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The Clinton Health Care Proposal: A Good Idea with Good Intentions, But Will This Dream Ever Come True?

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THE CLINTON HEALTH CARE PROPOSAL:
A GOOD IDEA WITH GOOD INTENTIONS, BUT WILL THIS DREAM EVER COME TRUE?

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An Abstract Presented to the Faculty of the Graduate
School of Lindenwood College in Partial
Fulfillment of the Requirements for the
Degree of Master of Health Care Management

1995

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DEDICATION

I would like to dedicate this paper to my parents, Ronald and Sandra Segall, and my grandmother, Dorothy Motchan who have all been so supportive in helping me achieve this long awaited dream. I love you all very much and could not have done it without you!

Preface

During the past year there has been an immense amount of discussion regarding a need for change in the health care of the United States. Numerous articles and television talkshows have been critical of the subpar medical practices that have been allowed to take place during the past several decades without any type of corrective action occuring by those empowered to so.

Admittedly, I also see a health care system with many flaws and it is because of these problems that I have decided to voice my frustrations. Physicians appear to be afraid of doing "too much" for a patient diagnosed with the most simple cold flu to agonizing pain of terminal cancer. Concerns of payments which may or may not be made by a patient and/or insurance company to the ever present liability factor are just two of a very long list of reasons why health care in this country has declined. On the opposite end of the spectrum, we, the patients should not always be viewed as angels when it comes to health care. Many of us abuse our bodies and do not practice what is termed "preventive medicine", taking steps to prevent health problems in the future.

Undoubtedly this problem has been going on for years, but it has received the majority of its publicity during the past several months. The costs for health care continue to skyrocket and

there appears to be no end in sight. It is for this reason that there has been so much concern for what is to come in the future. The means for tackling this problem varies depending upon whose opinion one seeks. Unfortunately none of these people's viewpoints seem to coincide with one another-- ultimately creating more confusion and aggravation.

Many of the issues will be discussed throughout this document and many of the "politically influential groups" will be heard. There is no telling which solution will be chosen, but the road to that decision will be long and hard.

ABSTRACT

This thesis will focus on the past, present and future status of health care in the United States. Much of the discussion will be centered around the controversial Health Care Reform Bill that was proposed by President Bill Clinton in October, 1993.

During the past century, researchers, scientists, chemists, and physicians have all made great strides regarding their knowledge of the human body. Many of their studies have provided valuable information of how people can live longer, healthier, and more productive lives. Additionally, technological advancements have played a large role in medicine. These machines and devices have aided physicians in determining location and causes of ailments so that steps can be taken to correct the situation or prevent it from getting worse. The problem however is that all of this good news comes with a hefty price. Many people living in the United States are unable to afford the care that is offered within their own country due to a lack of health insurance or because they are underinsured. A catastrophic accident would literally send these people into poverty. People have criticized the government for not taking a stand in this issue and rightly so, but no administration appears eager to take the challange and address the issues--until now.

This paper will encourage the reader to draw his/her own conclusions as to how this situation can best be rectified. Opinions from legislators and professionals in the industry of what approach would work best and why will be presented throughout this study. For all intense purposes, everything mentioned throughout this paper is assumed to be correct for no system has been implemented to measure success or failure.

The Clinton Health Care Reform Bill will be broken down completely during this study in order to determine if in fact it is the best solution to this problem. Based on the research which I have completed and will be presenting, it is my opinion that the Clinton Health Care Plan is not at this time, the best answer for this ongoing problem however, if certain areas of the plan were to be reconstructed, there is hope for success of this plan in the future.

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Chapter I

INTRODUCTION

A Health Care Dilemma Plaguing the U.S.

When the 1992 Presidential election pitted Republican George Bush against Democrat Bill Clinton and Independent Ross Perot, voters expected a close race. As in past elections, each candidate discussed what he felt the most important issues were and how he planned to improve them if elected to office. The nation's economy, lower taxes, and foreign policy have always been considered major, and this election was to be no different. The media provided plenty of coverage so that the citizens of the United States could listen to all answers provided by the candidates and draw their own conclusions as to who was best suited for the position.

This election, however, was slightly more important than those of the past because attention needed to be directed toward an issue that had raised concern in the minds of many people for quite some time-- health care. It was important for this issue to be pushed to the forefront not only because of the rising number of people who were uninsured or because low income individuals had poor access to care, but also, and perhaps more importantly, the effect that health care has on

middle-class Americans. Since the middle class represents the largest portion of the American society (and commands the majority of the voting public), it was necessary to listen to and hear their cries for change. Health care costs were continuing to skyrocket with no end in sight. Additionally, insecurity about future health insurance coverage has put fear into the minds of many individuals. The importance of having unemployment rates kept to a minimum, taxes lowered or left stagnant, and countries around the world at peace and doing well is pertinent, but the winner of this election was going to have to face the domestic problems here in the United States and the biggest obstacle was how to cure the health care dilemma.

During the past several decades the United States had made significant strides in the field of medicine, gaining the respect of many professionals internationally. Health care professionals of this country worked hard to continue that unparalleled reputation. Even the naysayers who were critical toward many of the research efforts have been amazed by the cures we have attained and the technological breakthroughs that have taken place. Yet with all of the training, nurses, advances, and medical school graduates, this country continues to face a challenge which demands immediate attention.

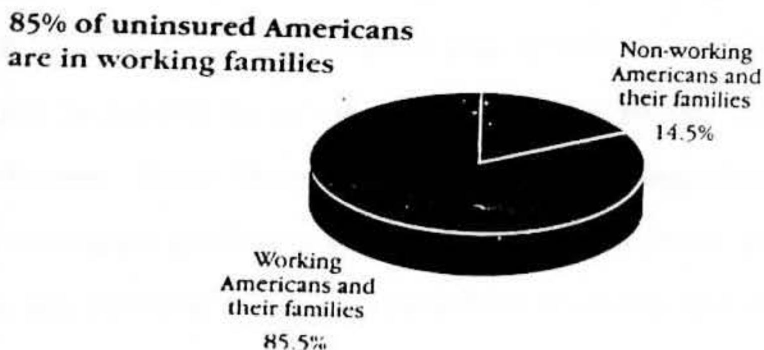
How could a country as strong as the United States be in such disarray with its health care situation? There are presently an estimated 37 million Americans who are uninsured for health coverage and that number continues to grow on a daily basis (Samuelson 47). In addition, many people who do have insurance do not have a sufficient amount of coverage. According to estimates prepared by Families USA, more than two million Americans lose their health coverage every month (Clinton 2). There are many different reasons contributing to these high figures. Some people who change or lose their job will move into and out of the uninsured status for at least a temporary period until they are able to find their next job. Individuals and families might lose their health insurance because they have fallen on hard times and cannot afford the high premiums. There are also those people who fear that if they change jobs they may not receive any, or will receive limited benefits. They might be unhappy with their work, but they choose to remain where they are, based on the health insurance packages they have. Unfortunately, some individuals or their family members may have a severe health problem which might prevent them from obtaining affordable health coverage or any coverage at all. This process stems from a term called risk selection and underwriting (also known as cherry picking) in the insurance industry (39). Finally, there

is that group of people who feel that the cost of coverage simply does not equal the service that is offered and choose not to be covered.

There are several types of groups of individuals that appear to have more difficulty obtaining health insurance, such as people in the service industry and those employed by a small company. These types of businesses are less likely to have employer sponsored insurance packages due to very expensive insurance premiums (See Figure 1).

Figure 1

Small Businesses Face Rising Costs Today



Source: Clinton 81 per National Small Business United

Those small companies that do offer insurance to their employees can find it burdensome. Some companies have been

hiring more part time employees in an effort to bypass the requirement of offering insurance to full-time employees, while others are alleviating some of the headache by shifting many of the costs to their employees in the form of higher premiums and deductibles. The unfortunate thing about this is that coverage offered for health care has also decreased at the same time.

In an effort to contain costs, some companies are opting for insurance in which their employees may choose from a list of doctors, one that they would like to treat them. This one doctor is considered the primary physician, and in the event that the employee needs medical attention, this is the doctor they must contact and visit. Regardless of the ailment, the patient is to see only that doctor and if that physician feels a specialist is needed he or she will refer the patient for that type of care. Since these Health Maintenance Organization (HMO) insurance packages are designed to cut costs and save money, the providers have no incentive to carry out additional tests, treat for an extended period of time, or hospitalize any individual unless it is deemed absolutely necessary.

Another group of people lacking health insurance are those with what is termed a preexisting condition. A preexisting condition could result from someone testing HIV positive, having heart disease, diabetes, or other types of disease

conditions. Costs to provide medical attention to these people can be astronomical. Insurance companies have no incentive to cover people with preexisting conditions because it would cost too much to cover them , thereby decreasing their profits.

The elderly of this country also face the difficult task of having insurance companies accept them as customers. Everyone over the age of 65 has Medicare, but even with this governmental coverage, these people are still having to pay a substantial amount of their costs out of their own pockets. To make things even worse, the supplemental insurance which was once available to many of these people has become extremely expensive, especially for people on a fixed income. In addition, some of the retirement programs offered by companies that were at one time very comprehensive are now nothing more than another alternative without answers, and may not offer what the retiree needs regarding health care coverage.

The health care dilemma extends far beyond people not having health insurance or subpar insurance. As previously mentioned, the costs of adequate health care are astronomical and could very well be the most hazardous part of this entire issue. Without some sort of cost containment there will be considerably more than 37 million people who will not be able to afford insurance.

How long can all of this continue? How much more tolerant should the United States citizens be before someone takes the initiative and does something about these problems? Why has the government not stepped in to take action on these matters? Questions like these are being asked by many people, but the answers do not come easily.

