtaining insurance, as Medicaid data have demonstrated, is an important factor in improved health.⁹⁵

The widely shared sentiments expressed by Senator Dole in the introduction to this article are that the American health care system is the best in the world, and that it is not in crisis.⁹⁶ The question arises, what kind of evidence would an objective observer seek to evaluate the quality and efficacy of a health care system?⁹⁷ If technical standards in diagnosis and treatment, excellence in professional training, and standards of specialist care were to be

90. ACCESS TO HEALTH CARE, *supra* note 38, at 17.

91. *Id.* at 3 (indicators that measure health outcomes suggest that low income persons with no health insurance experience profoundly different health outcomes).

92. See ACCESS TO HEALTH CARE, *supra* note 38, at 40; Emily Friedman, *Hospital Uncompensated Care: Crisis?*, 262 JAMA 2975 (1989).

93. See Jack Hadley et al., *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome*, 265 JAMA 374, 374 (1991).

94. See JOSEPH P. NEWHOUSE AND THE INSURANCE EXPERIMENT GROUP, *FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT* 183-243 (1993).

95. See EMILY FRIEDMAN, *THE PROBLEMS AND PROMISES OF MEDICAID* 31 (1977); Emily Friedman, *Medicare and Medicaid at 25*, HOSPITALS, Aug. 5, 1990, at 38, 46; Joyce M. Piper et al., *Effects of Medicaid Eligibility Expansion on Prenatal Care and Pregnancy Outcome in Tennessee*, 264 JAMA 2219, 2219 (1990).

96. See PEPPER COMMISSION, *supra* note 71, at 1 (“Our health care system still inspires awe—and rightly so. Americans should be proud of a system that can provide the best care in the world.”).

97. Victor R. Fuchs, *The Best Health Care System in the World?*, 268 JAMA 916, 916 (1992).

regarded as necessary and sufficient evaluative criteria, the United States could well lay claim to one of the finest health care systems in the world. However, the evaluation of a "system" necessitates a systemic approach which requires, first, consideration of the purposes of health care and, second, objective measures of the achievement of those purposes for the population as a whole.

I will assume the acceptance of my previously argued point that the principal purpose of a health care system is to prevent disease, injury, disability, and premature death for the whole population.⁹⁸ If "health" were regarded as the foremost objective of the system, then evaluative criteria would focus on health outcomes and health status. Unfortunately, there are no fully adequate indicators for monitoring the health of the population (or sub-populations) over time similar to national economic indicators—e.g., the unemployment rate, new housing starts, and the inflation rate.⁹⁹ However, the U.S. Department of Health and Human Services¹⁰⁰ and the Institute of Medicine¹⁰¹ have recommended objective measures that relate, *inter alia*, to successful birth outcomes; reducing vaccine preventable and other communicable diseases; early detection of treatable diseases; reducing the effects of chronic diseases; reducing morbidity and pain; and prolonging life.¹⁰²

While these detailed assessment standards have yet to be implemented, the United States ranks below average among economically developed countries on currently used measures such as infant mortality and low birth weight babies,¹⁰³ life expectancy,¹⁰⁴ and years of healthy life as a proportion of life expectancy.¹⁰⁵ Indeed, on the two most commonly used health measures—infant mortality and life expectancy—the United States has the worst performance when compared with other countries in North America and Europe (United Kingdom, Japan, Germany, Sweden, and Canada).¹⁰⁶ It may be argued that infant mortality and life expectancy are inaccurate and crude

98. See generally *supra* Part I.

99. See ACCESS TO HEALTH CARE, *supra* note 38, at 2 (mission of the IOM study is to propose national health indicators).

100. HEALTHY PEOPLE 2000, *supra* note 16, at 43-51.

101. ACCESS TO HEALTH CARE, *supra* note 38, at 5-18.

102. See generally Wendy K. Mariner, *Outcomes Assessment in Health Care Reform: Promise and Limitations*, 20 AM. J. L. & MED. 37 (1994).

103. See HEALTHY PEOPLE 2000, *supra* note 16, at 9.

104. Fuchs, *supra* note 97, at 916; George J. Schieber et al., *Health Care Systems in Twenty-Four Countries*, 10 HEALTH AFF. 22, 36-37 (Fall 1991).

105. HEALTHY PEOPLE 2000, *supra* note 16, at 45. See also Barbara Starfield, *Primary Care and Health: A Cross-National Comparison*, 266 JAMA 2268, 2270 (1991).

106. See generally ORGANIZATION FOR ECONOMIC AND COMMUNITY DEVELOPMENT, HEALTH DATA: COMPARATIVE ANALYSIS OF HEALTH CARE SYSTEMS (1991) [hereinafter COMPARATIVE ANALYSIS]; William C. Hsiao, *Comparing Health Care Systems: What Nations Can Learn from One Another*, 17 J. HEALTH POL., POL'Y & L. 613, 626-29 (1992).

measurements because health care is only one of many factors (e.g., nutrition, sanitation, housing, lifestyles) that effect these health status indices. While this argument has merit, health systems, as previously explained, can redistribute resources to focus more on prevention and public health services. Governments have a choice as to how to allocate scarce resources. In making that choice, services that best assure longevity among the population deserve a high priority.

Health systems are not only designed to extend life, but also to improve the quality of life,¹⁰⁷ relieve pain and suffering, and provide service and comfort.¹⁰⁸ Access to health care is a possible measure for these variables. Utilization rates, based on the number of visits to the doctor and the time spent during a visit, also show the United States to be last among these six developed countries.¹⁰⁹

Those who reject the view that health is the foremost objective of a health care system may instead prefer to focus attention to the finance system, administrative efficiency, or a favorable cost-benefit ratio.¹¹⁰ Health care is only one of many possible goods that government can provide. It is, therefore, not unreasonable to suggest that if health care could be provided more efficiently and less expensively, government could spend on other worthwhile social programs such as in housing, poverty, hunger, or education.

As explained previously, the expenditure on health care in the United States represents approximately 14% of the nation's gross domestic product.¹¹¹ Health care expenditures are expected to reach \$1.7 trillion, between sixteen and eighteen percent of the gross domestic product, by the end of the decade if effective controls are not instituted.¹¹² These figures stand in stark contrast to the percentage of the gross national product (GNP) that is devoted to health care in countries that offer their citizens virtually universal health

107. It is important to emphasize, however, that quality of life is highly subjective, and that individuals with disabilities can experience rich, rewarding lives. See Thomas M. Gill & Alvin R. Feinstein, *A Critical Appraisal of the Quality of Quality-of-Life Measurements*, 272 JAMA 619, 619, 624 (1994); Gordon H. Guyatt & Deborah J. Cook, *Health Status, Quality of Life, and the Individual*, 272 JAMA 630, 630 (1994).