There have been ideas suggested by people in the legislature as to how the present conditions could be improved upon. However these ideas never seem to result in any action taken because the opposition always cuts down the plan before it is able to mature. Regardless of all the conversation about this situation, some action needs to take place and in the very near future, for the state of this nation depends on it. Throughout the remainder of this chapter, the author will attempt to uncover the reasons which have driven this issue out of control and touch on certain key areas that should be addressed immediately. This discussion will lay the groundwork for the major focus of this paper, based on the proposals available to the United States, for what type of health care plan is most suitable for its people.

Who is to Blame and Why?

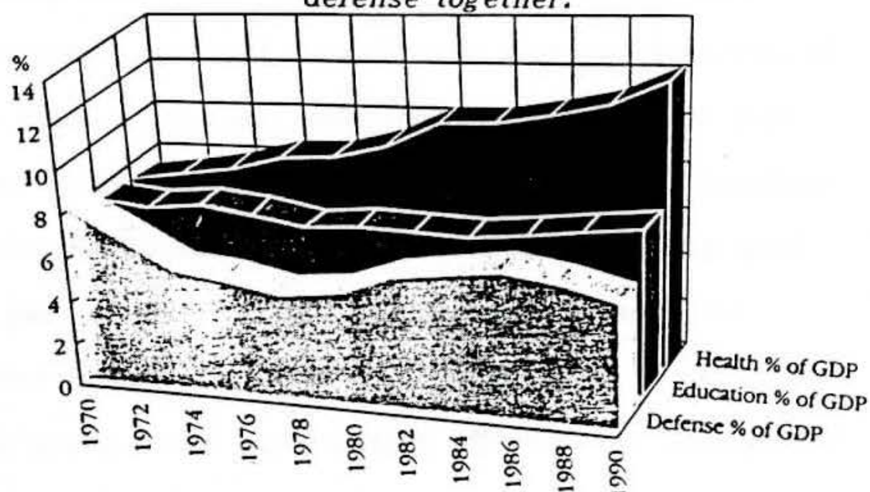
There is not a day that does not go by when the President, the First Lady Hillary Rodham Clinton, a doctor, a legislator, or

a chief operating officer of a major corporation does not criticize the sad state of health care in this country. For every remark that one of these people makes publicly, there seems to be literally hundreds of criticisms concerning why things got so bad in the first place. Unfortunately, no one ever seems to be in agreement, which might be one reason why nothing has been done to correct these problems.

Several facts remain unanswered and remind us all that change must occur soon. There are nearly 37 million Americans who are uninsured in the United States. To complicate this matter, the Commerce Department recently released a report predicting health care spending will reach one trillion dollars by the end of 1994 (See Figure 2); this equates to 15 percent of the Gross National Product (Wagner 2).

Figure 2

National Health Spending
In 1990, the U.S. spent more on health care than on education and defense together.



Source: Clinton 53 per HCFA, CBO Forecasts

The report also stated that spending will continue to grow at the rate of 13.5 percent for each of the next five years if cost constraints are not implemented. This will make it even more difficult for those 37 million presently uninsured to be able to afford coverage in the future. The above figures may not mean very much to the average individual, but they outline a very problematic situation. To dictate just how large these numbers are, the United States currently spends 14 percent of its Gross Disposable Product on health care; this figure is expected to rise to 17 percent by the turn of the century. It is important to consider that this 17 percent is projected based on action being taken to reduce spending on health care. The number could actually rise to 18 percent or higher if nothing is done. Paul Starr of The New Republic says that by comparing this to the seven point nine percent as the average of other industrialized countries, it is evident that a real problem exists (Starr 28). Individual states also may face these high costs. Medicaid expenditures average 14 percent of total state expenditures and have increased faster than just about every other component of the state budgets. Education is even being surpassed by the cost of Medicaid as the most expensive part of state funding (Clinton 9). All told, the United States is spending billions of dollars with no end in sight. For years, those high ranking officials, the same people

who run this country and who have known about this escalating cost have consistently chosen to put the issue on the back burner in hopes that it would cure itself. Unfortunately for them and for us, things have only gotten worse and are going to be ten times more difficult to solve as the situation has deteriorated so greatly.

Are politicians to blame because they have seen this problem grow for the past several decades and have done nothing to change the situation? Is it doctors who charge expensive fees to see their patients? Perhaps the blame should be placed on any citizen of this country abusing the health system, never being concerned until now about how much the doctor's visit really costs and have never worried about who was paying the balance of the bill. The answer would appear to be that everyone is to blame.

There are many external factors which have influence on this subject such as: an aging population, advanced technology, malpractice suits, and a desire to live as long and as prosperous a life as possible, that have all contributed to the high cost. In the next several paragraphs the author will attempt to explain how each of these elements plays an interrelated role in this situation which now appears out of control.

In our society anything that can be done to help an individual, whether it be comforting an individual in his/her dying days or providing expensive medical treatments in hopes of a full recovery is always a priority. Physicians, starting with their first day in medical school, are taught to save lives by using whatever measures are necessary. Medical breakthroughs and advanced technologies have enabled these same doctors to prolong and even enhance life in many different ways. Life expectancy rates continue to grow as more and more research is being conducted on what people should and should not do. With all of this good news, however, there is a very expensive price tag. Furthermore, doctors are expected to perform medical miracles while prolonging a human life. Anything short of this might result in legal and ethical attacks by the patient or other family members.

Pressure rests heavily on doctors to keep these high costs to a minimum, but at the same time provide the identical kind of quality work that assists people to maintain their health. Sometimes this pressure can be so great that many wonder if they are in the right line of work. Newsweek's Merlinda Beck reports that it is estimated that forty percent of doctors would not reenter the profession if they could do it all over again (30). Patients who come to a doctor want assurance that

everything is all right with them. If they have been suffering from migraine headaches, a doctor may tell them that these are stress related; the patient may ask or the doctor may order a CT Scan to be certain and the cost to have a CT done is high. Doctors may hesitate to order whatever it is that the patient has asked for; however if a brain tumor occured later and the doctor did not order this test, then he could be liable for the negative altered state of that patient's health.

Medical malpractice lawsuits are very expensive and can certainly disrupt an individual's career or strain the resources of a health care facility. We live in a litigious society; lawyers may encourage legal action if less than optimal outcomes occur. All of this adds to the overall cost of health care.

Many people are trying to lead more health conscious lives. Fitness programs and better eating habits are the major areas where this can be seen. The problem is that these steps are only done after persons have realized that they have not been taking care of their body. Prevention should occur long before it actually does. An example of this involves people who disregard the warning labels on cigarette packages. After inhaling carcinogens for years and often developing health problems, these people expect the state to pay their health costs when their own funds are depleted. But why should this be allowed when it was not the state who told them to smoke in

the first place? Another problem stems from the abuse of the 911 emergency assistance program. Many times emergency assistance is requested when it is not an emergency situation, similar to the overuse of emergency rooms in hospitals for non-emergency matters. If health care expenditures of this country are going to be decreased, these types of situations must be addressed in some other way, perhaps through more concentrated general health education information.

Fraud is another major problem in the health care system that must be addressed. There are many illegal practices that frequently occur including: overcharging for services; charging patients for care that was never rendered; giving kickbacks to doctors who refer patients to certain clinics and laboratories; and delivering unnecessary services. Medical fraud costs the health care system more than $200 billion annually (Beck 28).

Administrative costs also require attention. These costs take up to 40 percent of every health care dollar spent by small firms and the self employed, with only 60 percent going toward actual care. For all private health insurance, the cost of administration totalled $44 billion in 1991, an average of 16 percent of the benefits paid out (Clinton 58). It would appear that much of these costs could be eliminated if there was not so much paper work required by the insurance companies. Often a patient who is treated by more than one doctor will

have each of those doctors submit their own personal claims rather than sending them all in at one time. Having too many individual and small group insurance markets, nonuniform rules regarding coverage, and different types of claim forms all add to these administrative costs.

How to Start the Turnaround

There are two primary concerns regarding health care: how to make it available to all and how to curb the expensive costs that it commands. These are difficult problems to solve, and many people are beginning to feel that because of the magnitude of these problems the answers must be provided by the United States government. On the other hand there are those who disagree and point to the Medicare plan as being proof of this argument. When the Medicare program was established in 1965 government estimates were that by 1990 the cost would be $10 billion. Little did those innovators know that the actual cost would be closer to $107 billion dollars (Fineman & Thomas, 22). Because of the tremendous underestimation in this instance and a distrust of the government in general, people are hesitant to let government have another chance.

There are some things that can be done to curb portions of the expenses of health care. If more people joined HMO's

(Health Maintenance Organizations), if more physicians stopped performing needless tests and surgical procedures, if health awareness were stressed more often, if people followed healthy lifestyles, if hospitalization did not occur as frequently, if fraud was curtailed, and patient records were kept electronically, health care costs would surely drop tremendously.

Statement of Purpose

The purpose of this project is to attempt to assist the reader to a better understanding of the very unsettling problems regarding cost and access associated with health care existing in the United States, and what options there might be for possible solutions to these urgent situations. The issue has gained a sizeable amount of attention and there are currently several bills, including the Clinton Reform Plan, The Cooper Bill, The McDermott Plan, The Chafee Bill, The Gramm Bill, and the House Republican Bill, which are being offered as potential solutions. Each of these plans is slightly different from its counterparts and each therefore has created and continues to create debate and controversy. There are only a few different avenues which exist pertaining to structure of a health care plan, and in several cases these plans might be

patterned after those of other countries already implementing a health care plan for its citizens. In the next several chapters the author will discuss the merits and deficiencies of the various proposals and offer some suggestions as to possible directions we as a nation might take.