108. See Naoki Ikegami, *Best Medical Practice: The Case of Japan*, 4 INT'L. J. HEALTH PLAN. MGMT. 181, 183-84 (1989).

109. See generally COMPARATIVE ANALYSIS, *supra* note 106; Hsiao, *supra* note 106, at 629-33.

110. One might argue that another test of the success of a health care system is the satisfaction of the population with that system. In the 6 country comparison undertaken in the text, the U.S. has the lowest satisfaction rating (10%), while Germany (41%) and Canada (56%) have the highest. Robert Blendon et al., *Satisfaction with Health Care Systems in Ten Nations*, 9 HEALTH AFF. 186, 188 (Summer 1990).

111. UNDERSTANDING ESTIMATES, *supra* note 56, at 1.

112. *Id.* at 1-3 (figures 1-2); Sally T. Sonnenfeld, *supra* note 57 at 1, 4, 22. See also HEALTH EXPENDITURES, *supra* note 57, at 14 (table).

coverage such as Canada, Germany, Great Britain, and Japan; these countries devote from 5.8% to 8.7% of their GNP to health care.¹¹³ In 1990, while the United Kingdom, Japan, and Germany spent between \$909 and \$1,287 on each person for health care, the United States spent \$2,566,¹¹⁴ for every \$1 per capita spent in England, the United States spends \$3 per capita.¹¹⁵ The high per capita expenditures on health care in the United States relative to other countries is not all spent on personal care services. It is estimated that 19% to 24% of health care expenditures goes toward administrative expenses, including those of the nation's insurance companies.¹¹⁶

In summary, whether the U.S. health care system is measured in terms of infant mortality or life expectancy, utilization rates, or cost effectiveness, it appears to lag well behind other developed countries in North America and Europe.

III. INEQUITABLE ACCESS TO HEALTH CARE

There is another perspective on how to measure the quality of a health care system. All else held constant, it is possible to argue that if health care resources are distributed equitably, the system provides consistent and fair benefits for all citizens. Some may even be willing to sacrifice certain benefits of health care to achieve greater equity. If a society does very well in health outcomes for some of its citizens, say those who are in higher socio-economic classes and within majority racial populations, and others do very poorly, is that society worth emulating? Under Rawlsian theory, if individuals could not pre-determine whether they would be born into a favored or the disfavored class, most people would choose to be in a country that provides roughly equal access to health care for all classes.¹¹⁷ Professor Fuchs suggests: "The fact that most countries provide universal health insurance while one in seven Americans is uninsured denies the United States a favorable ranking from this perspective."¹¹⁸

A. Scrutiny of the "Equity" Principle

Before examining the substantial disparities in access to health care and health status among various classes in the United States, it is necessary to ask two interrelated questions: what ethical values support the claim of equity in the distribution of health services, and what exactly is the equity claim being

113. Schieber, *supra* note 104, at 22, 24. See Timothy S. Jost & Sandra J. Tanenbaum, *Selling Cost Containment*, 19 AM. J. L. & MED. 95, 96-97 (1993).

114. Hsiao, *supra* note 106, at 626-27.

115. Fuchs, *supra* note 97, at 917.

116. Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 NEW ENG. J. MED. 1253, 1255-56 (1991).

117. See JOHN RAWLS, A THEORY OF JUSTICE 95-100 (1971).

118. Fuchs, *supra* note 97, at 917.

made? To many, it is not intuitively obvious that equity is a principle that deserves general recognition in society. Americans are prepared to tolerate significant and pervasive inequalities in wealth and in the distribution of most social goods.¹¹⁹ A theory of equity in health care must provide an account of why health care deserves special treatment, unless the advocate is prepared to defend a considerably broader view of distributive justice for all goods and services.¹²⁰

One theory of equity in health care, examined in Part I of this article, relies on the special importance of health care in providing a necessary condition for the fulfillment of human opportunity.¹²¹ Professor Daniels observes that pain and disability, limitation of function, and premature loss of life all restrict human opportunities.¹²² If it is accepted that a certain level of health services is a precondition to affording human beings reasonable life opportunities, then some equitable access to those services is warranted.

Government is prepared to provide a public education to all children of school age. Access to education is presumably justified by the importance of education in furnishing fair opportunities for all children, irrespective of their social or economic class. Like education, a certain level of health care is essential to a person's ability to pursue life's opportunities on some roughly equitable basis.¹²³ Health care, at least in some fundamental ways, is as important to equal opportunity as education.¹²⁴ While health care does not provide opportunities by facilitating basic knowledge and skill, it does so by enabling the person to function mentally and physically in the application of that knowledge and skill.¹²⁵

More equitable access to health care is supported by collective, as well as individual goods. Health care does not only enable individuals to gain life opportunities for themselves, it also allows individuals to contribute to society.

119. See Ronald Bayer, *Introduction to IN SEARCH OF EQUITY: HEALTH NEEDS AND THE HEALTH CARE SYSTEM* ix (Ronald Bayer et al. eds., 1983).

120. Amy Gutmann, *For and Against Equal Access to Health Care*, 59 *MILBANK Q.* 542, 546 (1981).

121. See generally *supra* Part I.

122. See generally Norman Daniels, *Health-Care Needs and Distributive Justice*, 10 *PHIL. & PUB. AFF.* 146 (1981); Norman Daniels, *Health Care Needs and Distributive Justice*, in *IN SEARCH OF EQUITY: HEALTH NEEDS AND THE HEALTH CARE SYSTEM* 1 (Ronald Bayer et al. eds., 1983); NORMAN DANIELS, *JUST HEALTH CARE* (1985).

123. See generally RAWLS, *supra* note 117.

124. See Dan W. Brock & Norman Daniels, *Ethical Foundations of the Clinton Administration's Proposed Health Care System*, 271 *JAMA* 1189, 1191 (1994).

125. Other theories of justice rely on the value of equal respect among people, and also might provide a justification for equity in health care. John Rawls argues that without self-respect "nothing may seem worth doing, or if some things have value for us, we lack the will to strive for them Therefore the parties in the original position would wish to avoid at almost any cost the social conditions that undermine self-respect." RAWLS, *supra* note 117, at 440.

A healthy population, like an educated population, is much more likely to be socially and economically productive, and less dependent. A multi-tiered system of health care, in which those in the lower tiers receive clearly inferior and lower-quality services, perpetuates inequalities among individuals and groups. These inequalities occur not only in attaining health but, indirectly, in attaining status, acceptance, and livelihood in society. As various inequalities among individuals and groups expand, society must deal with the consequences of social unrest, alienation, and dissatisfaction. Strikingly disparate standards of health care for different social, economic and racial groups, then, is unjust for individuals who lose indispensable life opportunities and harmful for society generally which loses much productive activity and risks greater disaffection among major segments of the population.

Professor Daniels makes the following claim to equity in health care: “if an acceptable theory of justice includes a principle providing for fair equality of opportunity, then health care institutions should be among those governed by it.”¹²⁶ But to suggest that health care institutions ought to be governed by the principle of fair equality of opportunity, is not the same as stating precisely the claim being made. For reasons explained earlier, no claim to health, let alone equal health, is feasible since the vast variabilities in health are to a great extent biologically, socially, and behaviorally determined.¹²⁷ Nor do I make a claim for *equal* health care or even equal access to health care. Such a claim would not only require a fundamental redistribution of health care resources, but also would require restrictions on discretionary spending. Very few health care systems in developed countries restrict access to private health insurers, providers, and technology for people who can afford them, irrespective of the fact that these amenities are effectively inaccessible to the poor or near poor. Even in education, families are not restricted in their access to private educational opportunities of many kinds that are of better quality than public education. Nor is public education itself equal in quality, but is often superior in more affluent neighborhoods.

Rather than defending the broad re-distributive agenda implied in the principle of *equality* so that health care must be the same, I urge the modest claim of greater *equity*, so that health care is distributed more fairly. I do not even expect society to achieve anywhere near complete equity in the sense that health care is distributed in a totally impartial or unbiased way. But it is reasonable to expect society to set a goal of a more equitable system by reducing inordinately wide disparities in health care. The claim of equitable or fair access applies especially to those health services that most effectively

126. Norman Daniels, *Health Care Needs and Distributive Justice*, in IN SEARCH OF EQUITY: HEALTH NEEDS AND THE HEALTH CARE SYSTEM 115 (Ronald Bayer et al. eds., 1983). (emphasis added).

127. See generally *supra* Part I.

help prevent illness, disease, disability, and premature death, and which best care for and treat persons in ill-health.¹²⁸

B. Disparities in Access to Health Care Among Populations

Access to health care is measured by the use of health services, the quality of those services, and health outcomes.¹²⁹ The test of equity involves a determination of whether there are systematic differences in access, and whether these differences result from financial or other barriers to health care.¹³⁰ Using these objective measures of equitable access to health care, researchers have been able to demonstrate persistent and sometimes remarkable differences among groups in the United States.

There is a powerful and growing literature on inequitable access to health care.¹³¹ On each of the three dimensions just discussed—use,¹³² quality,¹³³ and health outcomes¹³⁴—considerable data exist to demonstrate significant differences among groups based upon their personal, social, and economic status.¹³⁵ The disparities in access to care are particularly sharp and enduring¹³⁶ for persons with low socioeconomic status (the poor or near

128. The term "access" is defined as "the timely use of personal health services to achieve the best possible outcomes." ACCESS TO HEALTH CARE, *supra* note 38, at 4.

129. *Id.* at 4-5, 32-34.

130. *Id.* at 4, 31-33.

131. See generally Feinstein, *supra* note 12.

132. See, e.g., Mark B. Wenneker et al., *The Association of Payer with Utilization of Cardiac Procedure in Massachusetts*, 264 JAMA 1255, 1256-57 (1990).

133. See, e.g., Helen R. Burstin et al., *Socioeconomic Status and Risk for Substandard Medical Care*, 268 JAMA 2383, 2383 (1992).

134. See, e.g., Paul H. Wise, *Racial and Socioeconomic Disparities in Childhood Mortality in Boston*, 313 NEW ENG. J. MED. 360 (1985).

135. Inequities in research, utilization, and outcomes have also been demonstrated for women. See John Z. Ayanian & Arnold M. Epstein, *Differences in the Use of Procedures Between Women and Men Hospitalized for Coronary Heart Disease*, 325 NEW ENG. J. MED. 221 (1991). See also Venessa Merton, *The Exclusion of Pregnant, Pregnable, and Once-Pregnable People (a.k.a. Women) from Biomedical Research*, 19 AM. J. L. & MED. 369 (1993).

136. For historical accounts of these relationships see generally Charles E. Rosenberg, *Social Class and Medical Care in 19th-Century America: The Rise and Fall of the Dispensary*, 29 J. HIST. MED. 32 (1974); John M. Eyler, *Poverty, Disease, Responsibility: Arthur Newsholme and the Public Health Dilemmas of British Liberalism*, 67 MILBANK Q. 109 (1989).

poor,¹³⁷ the uninsured,¹³⁸ and those in public programs such as Medicaid)¹³⁹ and persons in minority racial and ethnic groups.¹⁴⁰

The relationships between low socioeconomic status and poor health are deep and enduring.¹⁴¹ In 1991, there were 35.7 million persons below the official poverty level,¹⁴² accounting for 14.2% of the population.¹⁴³ If alternative methods of valuation were used that excluded non-cash benefits such as Medicaid and food stamps, there would have been 54.8 million persons in official poverty, accounting for 21.8% of the population.¹⁴⁴ From 1977 to 1990, the poorest 20% of the population suffered a 15% loss in real income, while the wealthiest one percent had a 110% after-tax rise in income.¹⁴⁵

While the rates of poverty substantially increased from the late 1970's, rates of social welfare expenditures dropped modestly. Total social welfare expenditures in the United States rose considerably from 8.8% of the gross domestic product in 1950 to a high of 19.1% in 1975. Since that time the percentage has remained around 18.5%, despite the considerably greater number of persons below the poverty line.¹⁴⁶ The percentage of low income people covered by Medicaid has actually fallen during this time period, primarily due to the tightened eligibility requirements.¹⁴⁷

137. See, e.g., Nancy E. Adler et al., *Socioeconomic Inequalities in Health: No Easy Solution*, 269 JAMA 3140, 3143-44 (1993).

138. See Lawrence D. Brown, *The Medically Uninsured: Problems, Policies and Politics*, 15 J. HEALTH POL., POL'Y & L. 413, 413-15 (1990); Jack Hadley et al., *Comparison of Uninsured and Privately Insured Hospital Patients*, 265 JAMA 374, 376 (1991); Burstin, *supra* note 133, at 2383. See also U.S. GENERAL ACCOUNTING OFFICE, *HEALTH INSURANCE: AN OVERVIEW OF THE WORKING UNINSURED* (1989).

139. See, e.g., Wenneker, *supra* note 132, at 1255. See also MEDICAID ACCESS STUDY GROUP, *supra* note 79.

140. See, e.g., Council on Ethical and Judicial Affairs, *Black-White Disparities in Health Care*, 263 JAMA 2344 (1990); Thomas A. Laveist, *Segregation, Poverty, and Empowerment: Health Consequences for African Americans*, 71 MILBANK Q. 41, 42-44 (1993).