Chapter II

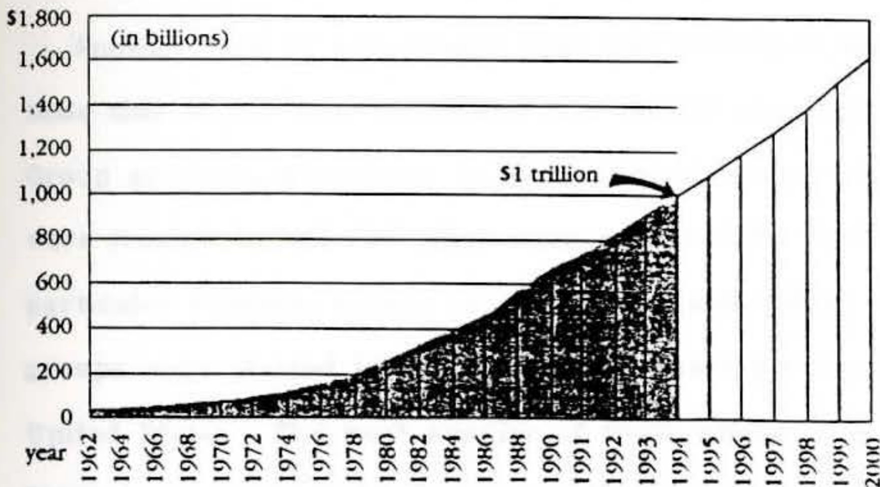
Literature Review

Historical Perspectives

The United States has always viewed health care costs as an important issue. Dating back to as early as 1929, health care expenditures accounted for 3.5 percent of the Gross National Product of this country. By 1935, that number had increased to 4.1 percent (Anderson 111). Today, that figure is almost four times that amount (See Figure 3).

Figure 3

In 1990, the U.S. spent more on health care than on education and defense combined.



Source: Clinton 8, per Statistical Abstract, 1992 (Tables 525, 135)

National health insurance did not exist in the early 1930's; when people became ill and needed medical attention, the cost came out of their own pockets. Two of the earliest private, voluntary health plans available for the people in the United States were Blue Cross and Blue Shield. These insurance plans provided health coverage to individuals in the event of a catastrophic situation or accident. Another purpose of the Blue Cross plan was to relieve the economic strain of the not-for-profit hospitals while providing care to patients for relatively small amounts of money. Blue Shield allowed private hospitals and physicians to control their financial status through prepayment plans and to pay for the high costs of medical services. Both of these plans gained popularity and, by as early as the 1950's, accounted for a large percent of coverage for hospital and medical services (Anderson 125).

Another form of prepayment plan was developed around the same time as the Blue Cross and Blue Shield plan began. Group practice, a business in which individuals enrolled and were treated by salaried physicians employed by that particular practice, gained recognition as well. Many of these groups were started in the West and Midwest portions of the United States. The most popular of these groups was Kaiser Permanente which virtually created the idea in the first place. The physicians within these groups specialized in several different areas of medicine, allowing convenience for the patient and more of a reason to use this service. People in the United States appeared receptive to this new form of

medical service, but Blue Cross plans were still more widely preferred (Anderson 132).

Voluntary health insurance was growing strong and was the preferred choice of Americans, but the insurance did have its share of critics also. Critics believed that voluntary health insurance was inadequate because coverage was not provided to the poor or self-employed. They appealed to the federal government for a federal program that could be administered so that everyone could have equal care and access to health care. After careful consideration, several of the legislators agreed and acted to address the situation. These legislators knew that cutting through the red tape of any issue on Capital Hill has never been easy and this issue would prove to be no different. Proponents for a national plan tried to convince the American people that it should be created to help relieve some of the financial burden placed on them for health care expenses. Their original goal was to, in some way, incorporate health insurance into the Social Security Act of 1935. The plan would then be subsidized through taxation and payroll deductions. However, before this idea even made it off of the ground, President Roosevelt ruled against the idea, saying that health care was not as important an issue as income transfer programs such as unemployment compensation and old age pensions. Just before the Social Security Act was introduced The Committee on Economic Security sent a report to Roosevelt reaffirming his feelings:

> We are not prepared at this time to make recommendations for a system of health insurance. We have enlisted the cooperation of advising groups representing the medical and dental professions and hospital management in the development of a plan for health insurance which will be beneficial alike to the public and the professions concerned. We have asked these groups to complete their work by March 1, 1935, and to expect to make a further report of this subject at that time or shortly thereafter. (113)

The above quotation would appear to confirm the fact that the issue of a national health care plan was just as controversial then as it is today. Interest groups including the American Medical Association (AMA), various organized labor and medicine groups, and some business and industry groups were vehemently opposed to a national plan. Research could not even be conducted without results being skewed to favor one side over the other (Anderson 118).

There still remained those who were determined to use their power to establish a national health plan. In 1939, the first of several national health care plans was introduced in Congress by Senator Robert F. Wagner. This bill, in addition to several others, discussed the importance of being federally initiated while having state participation. Additionally, each bill identified the importance of removing the economic strain of the high costs of care from the people through government interaction. It was suggested that automatic payroll deductions, taxes, or both be required so that each individual would be insured rather than have insurance offered on a voluntary basis. Unfortunately none of these bills even reached the floor for debate. It was clear that any form of a

national plan would have to come from a higher authority (Anderson 119).

For the next several years the idea of having a national plan had lost some of its momentum. However when president Harry Truman was elected to office the issue caught fire once again. Truman was the first Chief Executive of the United States to ever formally recommend a national health care plan. He was a firm believer in humanity and felt that if medical attention was necessary, one should not be denied access based on ability to pay for those services. Truman's administration was able to form a commission that was responsible for obtaining as much information as possible that would support a national health care plan. However, even with all of their efforts and attempts nothing ever materialized, as each idea was defeated in congressional hearings (Anderson 142).

In contrast to the Truman administration, Eisenhower did not believe in a federal health care plan; rather he believed that the voluntary plans which were available were satisfactory for the people. He did support the idea of reinsurance, a practice in which insurance companies could spread the risk and profits with their competitors. Eisenhower suggested that the federal government partially support the insurance industry similar to the Federal Deposit Insurance Corporation which supports banks. He felt that government should stay out of the picture and let private insurance cover people, unless it was necessary for them to become involved. The idea of reinsurance did not fare well with many in Congress and

met great opposition. Even after several months of strong lobbying by the Eisenhower administration, the idea failed to gain the support it needed and was no longer considered to be an option (Anderson 152).

No president since Eisenhower has been able to provide a national health care plan. President Lyndon B. Johnson did introduce the Medicare Act for the aged in 1965 (a federal program) and the Medicaid Act (a state/federal program) for the poor in that same year. Both of these programs work to alleviate the cost of care from families and the private sector, as well as support the revenue structures of the states respectively. While it is true that these programs provided some aid to those in need, the downside to these programs is that they have also created an increase in demand for health care, leading to cost shifting and many other less than effective experiences (Roberts 52). In the final analysis, there remain millions of people from every economic class level waiting for answers regarding this dilemma.

How Much Longer Until Action is Taken?

Although history appears to be against this country ever settling on a national health care plan, steps are being taken to initiate another attempt. This attempt has been anticipated by doctors, drug companies, and hospitals who have been hoping to head off the sterner measures that could be applied by those with political power. After years of rising twice as

fast as general inflation, medical care prices advanced an estimated six percent in 1993, the smallest rise in more than a decade (Faltermayer 76). Experts attribute this decrease to self-restraint on the part of these medical professionals, but as noted above, these moves appear to be too little, too late. Legislation is being proposed that will set the stage for government interaction with various controls to attempt to lower health care costs and/or obtain universal access. The many millions of people who have found it difficult in the past to receive medical treatment would then be able to access the system and share in the care that many others have enjoyed for years.

Many different plans are being considered as possibilities regarding a national health care plan. The variations found in many of these proposals will require compromise from all parties involved before any plan is selected for final approval. Indeed, several of the plans incorporate many of the same ideas and strategies of other countries with national health care plans. The citizens of those countries appear to be more satisfied by their plans effectiveness and fairness to all, but the reader should be forewarned that what may work for one country may not necessarily serve as a solution for another.

Many people have a difficult time understanding why it has taken the American government so long to set the wheels in motion for a national health plan. Contrary to what many believe, granting health care to all regardless of their income will not significantly increase the amount of care he/she may

want no matter how low the price for treatment may be. If you consider the Canadian health care system whose citizens differ from Americans in real income by less than ten percent, they manage to spend nearly forty percent less per citizen on health care (Fuchs 209). Add to this the fact that Canada spends more per capita than any European country with a national health care plan and one can see why the Canadian health care system has so many supporters in this country. Everything from administrative costs, resource allocation, centralized buying power, lower physician salaries, and global budgets account for savings in these health care plans.

The primary indicators determining the effectiveness of health care in a given country are infant mortality rates, life expectancy rates, and average cost of medical dollars being spent on people in that country (Francis 13). At this point in time the United States ranks poorly in each of these categories compared to other countries with national health care plans. There is a great deal of hope that a national health care plan may correct many of the problems currently encountered in the United States.

The remainder of this chapter will focus on the various health care plan alternatives available for the United States to consider. Additionally, several proposed plans which have been submitted to Capital Hill will also be discussed. Hopefully this in-depth look at the various aspects of health care and reform will assist the reader to understand why decisions are so difficult. The two major factors of cost containment and

accessability must be at the forefront of any potential solution.

So Many Choices!

As has been previously stated, there is no one plan that other countries follow in providing health care to their citizens. Based on factors including but not limited to economic, social, and cultural conditions, it would appear that each country currently providing care for its people has done so after careful consideration of what would work best for them. From a governmental standpoint there are three avenues which the United States might investigate regarding a health care plan structure (Reagan 85). A National Health Service (NHS) would call for the government to deliver health care services and finance them accordingly. National Health Insurance (NHI) is a publicly financed insurance plan devised to cover the entire population. It may be regulated completely by the federal government or by dividing responsibilities between the federal and state governments. Universal Health Insurance (UHI) is very similar to National Health Insurance. It is established by national law to cover the entire population using a mixture of public and private sector financing and operation. Universal Health Insurance is more broad based than that of National Health Insurance because it defines the scope of coverage without implying that the government is in charge (86). Additionally managed competition, employer

mandates supplemented by adjustments to existing public coverage programs, and plans that represent incremental attempts to improve the private insurance system without disturbing it, are also possible avenues worth considering (Reagan 8C).

In the following paragraphs, each of these avenues will be examined in an attempt to give the reader a clearer understanding of how these plans function and perhaps give some indication of what might work best for the United States.

National Health Service

A longshot is understood to be an entry given little chance of winning, and in this race a National Health Service could be considered just that. In a National Health Service the government has a great deal of responsibility. Russia, Canada, and Great Britain are three countries that operate under this type of health care plan. Financing care for patients, owning and maintaining all medical facilities, and hiring the medical staff are several of the more important roles the government must oversee. National taxes serve as the funding for all health care needs. No one living in that country can be denied health care and even people traveling to that country from around the world are eligible for care (Reagan 8C).

The largest pitfall attributed to this type of health plan is that the government is able to prioritize health care, meaning that those who are sickest get care first, and everyone else

waits their turn in line. Based on this fact alone the author contends that a program such as this would not work in this country. Americans are accustomed to being treated immediately, regardless of how minimal their problem might be.

There appears to be a less aggressive approach to obtaining second opinions and in the overall conducting of medical research by countries operating with this type of health care plan. The first diagnosis is rarely questioned regardless of the severity of the health ailment, and patients do not question the judgements that have been made by the physicians (Reagan 88).

These countries do not spend the billions of dollars each year the United States does on how a particular disease is created or how it should be treated; rather they take the more laid back approach, letting other countries do the legwork and gather any pertinent informational findings when information is provided.

National Health Insurance

In a National Health Insurance plan doctors operate as fee-for-service practitioners, patients are free to see whomever they want for consultation, and the government picks up the tab. The plan is subsidized through national taxation although budgets are developed between intermediaries of the government and the providers in each given area of that country. The most popular type of this plan is the Canadian

version. Citizens dwelling in countries with National Health Insurance are automatically eligible for health insurance regardless of their employment status (Marmor 424). Private insurance exists only for those services the provincial plans do not cover ("The Search for Solutions" 579).

In April, 1993, a New York Times/CBS poll revealed that 59% of Americans favor a single-payer health care system such as National Health Insurance (Meyer 1). Since then there have been additional studies that support these findings as well. Unfortunately, many other groups including physicians and employers are opposed to this format. At the 1992 National Association of Health Underwriters annual meeting a Canadian doctor spoke of physicians being "accountable to government, not patients," a fear that many feel should not go unchallenged (Mulcahy 10). However, some doctors feel that they are under enough stress to treat their patients without having to answer to any additional individuals. A study conducted by Medical Economics which surveyed physicians in September 1992, revealed that although eighty percent of the doctors felt that National Health Insurance of some sort was inevitable, only 12% reported they were happy with the idea (Goldberg 70).

Business executives have mirrored many of the same sentiments regarding government interaction in health care as their doctor counterparts. A study conducted by the Boston University Health Policy Institute revealed that 60% of the 254 business executives polled were not in favor of government providing national health care or requirements that employers

provide comprehensive health benefits (Woolsey 1). There would be additional costs to companies to provide what used to be considered fringe benefits to their employees. However, with all of the criticism being presented about this type of plan it remains as one of the frontrunning ideas, as far as a health care structure is concerned for the United States.

Universal Health Insurance

Another strong contender in the battle of the health care plans is Universal Health Insurance. This is very similar to National Health Insurance in which everyone in the country is insured and best of all the coverage is comprehensive and includes dental care, prescriptions, home medical supplies, maternity, funeral, and preventive care in addition to hospital and ambulatory care (Reagan 95). Essentially everyone who is employed is required to take part in the system. Individuals split insurance premium costs with their employers on a 50-50 basis. These people are then grouped into designated funds which have been budgeted for the fiscal year. Some companies are large enough so that they can form their own fund and do not need their employees to join others. There are hundreds of private non-profit insuring bodies working in conjunction with physician groups to determine how much money is needed to supply health care to everyone in these funds and how to establish the payroll deductions in a way to meet those needs.

For the most part government takes a back seat in this form of system. The government's job is to authorize financing and establish operations strategies (95).

A form of Universal Health Insurance is called the Play or Pay Approach and is one of the strategies currently being investigated as a possible solution to the American health care crisis (97). Under this type of plan employers would be required to provide health insurance to their workers or pay a tax that can be used to fund a publicly administered alternative plan, thereby allowing everyone to be covered. With this option, employers may choose to pay with the feeling that the annual insurance rates may jump, whereas the tax would remain stable. Employees would still be asked to contribute according to a fee schedule, including those employees who are uninsured, yet willing to contribute. Those presently with full insurance benefits might have some objections to paying a share of the premiums or any additional taxes bestowed upon them (Reagan 97).

This can be a risky form of UHI based on a report by benefit consulting company Millman & Robertson Inc.. They state that a play or pay national insurance plan for uninsured US citizens could result in a bankrupt public health system unless a risk-based financing scheme is used. The report notes that the 5% payroll tax on firms that did not have basic insurance coverage programs would not be enough to raise the money needed to sustain the health system and pay for medical bills. Other insurance consultants believe that risk-based

financing could not work on a national basis however, ultimately eliminating this entire option altogether (Woolsey 1).

Managed Competition

Another potential option that might or could be considered is that of managed competition. Managed competition is an idea developed by Alain Enthoven, a professor at the Stanford University Graduate School of Business and Paul Ellwood, president of InterStudy of Excelsior, Minnesota (Coughlin 8). This type of format does not currently exist but there is hope that it could work if it was given a chance. The idea itself has been intertwined into what has become known as The Jackson Hole Plan. In 1990 several of the highest ranking health officials in the United States came together at Jackson Hole, Wyoming to expand on what was then a very vague issue. The basis behind the plan is four-fold; a National Health Board would be developed to create a "standard" health package. People would be able to choose from whom they would purchase these plans, based on price competition and evaluation reports generated by an Outcome Standards Management Board (Roberts 105).

Health Insurance Purchasing Cooperatives (HIPC's) or health alliances operating as non-profit insurance purchasing entities would then be set up to provide coverage for individuals and small employer owned companies who have been denied affordable coverage for so long. Just as with the managed

competition model, if a large company wanted to act independently and provide coverage to all employees they would be allowed to do so(105).

In the third part of the Jackson Hole Plan, each health alliance would negotiate with what could be known as Accountable Health Partnerships (AHP) to provide the medical services included in the standard health package for a per capita annual fee. These AHPs would be comparable to what we know as Health Maintenance Organizations. The AHP would have information from which to base a budget and keep cost and efficiency at the forefront. Those unable to perform this way and deliver an acceptable level of quality care would eventually dwindle away from the remainder of the market (10C).

The final part to this plan addresses the tax laws of the employer and the employees. Presently all employer, and some employee contributions are not treated as taxable income. The law would be changed in order to treat these contributions as taxable income. Just who the responsibility would lie upon regarding costs remains a question. The plan provides for the standard benefit package; the least amount of cost (anywhere in each region) should serve as the basis. Anything above that level, would be paid by everyone with after-tax dollars (Roberts 10C).

Although this plan has much to offer, it does not guarantee universal coverage. In order for this plan to work public

financing, reform of the insurance markets, and required purchases into these alliances by everyone would be necessary.

The managed competition concept would also provide the opportunity to install an employee/employer mandate. All employers would be required by the government to have health insurance available to all employees working a certain number of hours per given week and in turn require the employees to purchase this insurance. Large companies have favored this approach for a long time because it would be a way to reduce their health care costs because they would no longer have to pay indirectly to cover the cost of those who are uninsured. Insurers and providers are also backing this approach because they claim coverage would be improved, boosting their business (Dowd 60). In the book, Your Money or Your Life: The Health Care Crisis Explained written by Marc Roberts, it is suggested that the easiest way to introduce an employer/employee mandate could be to have the employers pay a portion of the premium for the least costly standard plan in the region, and have the employee pay the balance if they decide to use a higher cost plan (Roberts 107).

The problem with employer/employee mandates lies with the small companies. Requiring employers to offer insurance to their employees would reduce profitability and in some instances could jeopardize the business itself. Additionally, the cost to support these employees could be overwhelming and many would feel the effects. Furthermore, mandating would require those who are self-employed and even the unemployed

to purchase insurance with premiums based on a sliding-scale government subsidy, since some individuals could afford to pay little or nothing toward their own insurance costs (100). This is almost like the government imposing a new tax, something which no one would favor.

The final strategy pertains to the reorganization of the private insurance markets providing health care coverage. Ultimately the goal is to ensure everyone access at affordable prices. Carl J. Schramm, Executive Director of the Health Insurance Association of America, believes that if loopholes were removed from the insurance industry, there would be no need for national reform. Specifically Schramm is talking about exclusions for higher risk individuals, no new restrictions when changing jobs or carriers, the cost differential between large versus small companies for equal health care services, and the financial support from states in the coverage of people who would otherwise be considered medically uninsurable. He adds that states should reduce their provisions regarding the range of services that must be offered in an insurance plan so that a "bare-bones" plan can be sold at a discounted rate to smaller businesses (Reagan 107).

These are some options that are available for the government and the people to consider. Although there are several good characteristics to each of these individual ideas there are also negatives that must be taken into consideration. These aspects are all part of the reason for the delay in making a decision regarding which of these plans would work

best. Some of these ideas are being used in national health care plans in other countries and in the following section the author will discuss the plans of Great Britain, Canada, and Germany in an attempt to provide the reader with additional information in order to determine more clearly which might work best in the United States.