141. See generally Paul R. Epstein, *Commentary: Pestilence and Poverty — Historical Transitions and the Great Pandemics*, 8 AM. J. PREVENTIVE MED. 263 (1992).

142. The poverty line was set in 1993 at the low level of \$11,890 for a family of three. This leaves many families living just above the poverty line who have difficulty affording housing, food, and clothing. See Victor W. Sidel et al., *The Resurgence of Tuberculosis in the United States: Societal Origins and Societal Responses*, 21 J. L., MED. & ETHICS 303, 307 (1993).

143. See Eleanor Baugher, *Poverty*, in BUREAU OF THE CENSUS, U.S. DEPT OF COMMERCE, *POPULATION PROFILE OF THE UNITED STATES 1993*, at 28 (1994).

144. *Id.* at 29.

145. Sidel, *supra* note 142, at 308 (citing STEFFIE WOOLHANDLER & DAVID U. HIMMELSTEIN, *THE NATIONAL HEALTH PROGRAM CHARTBOOK 24* (1992)).

146. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SOCIAL SECURITY ADMINISTRATION, *ANNUAL STATISTICAL SUPPLEMENT 1993*, at 128 (1994).

147. Michael A. Dowell, *State Insurance Programs for the Uninsured Poor*, CLEARINGHOUSE REV., June 1989, at 141; Barry R. Furrow, *Forcing Rescue: The Landscape of Health Care*

The subgroups that are over-represented in the poverty population are precisely those groups that are most affected by lack of health insurance and poor health. In 1991, nearly one-third (32.7%) of all African-Americans and more than one quarter of Hispanics (28.7%) were living under the poverty line.¹⁴⁸ One half of the nation's poor were either children or the elderly.¹⁴⁹ One-fourth of all children and one half of all African-American children were below the poverty line.¹⁵⁰

Health disparities between poor people and those with higher incomes are almost universal for all dimensions of health.¹⁵¹ For virtually all of the chronic diseases that are the leading causes of mortality, low income is a special risk factor.¹⁵² Thus, the incidence of heart disease and most all forms of cancer (lung, esophageal, oral, stomach, cervical, prostate) are significantly higher for persons in poverty than for the rest of the population.¹⁵³ The poor also suffer disproportionately from infectious diseases such as HIV and respiratory diseases such as tuberculosis.¹⁵⁴ Similar vulnerability is found among the poor for traumatic injuries and death.¹⁵⁵ Finally, the rate of developmental and other disabilities, especially among children, is associated with poverty.¹⁵⁶

The association between economic disadvantage and ill-health is manifested most strongly in strikingly poor pregnancy outcomes (e.g., prematurity, low birth weight, birth defects) and higher infant mortality;¹⁵⁷ the limitations in life activities due to ill health;¹⁵⁸ and elevated mortality rates.¹⁵⁹ Low

Provider Obligations to Treat Patients, 3 HEALTH MATRIX J. L.-MED. 31, 31 (1993).

148. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, POPULATION PROFILE OF THE UNITED STATES 1993, at 29 (1994).

149. *Id.*

150. Sidel, *supra* note 142, at 307.

151. See HEALTHY PEOPLE 2000, *supra* note 16, at 29-31.

152. See generally George A. Kaplan et al., *Socioeconomic Status and Health*, in CLOSING THE GAP: THE BURDEN OF UNNECESSARY ILLNESS 125-29 (Robert W. Amler & H. Bruce Dull eds., 1987) [hereinafter CLOSING THE GAP].

153. See HEALTHY PEOPLE 2000, *supra* note 16, at 39-40; REPORT OF THE EXPERT PANEL ON POPULATION STRATEGIES FOR BLOOD CHOLESTEROL REDUCTION, U.S. DEP'T OF HEALTH AND HUMAN SERVICES 93-100 (1990).

154. David H. Bor & Paul R. Epstein, *Pathogenesis of Respiratory Infection in the Disadvantaged*, 6 SEM. RESP. INFECTION 194, 194 (1991).

155. HEALTHY PEOPLE 2000, *supra* note 16, at 30.

156. See NATIONAL CENTER FOR CHILDREN IN POVERTY, FIVE MILLION CHILDREN: A STATISTICAL PROFILE OF OUR POOREST YOUNG CITIZENS 50 (1990) (table).

157. See generally COMMITTEE TO STUDY THE PREVENTION OF LOW BIRTHWEIGHT, INSTITUTE OF MEDICINE, PREVENTING LOW BIRTHWEIGHT (1985).

158. See generally LEWIS E. KRAUS & SUSAN STODDARD, NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH, U.S. DEP'T OF EDUCATION, CHARTBOOK ON DISABILITY IN THE UNITED STATES (1989); HEALTHY PEOPLE 2000, *supra* note 16, at 30 (people in families with incomes of less than \$13,000 a year are twice as likely as the total population to be limited

income people have death rates that are twice the rates for people with incomes above the poverty level.¹⁶⁰

Compared to other groups in society, African-Americans and other racial and ethnic minorities¹⁶¹ are three times more likely to live in poverty¹⁶² and to lack health insurance.¹⁶³ They also are subject to discrimination in health care.¹⁶⁴ The effects of these burdens are borne out by poorer utilization of services, outcomes, and health status "virtually across the board."¹⁶⁵ A major study on health and medical care for African Americans concluded: "Of all the inequalities in the distribution of health, one of the most pronounced is the distribution by race African-Americans are not as healthy as white Americans, and they do not live as long."¹⁶⁶

Virtually all health status indicators of African-Americans and other ethnic minorities are dire when compared with white Americans. African-Americans have considerably elevated disease rates of childhood diseases such as measles and chicken-pox,¹⁶⁷ chronic diseases such as diabetes, heart disease, and cancer;¹⁶⁸ and communicable diseases such as HIV and tuberculosis.¹⁶⁹

in major activities because of their health).

159. See William H. Foege, *Appendix: Closing the Gap*, in *CLOSING THE GAP*, *supra* note 152, at 204, 205.

160. *Id.*

161. For a discussion of other racial and ethnic groups including Hispanic Americans, Asian and Pacific Islander Americans, American Indians and Alaska Natives, see generally *HEALTH POLICY AND THE HISPANIC* (Antonio Furino ed., 1992); *HEALTHY PEOPLE 2000*, *supra* note 16, at 31-39.

162. *HEALTHY PEOPLE 2000*, *supra* note 16, at 32.

163. See Llewellyn J. Cornelius, *Access to Medical Care for Black Americans with an Episode of Illness*, 83 *J. NAT'L. MED. ASSN.* 617, 617 (1991); *ACCESS TO HEALTH CARE*, *supra* note 38, at 2-3. See also Cassandra Q. Butts, *The Color of Money: Barriers to Access to Private Health Care Facilities for African-Americans*, *CLEARINGHOUSE REV.*, May/June 1992, at 159.