In order to obtain the most current information, the embassies of the aforementioned countries were contacted for specific data. The development of each plan, who it involves, what services are of use, and any administrative information regarding the plan will be discussed. Access and quality are the key ingredients to each of these plans which attempt to serve their citizens as best thsey possibly can.

Great Britain

The author feels there is plenty of good to be said about this system. For example, in Britain waiting lists have shortened, childhood immunizations are at an all-time high, and hospitals are handling more patients (Britains National Health Service 57). A more thorough understanding of how the British National Health Service works will be discussed later in this chapter.

Great Britain began its National Health Service on July 5, 1948. Both England and Wales provide a comprehensive health service designed to secure improvement in the mental and physical health of the people through prevention, diagnosis,

and treatment of illness. The National Health Service covers a comprehensive range of hospital, specialist, family practitioner (medical, dental, ophthalmic, and pharmaceutical), artificial limbs and appliances, ambulance and community health services. When the Local Authority Social Service Act of 1970 was passed, the Secretary of State also became responsible for the provision by local authorities of social services for the elderly, the disabled, those with mental disorders and for families and children (Social Welfare 1).

Ten years later the Health Services Act of 1980 changed much of the old reform. For instance, in April, 1982, District Health Authorities (DHA's) became responsible for the operational management of health services and for planning within regional and national strategic guidelines. Presently 179 DHA's exist in England and 9 in Wales. District Health Authorities must arrange their services into units of management at hospital and community service levels, and as many decisions as possible are delegated to unit levels (1).

Arrangements for the Family Doctor Service are administered by Family Health Services Authorities (FHSA's). Ninety exist in England and eight in Wales. These also contribute to the planning of health services (1).

Finally, there are also 14 Regional Health Authorities (RHA's) in England that oversee regional planning, allocation of resources to the DHA's, FHSA's and GP fundholders and promote national policies and priorities. RHA's serve as the middle man of sorts in that each DHA reports to the RHA who

reports to the NHS Management Executive at the Department of Health (1).

The health plan is financed largely through the taxing of those living in Great Britain, National Insurance Contributions paid by employees and employers, land sales, as well as through the cost met from monies voted on by Parliament. Capital and revenue allocations to the program work in a filter down pattern from RHA's to DHA's (1).

In 1990 the National Health Service and Community Care Act was passed and provided for reforms in management and patient care. Better health care, a greater choice of services to patients, and a quicker response by those employeed in the NHS to meet needs in a more cost conscious fashion are largely what this act entails. This is to be achieved through specific initiatives such as the introduction of medical audits by peer review throughout the Great Britain NHS and through updated management and funding guidelines. The Patients Charter was established in October, 1991, to set forth patient rights and national quality standards in nine key areas. All Health Authorities must develop and publish their own local quality standards as of April, 1992 (1).

In England and Wales the Family Doctor Service (or General Medical Services) is managed by 98 Family Health Services Authorities (FHSA's) which also organize the general dental, pharmaceutical, and ophthalmic services in their areas. The Family Doctor Service is open and there are presently 28,000 doctors enrolled. These physicians are also free to treat

patients on a fee-for-service basis as well. Doctors are paid according to a formula involving the combination of a basic practice allowance, capitation fees, reimbursement for certain practice expenses, and payments for out of hours work (1).

General practice services with at least 9,000 patients are able to apply for fund-holding status. This allows the practice to be responsible for its own NHS budget for a specified range of goods and services. At the time of this report, 580 fund-holding practices are in existence (Social Welfare 1).

The general guidelines of the plan regarding who is eligible for coverage states that anyone age 10 or over may choose his/her physician. Physicians, however, may refuse consideration of that request to be the person's primary care physician. Finally, a clause in the national health plan allows for patients to transfer at any time from one doctor to another. New forms must be filed and corrections must be adjusted on the patient's health card (1).

Dental services are also available for British citizens and are supplied by nearly 10,000 doctors that answer to the Family Health Services Authorities. Again, patients may choose their doctor provided the doctor agrees to treat the patient. Patients are required to pay for three quarters of the dental costs unless they are one of the following: under 18 years of age; full-time students 19 years of age or younger; expectant mothers; and any woman having given birth in the previous twelve months; these people are exempt from all costs. The same applies for any person on welfare (income support)

and/or their family members. The dentists themselves are compensated through capitation fees for treating those less than 18 years of age and through payment for items of treatment for individual adult patients and continuing care payment for those registered with them. There is a maximum cap set on how much a person can be charged per visit which is roughly $400 in American dollars at the time of this writing (2).

In addition, prescription drugs are available to all citizens in Great Britain. A flat rate of roughly $7.50 per item distributed is the charge unless the person is exempt and the declaration on the back of the prescription is completed. Exemptions include those under 16, full-time students 19 years of age and younger, the elderly, pregnant women or those who have recently given birth, individuals suffering from certain medical conditions, and those who receive income support (2).

Ophthalmic services work in much the same way as that of prescription services. Family Practitioner Committees administer these services which allow for free sight tests for children under 16 years of age, full-time students under 19 years of age, Income Support recipients, people prescribed complex lenses, those legally or partially blind, any diabetic or glaucoma patients, or any close relatives older than 40, related to a person diagnosed with glaucoma. If glasses are needed many of these same people are entitled to help with the purchase of glasses under the NHS voucher scheme. This provision states that the value of the voucher depends on the

lenses required and that these vouchers may be used to help pay for the glasses or contact lenses of the patient's choice. Vouchers may be obtained from that person's ophthalmic medical practitioner; this will be awarded to the patient with the prescription. Both documents are then taken to the supplier of the glasses of that patient's choice and the prescription can then be filled (2).

The aforementioned material discusses all primary care services offered in England and Wales. In addition, the government must see that hospitals and other ambulatory facilities are available and acceptable. Persons being admitted as an inpatient will be covered under the national plan unless they desire a private room. Most hospitals have these kinds of accommodations for people willing to pay the full costs of the hospital stay, including services and any additional medical fees to specialists. The amount of medical fees is a matter for agreement between doctor and patient. Hospital charges for private resident patients are determined by District Health Authorities either on a local basis or in line with a central model list (2).

Citizens of Great Britain are also free to seek out rehabilitation services including occupational therapy, physiotherapy, and speech therapy; all surgery and prosthetics are to be distributed as part of the health plan as well, with no added cost to the individual (2).

Canada

The Canadian Health care plan originated in the Saskatchewan province in 1947. It was the first province to offer the public universal hospital insurance. By 1949 British Columbia had a similar program and Alberta and Newfoundland had hospitals that provided partial coverage. In 1957 Parliament passed a law that had the federal government share in the cost of provincial hospital insurance plans that met minimum eligibility and coverage standards. By 1961 each of the ten provinces and two territories had public insurance, which plans provided comprehensive coverage for hospital care for all residents. By 1972 coverage was extended to include physicians' services as well as outpatient and emergency services (<u>Health Care in Canada</u> 2). This type of system is called the single-payer arrangement because one entity, the government, pays the bills.

For the first twenty years the federal government's financial contribution to these coverages (known as Medicare) was determined as a percentage of actual provincial expenditures on insured health services; this amount usually came to one half. In 1977 this system changed based on per capita block funding. Today the federal government's contributions are based on a uniform per capita entitlement which takes the form of a tax transfer and cash payments (2). Each province entitlements are based on their compliance with the five principles set out in federal legislation. These include

public administration, universality, portability, accessibility, and comprehensiveness ("The Search for Solutions" 579).

The strategy behind the role of public administration suggests that the insurance plan must be administered on a non-profit basis by a public authority responsible to the provincial government. Universality is defined as the health plans cover all legal residents of the province who are eligible for coverage after a minimum period of residency of not more than three months. Portability means that even if a person should move from one province to another, their health coverage will continue uninterrupted. Accessibility is defined as each provincial health plan is required to provide access to necessary hospital and physician care, without regards to financial and/or other barriers; no one can be discriminated against based on age, race, or health status. Finally, comprehensiveness deals with all services being covered through provincial health care plans, including home care, and nursing home care although a small charge may be assessed for accommodation costs (579).

In 1991 Canada spent $50.9 billion on health care; this accounted for one third of the provincial budgets. Income, sales, and payroll taxes account for the majority of the funding for this health plan. Currently, only Alberta and British Columbia collect premiums which are not rated by risk in either province, and prior payment of a premium is not a pre condition for treatment (Health Care in Canada 2). A Canadian citizen earning $20,000 (US) in the Ontario province would pay

roughly $7,200 or 28% in federal and provincial taxes. In the United States the individual earning the same amount would pay $6,100 or 23% to federal and state taxes. The important difference is that the $1,340 extra of Canadian money goes toward health care cost (Fishman 277).

Canada has been able to keep costs to a minimum because of the close eye it keeps on administrative costs. The costs for administering public and private health insurance loans, hospitals, nursing homes, and physicians' offices account for 8-11% of total care costs in Canada, compared to 19-24% in the United States. With a single payer system that operates with only a limited number of private insurers, Canada does not have to address or deal with marketing, estimating risk status, and deciding who should be covered. Furthermore, administrative costs for hospitals and doctors are also lower. Since the physicians bill the province and not the patient, they do not need to verify coverage or complete the paperwork required by multiple private insurers, or cope with problems of double billing and uninsured patients. Malpractice insurance for doctors is also much cheaper and is obtained through the non-profit Canadian Medical Protective Association (Health Care in Canada 3).

It would appear that doctors in Canada are very similar to their American counterparts although nearly 63% of all Canadian physicians are primary care doctors as compared to 45% in the United States (Health Care in Canada 1). They work for themselves (putting to rest the myth of socialized medicine)

and in their own offices, but the difference lies in the billing. Canadian physicians are not allowed to charge whatever they wish; rather their fees are set according to a schedule negotiated by the Ministry of Health in each province and the provincial medical association. Canadian physicians may not practice "balance billing", that is the difference between what the insurers will pay and what the doctor really wants to charge (The Search for Solutions 580).

Under the Canadian system, patients are able to choose their physicians. When they need medical assistance all they must do is show their identification card prior to treatment. There are no bills, claim forms, out-of-pocket costs, or waits for reimbursement from insurance carriers for these patients, often problematic in the United States. Every Canadian is literally on the same provincial health insurance plan as his/her neighbor. They also have the same coverage under their provincial plan of equal terms and conditions, not varied options.

Germany

Germany's health insurance is a combination of government-mandated financing by employers and employees, private provision of care by physicians, controlled hospital expenditures, and administration by non-profit insurance companies (GDR Fact Sheet 1).

Established in the early 1880's by Otto von Bismarck, Germany has watched patiently as its health plan has fully evolved to its potential. The major provision requires that everyone have health insurance based on the wages they earn; it is not dependent on preexisting conditions, age, or any other discriminatory factors. Employee and employer mandates set the stage for an even 50-50 split of insurance premium costs. This qualifies for a 12.8% share of the total costs of operating a business. The accounts are known as sickness funds or Krankenkassen and are in ample supply, totaling close to 1,100 (Harper 150). These Krankenkassen work with 19 regional organizations of ambulatory physicians in order to negotiate fees. The government's role in these negotiations is minimal; it simply sets the guidelines for what should be considered and allows those parties to act accordingly (Reagan 94).

It is possible for some people, namely those who are self employed, to obtain private insurance and bypass the statutory health insurance. Provided that an individual earns more than $37,000 per year he may pursue this route. To date, approximately 8% of the population in Germany is insured under private health plans (Reagan 95).

In the event of illness, all insured persons receive the necessary medical services and benefits free of cost or at greatly reduced prices. As the health insurance agencies enter into contractual obligations with physicians, hospitals, and pharmacies, this assures that all treatment will be paid by that person's health insurance. Services provided for all people

remain the same. This includes the unemployed and retired who are in sickness funds obtained from pension funds and government payments, and are collected from the working cohort (GDR Fact Sheet 2).

When patients need treatment they are free to seek help from any doctor, specialists included. This places a great deal of pressure on doctors because competition can be fierce. Doctors in the German plan are issued booklets of health care tickets each quarter by the sickness funds. The doctors then exchange these tickets for medical treatment. The doctor collects one ticket per quarter from each patient he sees, writes a description of his services for the period on the back of the ticket, then sends it to the local sickness fund which reimburses the physician at the end of the quarter. Points are assigned by that sickness fund based on a uniform national scale, similar to the resource based relative value scale of our new Medicare fee schedule. Doctors are paid according to the number of points they accumulate. If a physician scores ten percent better than the average doctor he is awarded ten percent more (Harper 157).

The German National Health Plan is comprehensive in coverage and includes everything from dental care, prescriptions, funeral benefits, and hospital and ambulatory care although some services require a small co-payment. The plan has one large advantage in that it offers sickness benefits, that is, in the event of a sickness, the employer has

to continue to pay the full wage or salary for a period of six weeks. After six weeks the insured person receives 80% of the last income from the health insurance fund. The maximum of the sickness benefit is 78 weeks within a period of three years. Similarly, ten days for each sick child under the age of 12 which must be cared for by the parents is allowed. For single parents this period is extended to a maximum of 20 days (GDR Fact Sheet 4).

The German health plan has a very comprehensive utilization review system which keeps a close watch over its' physicians. Detailed physician practice profiles compare a doctors use of a wide range of services with average patterns in his specialty. If his usage is more than 50% above the average, his reimbursement may be cut. Also if physicians prescribe more drugs to a patient than is considered appropriate, he has to reimburse the Krankenkasse for the overage in cash (Stevens 152).

The Pending Proposals in the United States

Six major health care reform bills that to this point in time have received the most publicity will be discussed in the following section; these include The Clinton Plan, The Gramm Bill, The House Republican Bill, The Chafee Bill, The Cooper Bill, and the McDermott Plan. All of these plans attempt to incorporate similar ideas on what the people of this country need through carefully devised policy strategies. Each also attempts to provide the solution to the problem this country

has regarding health care in all aspects of the word. They differ from one another in their priority to collectively capture, address, or deal with all of the issues and speak to majority needs or wishes while maintaining their credibility.

The Clinton Plan

There are six basic principles which underlie this Health Security Act including security, simplicity, savings, quality, choice and responsibility (Clinton 17).

Security involves the guarantee to all that they will have comprehensive benefits that can never be taken away. Furthermore, this act outlaws practices by insurance companies that hurt consumers and small businesses. Insurers will not be allowed to deny coverage or impose a lifetime limit (ensuring that benefits will continue, no matter how much care a person may need) on people who are seriously ill. Clinton also believes that those who are older should pay the same amount as those who are younger; the same holds true for sick people not having to pay any more than their healthy counterparts. Limits would also be set on what consumers would have to pay for coverage, how much premiums could rise per year, and maximum amounts that families would spend out-of-pocket each year, regardless of how much or how often they received

medical care. Medicare would be preserved and strengthened through the addition of new coverage for prescription drugs and a new, long-term care initiative would expand coverage of home and community based care. Finally, access to quality care would expand so that people would know that there would always be a doctor that they can get to and a hospital that would treat them. Particular attention would be paid to the needs of the underserved rural and urban areas (Clinton 18).

The Health Security Act would reduce the paperwork by handing out to each citizen a Health Security card and establishing a standard claim form to replace the hundreds of different ones which exist today. Additionally, the plan would cut insurance company red tape by creating a uniform comprehensive benefits package, standardizing billing and coding, and eliminate all fine print (18).

The biggest concern to many is cost. The Health Security Act will control costs through several different measures. First, by increasing competition, health plans will be forced to compete on price and quality, instead of on who does the best job of excluding sick and old people. Second, the various health plans available in the Health Security Act will have an incentive to provide high quality care and control costs to attract more patients. The Act will also strengthen buying clout by bringing together consumers and businesses in "health alliances" to get good prices on health coverage. Today big businesses use their clout to get low prices;

alliances will allow consumers and small business to get a good deal also. Third, administrative costs will also be drastically reduced through a more simplified claims system and reduced paperwork. Fourth, The Act places limits on how much premiums can rise, acting as an emergency brake to ensure that health care costs do not spiral out of control. Finally, the Act vehemently opposes any form of fraud and makes it punishable through extremely stiff penalties (Clinton 19).

Quality is also one of the more important characteristics of the Health Security Act. Doctors and hospitals will have access to the best information and latest technology which will make for a healthy, but competitive market place. Investments will be made into new research initiatives on how to make prevention work, new treatments, and new cures for disease. Additionally, a new emphasis will be placed on preventative medicine and how to keep people healthy rather than treating them after they have become ill (19).

Everyone will be able to sign up for a health plan where they work. They will be free to choose the doctor of their choice and follow him/her into a traditional fee-for-service plan, join a network of doctors and hospitals, or become a member of a health maintenance organization. Brochures will be made available that will detail information regarding the health plans, their doctors and hospitals, and an evaluation of the quality and prices of each of these. Consumers will have an opportunity once every year to choose a new plan without

explanation to anyone. Employees will contribute approximately 20% of the cost of these plans unless the employer chooses to pick up the entire amount. This twenty percent will be deducted from employee paychecks. The only other cost to the employee will be the limited co payments or deductibles to their health plan as part of their coverage. Under the Health Security Act, no business will ever pay more than 7.9% of their payroll for health insurance (Clinton 22).

Those who are self-employed or unemployed may sign up through health alliances in their areas. The alliances are operated by boards of consumers and local employers who contract with and pay health plans, guarantee quality standards, provide information to consumers looking to choose a plan, and collect premiums (22).

The Health Security Act maintains that cost can be kept to a minimum based on the monetary provisions which are set. According to the immense studies which have been conducted on this topic, the government feels that if the following provisions are carried out, all will be able to attain health care coverage at minimal costs. The Act ensures that all people, regardless of income or health, be covered. Monthly premiums are set in such a way that affordability is a priority. Under the act, even low income families might be eligible for monthly premium discounts if they are in a two parent family with an income below $22,200, a single parent family with an income below $18,400, married couples with an income below $14,600, or

a single person with an income below $10,800. Those people who are 65 years of age or older will continue to receive their health care through the Medicare program. Older workers and their spouses will receive the same comprehensive coverage as other working Americans through the health alliances. The unemployed will have coverage without interruption, paying only 20% of the premium with discounts based on their income. Those with non-wage income- such as interest payments, may also be responsible for some or all of the employer's (80%) share. Part-time workers will pay for a portion of their health insurance premiums. As long as they are working, their employers will also pay a portion of their premiums. Depending on their incomes, part-time workers may receive discounts for the remainder. Those who are self-employed may be the largest beneficiaries of the Health Security Act. They presently are only allowed to deduct from their taxes a total of 25% of their health care premiums, but under the new act they would be able to deduct the entire amount of those premiums. They pay the employer's share and are eligible for any discounts that might apply. They also pay the individual/family share, and may be eligible for discounts on that as well, depending on their income. Finally, retirees would only be responsible for the 20% share of the premium, although former employers may choose to cover that 20%, or could be required to do so under collective bargaining agreements (Clinton 30).

The financial protection of the plan appears to be very stable as well. Whereas in today's available health coverage deductibles may range from $300 to $3000 dollars, under the act many plans will not have deductibles and those which do will not exceed $220 for an individual or $400 for a family. Additionally, there will be no limit on what insurance companies will pay, unlike today's system where 60% of the insurance companies have policies that may run out if the person gets very sick (Clinton 31).