164. See Vernellia R. Randall, *Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African-Americans*, 3 *HEALTH MATRIX J. L.-MED.* 127, 144-60 (1993); Sidney Dean Watson, *Minority Access and Health Reform: A Civil Right to Health Care*, 22 *J. L., MED. & ETHICS* 127, 127-29 (1994).

165. *ACCESS TO HEALTH CARE*, *supra* note 16, at 2-3.

166. *HEALTH AND MEDICAL CARE OF AFRICAN-AMERICANS* xvii (Wornie L. Reed et al. eds., 1993) [hereinafter *MEDICAL CARE OF AFRICAN-AMERICANS*].

167. See James W. Buehler et al., *The Reporting of Race and Ethnicity in the National Notifiable Diseases Surveillance System*, 104 *PUB. HEALTH REPS.* 457, 460, 462 (1989) (for example, in 1987 the incidence of measles among Hispanics was 4 to 5 times higher than for other groups).

168. See 7 *REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *CHEMICAL DEPENDENCY AND DIABETES* (1986); *ACCESS TO HEALTH CARE*, *supra* note 38, at 80-89, 96; *MEDICAL CARE OF AFRICAN-AMERICANS*, *supra* note 166, at 10-11, 31-42.

Some of the most striking differences in health status between African-Americans and white Americans can be found in their respective infant and adult mortality rates. African-American infants are more than twice as likely as caucasian Americans to die during their first month of life, first year of life, and during the post-neonatal period.¹⁷⁰ High rates of low birth weight among African-American babies account for many of these deaths, but even normal-weight African-American babies have a greater risk of death.¹⁷¹ After controlling for a number of behavioral risk factors, a wide gap persists between adult mortality rates of African-Americans and white Americans.¹⁷²

The seriousness of the health status of African-Americans in urban areas was illustrated in a study comparing mortality rates of blacks in Harlem to all whites in New York City. African-Americans were several times more likely to die than whites, and the mortality rates in central Harlem were lower than for males in Bangladesh, one of the poorest countries in the world.¹⁷³ Not only are the differences in mortality rates between races wide, but they are steadily increasing.¹⁷⁴

Plainly, the reasons for the pronounced differences in health status and mortality rates between poor people, particularly racial minorities, and the rest of the population are attributable to many factors unrelated to health care, such as environment, housing, behavior, and nutrition. Yet, most thoughtful observers conclude that barriers to access to health services, measured by utilization of services and health outcomes for equivalent conditions, remain a significant contributing factor explaining the increased morbidity and mortality among the poor and minorities.¹⁷⁵ For example, the Institute of Medicine estimates that one-third to one-half of the gaps in mortality rates are attributable to difficulties in obtaining access to health care.¹⁷⁶

The markedly elevated rates of morbidity and mortality among poor people and ethnic minorities suggest that, if access to health care were equitable, the sicker populations would use health services more frequently. Exactly

169. I have discussed the inter-relationships between low income, race and communicable disease in other papers. See Lawrence O. Gostin, *The Resurgent Tuberculosis Epidemic in the Era of AIDS: Reflections on Public Health, Law, and Society*, 54 MD. L. REV. (forthcoming 1995); Larry Gostin, *The Inter-connected Epidemics of Drug Dependency and AIDS*, 26 HARV. C.L.-C.R. L. REV. 113 (1991). See MEDICAL CARE OF AFRICAN-AMERICANS, *supra* note 166, at 65-82.

170. ACCESS TO HEALTH CARE, *supra* note 38, at 58-60.

171. HEALTHY PEOPLE 2000, *supra* note 16, at 33.

172. ACCESS TO HEALTH CARE, *supra* note 38, at 3; Randall, *supra* note 164, at 140-43.

173. Colin McCord & Harold P. Freeman, *Excess Mortality in Harlem*, 322 NEW ENG. J. MED. 173, 174 (1990).

174. MEDICAL CARE OF AFRICAN-AMERICANS, *supra* note 166, at 9.

175. See ACCESS TO HEALTH CARE, *supra* note 38, at 3-4, 17-18, 32-34; HEALTHY PEOPLE 2000, *supra* note 16, at 29-31.

176. ACCESS TO HEALTH CARE, *supra* note 38, at 3.

the opposite result has occurred. The use of health services among poor, racial minorities is extremely low compared to other groups including the use of prevention services (e.g., childhood vaccines, pap smears, mammograms), ambulatory care, inpatient care, dental visits, and high technology services. Despite their elevated rates of ill-health and disease, poor people and minorities have significantly fewer visits to the doctor.¹⁷⁷ For example, more than twice as many uninsured people (22%) than insured people (9%) who are in poor or fair health visit a physician.¹⁷⁸

Not only are poor people and minorities sicker and use health services less, the quality of the care that they do receive is generally inferior,¹⁷⁹ and they express greater dissatisfaction with their health and physical condition.¹⁸⁰ The profound synergy between poverty, lack of health insurance and race on the one hand, and poorer health status and lower life expectancy on the other provides a telling critique of the U.S. health care system.

IV. HEALTH CARE AND MARKETS

Any inquiry into the appropriateness and effectiveness of private competition must begin with the objectives of a market in health care services. Any number of valid goals are possible ranging from cost, administrative efficiency, and quality to access, equity, and justice.¹⁸¹ In the previous sections I presented a justification for the preeminence of access and equity as values in guiding the health care system. In this section I show why competition has marginal utility in relation to cost and why it actually cuts against the primary goals of access and equity. If my arguments are correct, or even partially correct, this ought to give readers pause in evaluating the vast and growing literature devoted to competition in the health care system. My critique of much of the existing literature is that it assumes, without rigorous justification, that "better" or "purer" competition in health care is an inherent good. Advocates of a competitive approach seldom dwell on the questions "better for what?" and "better for whom?"

A. *The Applicability of Market Theory to Health Care*

Competition is widely thought to be an effective mechanism for lowering the price and increasing the quality of goods and services in the marketplace. The question, however, is whether competition is an appropriate theory, or the

177. MEDICAL CARE OF AFRICAN-AMERICANS, *supra* note 166, at 95-119.

178. ACCESS TO CARE, *supra* note 38, at 12, 96.

179. See generally KATHERINE L. KAHN ET AL., ANALYSIS OF QUALITY OF CARE FOR PATIENTS WHO ARE BLACK OR POOR IN RURAL AND URBAN SETTINGS (1993).

180. Ronald M. Andersen et al., *Black-White Difference in Health Status: Methods or Substance?*, in HEALTH POLICIES AND BLACK AMERICANS 72, 83 (David P. Willis ed., 1989); Randall, *supra* note 164, at 135-36.