The co-payment system will vary according to the three different types of plans (fee-for-service, doctor networks, and health maintenance organizations) available. In each plan there will be no out-of-pocket cost for any type of preventive services. Fee-for-service patients will be required to pay 20% of the cost after the first individual/family deductible has been paid, not to exceed an annual out-of-pocket amount of $1,500 per individual or $3,000 per family. The Doctor Network (PPO) will have low co-payment of $10 with no deductible, if patients use the doctors within the PPO. Should doctors outside of the network be used, copayments would be 20% of the cost per visit, after the $200 individual or $400 family deductible has been reached. Nothing more needs to be paid by the person once the maximum out-of-pocket totals have been reached ($1,500 for an individual and $3,000 for a family). Health Maintenance Organizations would have patients pay no more

than $10 for each doctor visit with no co-payments for hospital care and no deductible to be met (Clinton 31).

The Gramm Bill

U.S. Senator Phill Gramm's (R-Texas) health care plan is being co-sponsored by Senators John McCain (Arizona) and Hank Brown (Colorado). Gramm's Bill proposes the shifting of responsibility of the entire $900 billion a year U.S. health care system to individual citizens by creating a special tax-free account that would enable people to save for their own medical needs (Dowd 83). Gramm's Bill features massive new federal regulations of the insurance and health care industries; lesser new regulatory burdens on all employers; and a massive new government-funded entitlement program. The bill avoids requiring employers to provide insurance, opting instead for direct government subsidies to those who cannot afford insurance. The bill also avoids mandatory spending caps, preferring to control cost through increased competition (Kinsley C).

Gramm's bill would let self-employed workers exclude health care costs from their income, equal to the national average of employer's contributions. It would be calculated annually and, says Gramm, "will ensure that anyone without employer-based health insurance coverage" is treated fairly (Herrmann 24). Additionally, coverage will continue to exist for any employee

who leaves a job for 18 months following his departure. Gramm would also make tax credits available to families and individuals not covered by Medicaid and with incomes below 100 percent of the poverty level, with credit reducing as income rises (24).

Estimates reveal that should his bill pass by the end of 1994, the tax benefit would be the single most expensive part of the proposal, costing $8.7 billion in 1990. The total price tag for the bill is set at $144 billion over a six year period and does not call for new taxes. Some funding could come from Medicare/ Medicaid and other savings. The bill would also create medical savings accounts for employers to deposit before-tax money of an amount currently spent on health insurance premiums into an account to purchase catastrophic coverage for employees (24).

The Gramm Bill offers a cost control device that would strong-arm people into going without insurance for the first $1,800 to $3,000 of annual medical expenses (at which point "catastrophic" insurance would kick in). The idea behind this is that it would make consumers much more price conscious (Kinsley 49). Another cost control variation would be in the three new health care benefits in this proposal, universal health insurance tax exclusions, high-risk insurance pool subsidy, and low income worker tax credit for insurance. None of these would take effect until the savings from reforms in the plan actually occur. Also, financially capable persons not

purchasing insurance will not receive federal premium assistance (Herrmann 30).

There are several strong selling points to the Gramm Bill. First, it could provide equal tax treatment for the self-employed, uninsured workers, and all others. Second, those under Medicare could keep their current coverage or use annual government assistance up to expected cost of annual Medicare coverage to enroll in private HMO's or buy a medical savings account where the employer would contribute the amount currently expended on coverage. Third, the Medicaid system could be reestablished in a more effective way by having the federal government pay states on a per capita system. The states could then have more flexibility to redesign their own kinds of Medicaid systems that could best suit themselves. This could be accomplished by either continuing their current system, enrolling recipients in a private HMO or other arrangement, establish Medical Savings Account plans to cover recipient medical expenses, or use co-pays and/or other innovations (Herrmann 27). Savings in these Medicaid systems could be achieved in a variety of different ways. Capitated payments can be used where the states receive annual federal payments based on the number of recipients and risk classes they fall into. The payment to the states would change with increases in the medical price index. With price competition being introduced, the differential between the medical price inflation index and consumer price index should decrease by

1/2 over a given five year period. Finally, with high-risk subsidy and universal tax exclusions, some Medicaid recipients will purchase private plans. When this happens, price competition will halve the growth rate difference between Medicare and the medical price index within a given five year period as well. It is estimated that risk pool coverage and universal access will cut the use of deduction of health care costs over 7.5% of income (29).

The House Republican Bill

This bill is being introduced by the House Republican leaders and members of the Leader's Health Care Task Force. Its official name is the Affordable Health Care Now Act. It does not serve as a comprehensive plan and does not offer the universal coverage guarantee. It does however require employers to offer coverage (although not through employer payment mandates) and make health costs 100% deductible for the currently uninsured and for the self-employed. Similar to the Gramm Bill, it would establish tax-free medical savings accounts and reform insurance sales practices (Herrmann 24).

The House Republican Bill provides for an imposition of small group market insurance reforms to help small businesses provide insurance to workers. For instance, all insurers that sell to small group markets (2-50 workers) must offer the standard plan, catastrophic plan, and Medisave plan (24).

At the time of the author's research, there was no information that could be found regarding the proposed financing of this bill. This bill does, however, call for the creation of risk pools so that risk can be spread among insurers, federal programs that will eliminate barriers that could prevent employer groups from offering tax-exempt coverage, and the establishing of standards that could provide incentives for multi-employer insurance purchasing groups. Guaranteed renewability, portability, limited year-to-year premium increases, limited premium variation, and no preexisting condition exclusions are other key components to this bill's structure (27).

As previously mentioned, The House Republican Bill believes in the developing of medical savings accounts. These accounts will feature deductibles of $1,800 for individuals and $3,000 for families. The maximum yearly contribution equals the maximum yearly deductible or $2,500 for individuals or $5,000 for families. These accounts would also feature tax free interest (Herrmann 27).

Several cost control measures particularly catch the attention of political counterparts regarding this bill. This legislation preempts state mandated benefits and anti-managed care laws, permits states to use private insurance for Medicaid, allows state Medicaid flexibility, simplifies administration by streamlining paperwork and bills electronically, merges Medicare Parts A & B, and reforms illegal and unethical practices. The

organizers of this bill strongly feel that any plan that is approved will require these to be present for passage (30).

The Chafee Bill

Senator John Chafee, a Republican from Rhode Island, was appointed in the Fall of 1993, by GOP leader Bob Dole to head a task force which dealt with the health care issue. Crafting the principles that 23 Republicans signed as a buffer against the Clinton Health Security Act, Chafee's Bill does not include any price controls or employer mandates. Universal coverage, a comprehensive benefits package, a National Health Board, and purchasing alliances, however, are in this program. Chafee's Bill has been redrafted under pressure from conservatives and Dole himself. It now institutes voluntary purchasing alliances from the original mandatory purchasing alliances. Chafee's intention to include the mandatory alliances was to end adverse risk selection, reduce administrative costs, and enhance consumer choice. The senator's concern that a participation cutoff of businesses with fewer than 100 workers would put nearly all employers and about half of the market in alliances was troubling. So, too, was his concern the creating a "third layer telling people where they must buy insurance," on top of his mandate that people purchase specific coverage (Blankenau 10).

Similar to the Gramm Bill, the Chafee Bill also calls for medical savings accounts, but insists on delaying universal

coverage until the year 2005, extending coverage only as savings are realized (Barnes 13).

Chafee's bill incorporates many of the features of managed competition but differs from the Clinton Plan in several key areas. There are no requirements for employers to pay premiums, nor are there any controls on insurance pricing. Small employers, however, must join Small Business & Individual Purchasing Cooperatives (SBIPC) or cover employees via Qualified Health Insurance Plans (QHIP). Chafee's Bill also calls for the establishing of corporate alliances within companies having 500, not 5000 employees, as the Clinton Plan boasts. Additionally, the Chafee Bill offers a standard benefits package which includes hospital , physician/professional services, prescription drugs, preventive services, durable medical equipment, lab/diagnostic testing, home health care, skilled nursing, eyeglasses, severe mental health, and substance abuse treatments. Putting an end to "red-lining", that is, covering only the healthy and/or increasing prices for those with a history of illnesses, is also a priority. Finally, this plan features coinsurance and deductibles for all but certain preventive services. A catastrophic alternative exists and is similar to the standard benefit package, but has high patient cost sharing. Qualified Health Insurance Plans must offer both the standard plan and the catastrophic plan (Herrmann 25).

The overall cost control provisions of this plan include employer/employee dollar tax capitation, administrative

simplification including standardized electronic data transmission and uniform reporting, malpractice reform, antitrust reform, and anti-fraud provisions (30).

According to the structure of this bill, it appears to be exclusively formulated and well developed. To begin, a Benefits Commission recommends a package to Congress and ultimately would recommend annually any updates to that package. Small Business & Individual Purchasing Groups (SBIPG) are then voluntarily formed within state-defined geographic areas, but may cross state lines. Appointed members would govern these SBIPG's which are to collect premiums and premium surcharges and disseminate consumer information to those small firms and individuals taking part in that given SBIPG. Each individual state has responsibility for certifying health plans, defining the geographic areas of the SBIPG's, determining if the SBIPG's are exclusive, and establish, if they choose, alternate programs. States would also see to the creation of medical savings accounts and deductibles to tax capitation. Qualified Health Insurance Plans (QHIP) would conversely have a grievance procedure, establish a risk management program, comply with states' risk adjustment procedures, meet quality criteria, meet solvency criteria, guarantee renewability and portability, limit preexisting conditions, not discriminate based on health status, and limit year-to-year increases on deductibles. The bill also ensures for long term care insurance which is treated as health insurance for tax purposes, and allows insurance

companies to deduct long term care reserves provided they meet consumer protection standards (Herrmann 27).

From a financial standpoint, the Chafee Bill could reduce the combined rate of growth for Medicare/ Medicaid from 14% to nine percent by increasing the Medicare Part B Premium, means testing that premium, eliminating Medicare disproportionate share payments, eliminating bad debt payments, changing the asset transfer rule, and by mandating Medicaid managed care (29).