181. See generally Brock & Daniels, *supra* note 25.

marketplace is the appropriate approach, to the cost effective allocation of health care services. Competition in health care can occur at least on two levels — health care plans can compete for subscribers, and individual providers can compete in offering services to patients.¹⁸² Each level of competition presents its own set of opportunities for reducing cost and its own set of theoretical and practical problems.

Competition among health care plans, which is the organizing theory behind managed competition,¹⁸³ is vehemently put forward as a strategy for cost containment.¹⁸⁴ Managed competition remains a proposal constructed in theory, not practice. No health care system outside of the United States has demonstrated the worth of managed competition in promoting quality and constraining medical inflation.¹⁸⁵

The theory of managed competition assumes that a sufficient number of health care plans exist to sustain competition in the market. A study by one of managed competition's original proponents suggests that populations large enough to support three or more competing health plans exist only in middle-sized to large metropolitan areas.¹⁸⁶ Professor Kronick and his colleagues assume that a minimum of three competing health plans is necessary for the system to work effectively,¹⁸⁷ however, no empirical evidence exists to rely on this number to foster competition. Would players in the market truly compete or would they collude to maintain prices? What economic conditions and/or antitrust arrangements would have to exist to ensure genuine competition?

Dr. Arnold Relman expresses concern about how managed competition would work even where the population is dense enough to support competing health plans:

In the absence of some limit on total expenditures, how can we be sure it would save money in a system so driven by expansive entrepreneurial forces?

In our present profit-oriented medical insurance market, wouldn't all insurers try to keep their prices as high as possible while still staying competitive?

182. For an excellent discussion of health care markets and competition under several levels of analysis, see Rand Rosenblatt, *Health Care Markets and Democratic Values*, 34 VAND. L. REV. 1067, 1078-85 (1981).

183. Managed competition restructures the market for health care services into competing pre-paid health plans, giving providers built-in incentives to offer a standard benefits package at the lowest cost.

184. See, e.g., Alain C. Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy*, 320 NEW ENG. J. MED. 29, 94 (1989) (pts. 1 & 2).

185. For a critique of managed competition, see Thomas Rice et al., *Holes in the Jackson Hole Approach to Health Care Reform*, 270 JAMA 1357 (1993).

186. Richard Kronick et al., *The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148 (1993).

187. *Id.*

And as a result might not the prices of all competitors still continue to rise, even though none would be far out of line with the others?¹⁸⁸

Predicting the economic effects of managed competition on national health spending is fraught with complexity. Managed competition is not based on empirical evidence, and since the elements of proposals are diverse, it is exceedingly difficult to determine the probable economic effects. Estimates of the economic impact of managed competition on national health care expenditures vary significantly, "rang[ing] from *increased spending* of \$47.9 billion in 1993 to *decreased spending* of \$21.8 billion in 1994."¹⁸⁹ Given the totality of the evidence, competition among health care plans has theoretical potential for impeding the rise in health care spending, but the potential is unproven and would be unlikely to produce significant reductions in national health expenditures.¹⁹⁰

Would greater competition among health care plans help achieve the primary good of increased access or equity? Managed competition theorists argue that the savings from their program might be used to fund subsidies for increased access, but no assurance exists as to when, or if, savings would occur. Even if savings do occur, much of the economic benefit will accrue to the private sector; it is unclear to what extent, if any, government would benefit or whether government would use any cost savings to subsidize health care for the poor. Competition at the level of the health plan, in and of itself, promises little to increase access to health services for the currently uninsured or under-insured.

Competition can also occur at the level of the individual provider who competes in offering services to patients. The implicit assumption behind competition is that consumers purchase health care in the same way they buy durable goods or personal services. Good reasons exist, however, for believing that consumers view health care rather differently than most other goods and services. Health services are unique because they can relieve unremitting

188. Arnold S. Relman, *Controlling Costs by "Managed Competition"—Would It Work?*, 328 *NEW ENG. J. MED.* 133, 134 (1993).

189. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, *AN INCONSISTENT PICTURE: A COMPILATION OF ANALYSES OF ECONOMIC IMPACTS OF COMPETING APPROACHES TO HEALTH CARE REFORM BY EXPERTS AND STAKEHOLDERS* 34 (1993) (emphasis added). See CONGRESSIONAL BUDGET OFFICE, *AN ANALYSIS OF THE ADMINISTRATION'S HEALTH PROPOSAL* 25-39 (1994); CONGRESSIONAL BUDGET OFFICE, *AN ANALYSIS OF THE MANAGED COMPETITION ACT* 15-26 (1994); CONGRESSIONAL BUDGET OFFICE, *MANAGED COMPETITION AND ITS POTENTIAL TO REDUCE HEALTH SPENDING* (1993).

190. Health care expenditures in the United States have grown steadily over the last several decades. In 1960, health care consumed 5.3% of the Gross Domestic Product (GDP); by 1994, the costs had risen to approximately 14% of the GDP. UNDERSTANDING ESTIMATES, *supra* note 56, at 2, 3 (1994). In 1994, national health expenditures were estimated at over \$900 billion; they are projected to climb to \$1.7 trillion by the year 2000, accounting for approximately 18 percent of the GDP. *Id.*

pain or suffering, restore normal functioning, or prevent premature death. If a medical service could provide a small chance of an improved quality of life or a longer life, most people would be prepared to pay an inordinate price for the service. It is precisely because health is a preeminent human value that markets cannot determine the worth of medical services to individuals in need of care.¹⁹¹

Additionally, when persons become ill they are more appropriately seen in the subservient position of a patient rather than of an educated consumer. Patients who are suffering seldom are able to make the clear-headed economic judgments society expects of consumers in the marketplace. They are unable to accurately assess the quality of the "product" or to make reasoned judgments about alternatives.

Even if it were accurately assumed that the market would behave as theorized when buying and selling health services, the result of a well functioning market would be the opposite of that which is desirable. The essential characteristic of the marketplace is that it allocates goods and services on the basis of the ability to pay rather than on the basis of the need for the service. The market, therefore, excludes those who are unable to afford the service being sold. Seen in this way, it is not surprising that the U.S. health care system has exhibited two notable trends, both harmful to the social fabric—steadily increasing prices and greater numbers of persons unable to afford medical services. If it is true that health care is a precious and sought after commodity, the demand for services would be expected to rise. As demand increases, so should price. It would be similarly expected that individuals in poorer income groups would have a decreasing ability to purchase the product as the price rises. Since poverty is often associated with poorer health for a variety of environmental, nutritional and behavioral reasons, those who need the service most would be least likely to afford access.

Free market scholars acknowledge that the market has not worked efficiently. Rather than abandoning the idea, they choose to "fix" the health services market through greater deregulation.¹⁹² The results of these efforts,

191. For example, why is it that hospitals feel it is economically feasible to purchase the most expensive technology (e.g., ever more sophisticated imaging equipment) in the absence of evidence that it is more cost effective than existing equipment? The most probable answer is that patients, through their third party insurers, are willing to pay a great deal more for a marginal benefit when it comes to health care.

192. See generally CLARK C. HAVIGHURST, *DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION* (1982); James F. Blumstein, *The Use of Financial Incentives in Medical Care: The Case of Commerce in Transplantable Organs*, 3 *HEALTH MATRIX J. L.-MED.* 1 (1993).

however, are likely to exacerbate existing problems precisely because inaccessibility and inequity are inherent concerns with competition in all markets.

B. The Effects of Insurance Underwriting on Access and Equity in Health Care

Pro-market scholars often see the health insurance contract as an arms-length agreement between the parties based on the disclosure of full information on both sides. If the insurance industry is impeded by law in its attempts to gather relevant information (i.e., a current health condition or a known future risk), or if consumers are not required to disclose relevant information, the industry is severely disadvantaged in the marketplace. Without sound actuarial data, insurance companies cannot realistically set a price for the product and they will become less competitive, or worse, go out of business. For the health insurance industry, one of the most persistent problems is adverse selection—a problem occurring when an insurance applicant fails to disclose a material health risk which is unknown and unknowable for the company.

If the health insurance industry is regarded strictly as a business, it is difficult to question the ability to discriminate on the basis of sound actuarial data. The very essence of underwriting is to classify people according to risk, treating those with higher risks differently. If on the other hand the health insurance industry is viewed as an instrument of social policy, then its traditional underwriting activities become worrisome. The social purpose of health insurance is to spread risk across groups, enabling wider access to services. If health benefits become unavailable or unaffordable to those who are most likely to become ill, then the social purpose of health coverage is thwarted.¹⁹³

The activity of underwriting in the health insurance industry has indeed tended to exclude those who most need services. Health insurers have increasingly adopted principles of experience rating. Under experience rating, premiums are based on a particular group's historical costs, not on the expected costs for all persons in the community (a practice known as community rating).¹⁹⁴ As a result, groups with the best health risks (by definition, those

193. Lawrence O. Gostin, *The Americans with Disabilities Act and the U.S. Health Care System*, 11 HEALTH AFF. 248, 253 (Fall 1992).

194. Under community rating, insurers aggregate into one "community" individuals or groups for the purpose of providing insurance. A community rated plan generally charges the same rate for all members, spreading the costs for the entire group evenly over its members. Under experience rating, the past claims experience of a group is used to determine the premium. CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS, HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS 10-11 (1988).

with the least needs for services) will receive lower priced services in the market than those with the worst health risks (by definition, those with the greatest needs for services). The predictable outcome is that the poorest, who can least afford health services, and the sickest, who most need services, are the least likely to have access. As the group becomes increasingly less attractive to the industry because of the health risks of its members, the more likely it is that private insurance simply will not be offered at any price.¹⁹⁵

Under the system of experience rating, it is advantageous both for the insurance industry and for the group seeking health insurance to select the best risks. Thus, competition in the industry is not based on offering the best product at the most reasonable price. Rather, competition is based on attracting the best risks—a practice that might be regarded as “skimming” or “cherry picking” healthy consumers. Groups such as large employers will seek members who are healthiest, and insurance companies will seek groups with the best aggregate risks. For large employers, this reduces health care costs, and for insurers this increases profits. On its face, experience rating represents a triumph for the market because it rewards the best competitors. However, for those left out (i.e., individuals with higher risks, small employers, and larger groups with higher aggregate risks) the health care system has failed because price rises and accessibility decreases. Furthermore, experience rating expands existing gaps between poorer and richer and between sicker and healthier, thus making the system more inequitable.

The health insurance market also reduces access by its use of pre-existing condition provisions and capitations on coverage. These provisions, typically seen in individual health insurance contracts, exclude or limit coverage for physical or mental conditions from which insured persons already suffer. Accordingly, consumers can be assured of reasonable reimbursement for health care services except the ones they are most likely to need. The market, therefore, operates in a number of ways to reduce access for individuals with the greatest needs for health care.

1. The ERISA Vacuum

Market forces that make it profitable to experience rate and exclude or limit coverage for preexisting conditions have worked so well that approximately two thirds of the employers that provide health care benefits for their employees do so by establishing risk retention plans, commonly referred to as self-funded arrangements or self insurance.¹⁹⁶ Risk retention plans generally

195. See Katherine Swartz, *Community Rating: An Idea Whose Time Has Come (Again)*, J. AM. HEALTH POL'Y 34 (1993).

196. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, 1990 STATISTICAL ABSTRACT OF THE UNITED STATES 413 (109th ed. 1990).

have not been classified as "insurance" or the "business of insurance" because no transfer of risk from one entity to another occurs. Under the preemption provisions of the Employee Retirement and Income Security Act of 1974 (ERISA), states are permitted to regulate employee benefit plans provided by group insurance but may not regulate risk retention plans. This distinction between risk retention plans and insurance arrangements has been sustained by the Supreme Court.¹⁹⁷ ERISA prevents the states from mandating minimum health benefits or proscribing discrimination. The statute has a crippling effect on the ability of state governments to ensure that adequate and fair health care coverage is provided under risk retention plans, yet the act fails to perform either of these functions itself.

This regulatory vacuum enables employers to construct a closed, self-contained market free of impediments of government.¹⁹⁸ It probably is because of the purity of the market that self insurers can engage in exclusionary practices that would make even the most determined marketeer wince. In *McGann v. H & H Music Company*,¹⁹⁹ Mr. McGann's employer terminated the company's existing group insurance plan after he began to make health insurance claims seeking reimbursement for HIV-related medical services.²⁰⁰ The plan had provided health care benefits of up to \$1 million for all diseases.²⁰¹ Subsequently the employer established a risk retention plan providing health care benefits of up to \$1 million for all diseases except AIDS, which was limited to a lifetime maximum of \$5000.²⁰² The Fifth Circuit, consistent with most appellate decisions on ERISA discrimination, found the employer's actions lawful, even though "the employer's decision . . . may stem from some 'prejudice' against AIDS."²⁰³ The court's decision rested on the premise of "arms-length" agreements characteristic of competition: when an employer's group insurance plan clearly provides that it may be amended or terminated, an employer is free to eliminate the entire plan even though it may result in the cessation of benefits for individuals who are already receiving benefits because of illness.²⁰⁴

197. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985).

198. See Daniel M. Fox & Daniel C. Schaffer, *Health Policy and ERISA: Interest Groups and Semi-Preemption*, 14 J. HEALTH POL., POL'Y & L. 239, 240 (1989).

199. 946 F.2d 401 (5th Cir. 1991), *cert. denied sub nom.*, *Greenberg v. H & H Music Co.*, 113 S. Ct. 482 (1992). For a similar case see *Owens v. Storehouse*, 984 F.2d 394 (11th Cir. 1993).

200. 946 F.2d at 403.

201. *Id.*

202. *Id.*

203. *Id.* at 408.

204. The Equal Employment Opportunity Commission takes the view that, at least with respect to the extreme facts of *McGann*, the Americans with Disabilities Act would proscribe

The consequences of the *McGann* decision, specifically, and the ERISA vacuum, generally, are contrary to the goals of (1) providing universal and equitable health care coverage because it allows employers to strictly limit reimbursement for serious health conditions; (2) preventing discrimination against employees who have chronic diseases, particularly those that are often treated less favorably, such as sexually transmitted diseases, AIDS, mental illness, and alcohol or other drug dependency; and (3) ensuring that persons are not subject to termination of their benefits after they make health care claims.²⁰⁵

2. Fixing the Insurance Market

While some advocates of competition are willing to tolerate the serious problems in the market, others believe it is necessary to "fix" the market through insurance reform.²⁰⁶ One possibility would be to require insurance companies to adopt community rating procedures and to prohibit the use of pre-existing condition provisions. Many such proposals for insurance reform would not apply to risk retention plans, or would permit some large employers to opt out of the regulatory requirements by self-insuring. Another possibility would be to provide greater security for employees by requiring extension of health insurance coverage for a period of time after the person has left the employment.

It is important to notice that several of the proposed reforms of the insurance market would make health insurance distinctly less like a market. The reforms prohibiting experience rating and pre-existing condition provisions, for example, would not permit insurers to obtain all relevant data and to make actuarial decisions in an arms-length agreement. To the extent that supporters of these proposals perceive a problem with current insurance practices, the problem they see is with competition itself.

It ought to follow that liberal-minded advocates of universal coverage would applaud insurance market reforms. However, many have argued that

discrimination. See EEOC, EEOC ISSUES INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE ADA TO DISABILITY-BASED PROVISIONS OF EMPLOYER-PROVIDED HEALTH INSURANCE, June 8, 1993, available in 1993 WL 204538 (E.E.O.C.).

205. Lawrence O. Gostin & Alan I. Widiss, *What's Wrong with the ERISA Vacuum? Employers' Freedom to Limit Health Care Coverage Provided by Risk Retention Plans*, 269 JAMA 2527, 2529 (1993); Alan I. Widiss & Lawrence O. Gostin, *What's Wrong with the ERISA Vacuum?: The Case Against Unrestricted Freedom for Employers to Terminate Employee Health Care Plans and to Decide What Coverage is to be Provided When Risk Retention Plans Are Established for Health Care*, 41 DRAKE L. REV. 635, 641-44 (1992).

206. See generally Hall, *supra* note 9, at 108. For a brief review of other reform proposals such as Medicaid expansion, state subsidies, and risk pools, see Thomas Bodenheimer, *supra* note 9, at 199-204 (1992).

this less robust approach to health system reform is worse than no reform at all. To the extent that insurance market reform solves the problem of inaccessibility, it does so principally for those populations with more political might—those who are currently insured. It is the insured population that faces the brunt of the burden of preexisting condition provisions and the need for continuous coverage. From a purely political perspective, there is concern that insurance market reforms would not solve the major problems of inaccessibility and would have coopted the middle class so they would no longer support more robust reform.

Fixing the insurance market by limiting or proscribing the use of experience rating could cause a problem of even deeper dimension. If insurers were required to charge the same premium and provide the same coverage to all applicants irrespective of risk, it follows that the price of insurance would rise because the pool of insured would be sicker. As the price rises, younger and healthier individuals would refuse to subsidize older and sicker individuals. The best risks, therefore, would find it increasingly less attractive to enter or remain in the insurance market. The result might be a spiral effect whereby the insurance pool increasingly comprises high risk individuals, prices rise, the better risks leave the market, and so forth. Consequently, insurance reforms have the potential of shrinking, not swelling, the pool of persons with health insurance.

Market solutions appear ill-suited to the vexing problems associated with allocation of health care resources. If seen from the perspective of insurers (who are freed from government regulation), health care providers (whose services are paid by third party payers), or younger and healthier individuals in the work-force (who gain access to generous benefits at reasonable, tax advantaged prices), competition appears attractive. However, if seen from the perspective of poorer, older, and sicker individuals, competition exacerbates the dual problems of inaccessibility and inequity.

3. From Truman to Clinton: A Legacy of Failure on Health Care Reform

The political system has for some time attempted to comprehensively reform health care in the United States. In addressing the Congress on November 19, 1945, President Truman recalled his Economic Bill of Rights which proposed “[t]he right to adequate medical care and the opportunity to achieve and enjoy good health.”²⁰⁷

207. SPECIAL MESSAGE TO THE CONGRESS RECOMMENDING A COMPREHENSIVE HEALTH PROGRAM, *in* PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES: HARRY S. TRUMAN, 1945, at 475, 475-76 (1961).

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.²⁰⁸

Nearly a half century later, President Clinton, referring to earlier Presidential attempts, asserted in his State of the Union Address to Congress that "this year we will make history by reforming the health care system."²⁰⁹

I know there are people here who say there's no health care crisis Tell it to the 58 million Americans who have no coverage at all for some time each year. Tell it to the 81 million Americans with . . . preexisting conditions Tell it to the small businesses burdened by skyrocketing costs of insurance Or tell it to the 76 percent of insured Americans, three out of four whose policies have lifetime limits, and that means they can find themselves without any coverage at all just when they need it the most.²¹⁰

At least from the time of President Truman to the present day, reform of the health care system at the national level has been very much a part of the public and scholarly discourse in the United States. Yet comprehensive reform of the health care system has become, for now and the immediate future, unattainable. The country appears caught in a paradox. We value the choice and quality in the current health care system, but recognize the harm to the economy of escalating costs and the harm to the social fabric from inadequate access and inequitable distribution of services. It appears that with each effort to improve one key variable there is a tradeoff with another. Tradeoffs are, of course, inevitable particularly with a pluralistic system that envelops one seventh of our national economy and has numbing complexity.

I have sought, through discussion of normative principles and supporting empirical evidence, to demonstrate that access and equity are the preferred values to guide the complex choices needed for the fair and efficient allocation of health services. Those in our society who tolerate significant numbers of their fellow men, women, and children going without health care coverage have a burden of carefully explaining the values that underlie their position and demonstrating why they take precedence over the health of the wider community.

208. *Id.* at 476-77.

209. President Bill Clinton, The State of the Union Address (Jan. 25, 1994), in WASH. POST, Jan. 26, 1994, at A12.

210. *Id.*