The Cooper Bill

Democratic Congressman Jim Cooper, author of Tennessee health care bill, has become the clear favorite of the Democratic Leadership Council. Co-sponsored by Republican Representative Fred Grandy of Iowa, his plan is appealing to a variety of those in the political forum because it, unlike the Clinton Plan, does not require all employers to pay 80% of workers' health premiums, trimming employer's tax deductions on premiums, or do away with caps on insurance premiums. This bill is very similar to the single-payer Canadian system and would offer universal access, which would enable, but not require, all Americans to buy coverage. Like the Clinton Plan, Cooper promotes regional health purchasing cooperatives, guaranteed coverage for people with pre-existing medical conditions, and competition among providers to push down costs (Smolowe 39). Other key ingredients to this proposal involve the

standardization of benefits so that buyers can make easy price comparisons among insurance plans; requiring doctors and hospitals to publish performance data so patients may learn who is dispensing quality medicine; and establishing health alliances to give individuals and small firms the purchasing power enjoyed by the larger companies (Fineman 2C).

The Cooper Plan would defer the issue of a basic benefits package to the National Health Board (NHB) created by the bill. It appears to be very generous , with very low deductibles and/or co-payments. However, unlike the Chafee Bill, the Cooper Plan does not permit "patient power" plans which allow consumers to purchase catastrophic insurance with high deductibles and deposit their premium savings in medical savings accounts to pay for routine expenses directly. It would be up to the board to determine what procedures are "medically appropriate." As stated in the New Republic, Cooper appears extremely conscientious about getting a handle on the explosion in costs and is making a statement that basic insurance cannot pay for treatments that are not cost-effective. The board would also be responsible for setting rules for risk adjusting, setting reporting standards for Accountable Health Plans, authorizing centers for care, setting quality standards, assessing quality, and regularly reporting the uninsured ("For the Cooper Plan" 8).

The Cooper Plan attempts to control spending in ways similar to the Clinton Plan. In a managed competition setting,

small purchasers of insurance band together in statewide cooperatives and use their purchasing power to negotiate with health plans. These are known as Health Plan Purchasing Cooperatives (HPPC) and would serve small employers with less than 500 employees in the state defined areas. It is required that each health plan purchasing cooperative cover 250,000 eligible individuals, contract and enroll people with Accountable Health Plans, establish a grievance process, assess enrollee satisfaction, and may not set payment rates or assume financing risk (Herrmann 2C).

Accountable Health Plans (AHP) include closed plans with one or two employers and open plans which are open to anyone to join. They must cover the standard benefit package, but may offer added benefits. Each (AHP) must report to the National Health Board. They may not waive cost sharing or use pre-existing condition exclusions. Additionally, open plans must have an agreement with the Health Plan Purchasing Cooperatives guaranteeing issuance and renewability (2C).

Each independent state has a role in the Cooper Plan as well. They must designate all Health Plan Purchasing Cooperative areas, agree with other states regarding multi-state HPPC's, certify Accountable Health Plans, and designate underserved areas (2C).

Cooper's Plan relies purely on managed competition devices such as the so-called tax cap, which reduces expenditures by

limiting the deductibility of employer-provided plans. The plan has no mandates on employers or individuals and offers subsidies to individuals who cannot afford coverage. Cooper suggests a total subsidy for workers at or below the poverty line. The subsidy would decline along the income scale, up to 200% of the poverty line, at which point it would disappear altogether ("For the Cooper Plan" 7).

The McDermott Plan

Democratic Representative Jim McDermott of Washington has also proposed a bill on health care. Under this plan, states would receive 81%-91% of the pop-based share of the national health budget. The national health budget will be allocated to the states based on average per capita costs with adjustments for variation and health status. They in turn would be responsible for all payments owed to providers or health care facilities (Herrmann 30).

The plan is extremely dependent on taxation as it calls for an increase in the corporate tax rate to 38%; an increase in individual tax brackets to 15-31-34-38 percent tax brackets, an increase in the minimum tax rate to 25%; instituting payroll taxes of 1.45%; on employees-7.9% on employers-8.5% on the self-employed; instituting a 10% millionaire surtax; a raise in estate taxes; and many other tax changes (28)

There are to be no deductibles, coinsurance, charging of patients, or duplicate coverage under this plan. Furthermore, the standard benefits package would include: hospitalization, physician/professional services, prescription drugs, preventive services, durable medical equipment, lab/diagnostic testing, home health care, hospice treatment, nursing facilities, therapy of any kind, dental for those less than 18 years of age, eyeglasses, and mental health and substance abuse treatment (28).

Individuals are free to choose their own providers under the McDermott Plan which, if passed, would classify as a single payer program slated to begin in 1995. A national health budget will be set annually based on the prior year's spending and Gross Disposable Product growth. Additionally guidelines to this proposal include: states being able to create a capital improvement approval process, administrative simplification that is to involve electronic patient records and be capped at 3% of the total budget for health care; and assigning 1% of the budget to retrain displaced health workers (Hermann 30).

The basic structure of this plan would call for the developing of four agencies specifically intended to oversee the health care situation in the United States. The first of these agencies would be the American Health Security Standards Board (AHSB) which would develop policies on enrollment, benefits, provider participation, national and state level funding, quality assurance, and uniform reporting standards.

Several advisory committees within the AHSB would share the responsibilities for keeping costs contained, while seeing that everyone is served and is obtaining quality health care. The board would ultimately be responsible for adjudicating any fraud or abuse taking place within the system. Second, the American Health Security Advisory Board (AHSAB) would be responsible for representing providers, consumers, public health professionals and representatives of state programs. In addition, the American Health Security Quality Council (AHSQC) would oversee the development of practice guidelines, professional education programs, the identification of outliers, and sanctioning methodology. Finally, the Comprehensive Health Service Organizations (CHSO's) would serve this plan as an HMO equivalent and provide comprehensive care on a capitated or annual budget basis with annual enrollment (20).

The state's responsibility lies in the establishing of health security programs which supersede Medicare, Medicaid, FEHB, and Champus (Military health insurances); they may join other states in regional programs. In addition, they would also coordinate tertiary care resources with each other and establish fraud and abuse control units. Managing compensation to hospitals, nursing facilities, and other institutions directly through their annual budget allocations would be another objective. Finally, each state would also establish an agency to monitor the quality of the health care system (Hermann 20).

Although each of these plans differ in some respects from one another, they all nonetheless attempt to offer the American people something to think about. The issues of cost control and insurance coverage for all remain at the forefront of this debate, although there appears to be a great deal of disparity in the way this might be accomplished. Provided there can be some kind of agreement among the various parties and specifiaclly the members of Congress, the American people may see some type of legislation passed in the not too distant future.

Chapter III

SELECTIVE REVIEW AND EVALUATION OF RESEARCH

The health care issue facing the United States would appear to be the single most debated political issue since the appointment of Bill Clinton to the Oval Office. As the information presented in Chapter Two indicates, there is great importance or urgency for seeing that everyone has access to medical attention at affordable prices. It is difficult to say which plan, if any, will gain enough votes for passage from those on Capital Hill.

Inevitably there will be winners and losers if and when health care reform is established in the United States. One example of this dates back to April, 1993, when New York took the initiative to become the first state to require insurers and health maintainance organizations to accept all applicants regardless of condition and to charge prices based on community averages. The reforms affected only insurers selling to individuals and businesses with fewer than 50 employees. However, small companies with older or sicker employees came out winners. With open enrollment and community ratings, it is now forbidden for insurers to charge outrageous prices for care or refuse to sell to high risk people outright. However, small companies with younger, healthier workers came out losers. Before reform, they could shop the insurance market and buy cheaper policies that reflected their

below average health risks. Now they must pay the same as everyone else purchasing the same policy. Finally, the self employed and other individuals who purchase their own insurance felt the same impact from reform as did small business. Older, sicker individuals now have access to guaranteed insurance and pay less for it while those who are younger wind up paying for the higher costs than they normally would have. (Reforms Help Some and Hurt Others 59).

Everyone is beginning to feel the pressure. One large insurer in New York State, Mutual of Omaha, stated that the reform boosted rates for 60 percent of its customers. In addition, 30 percent canceled their policies in the first eight months after reform occurred, mostly due to price hikes (59).

The author's viewpoint is in agreement that the passage of any type of health care reform will not be easy. There are many politically powerful individuals who want to see some form of action taken; however, there remain a fair number of people in powerful positions who feel that reform may not exactly be the best approach to take. Many of these people are members of Political Action Committees (PAC's) which fight for the doctors, hospitals, and health insurers opposed to health care reform. Passage of a reform plan that could jeopardize the success of any of these individual's companies would be very difficult. These politicians are dedicated to these companies which have often paid for their political campaigns and fund-raisers. In a show of appreciation, these politicians appear to have taken a slow, drawn-out stance on the subject, ultimately

creating a stalemate during negotiations with their counterparts. They believe and argue that a similar result may be attained through a more simplistic approach than reform. Additionally, they claim that the cost to insure everyone under any of the given plans is too expensive. Hence, the action taken by their colleagues with health care proposals listed in Chapter Two.

In the following sections the author will discuss major segments of these proposals and discuss the key components involved in each. Although these plans vary from one to the other, there appears to be some common beliefs shared, regarding several certain basic principles which are spelled out in these plans; in some cases the primary differences derive from the specific numbers involved. It is the author's intention to present comments on each in neutral fashion, so that the reader can determine for him or herself which plan, or combination of plans,would work best in the United States. From the author's perspective however, it would appear that the majority of research demonstrates why these plans will not work, rather than focusing on any of the strong points that they may have to offer.

Health Care Around The World

While attempting to put together a national health plan of its own, the United States has looked at various other countries including Great Britain, Germany, and Canada. These

countries have gone through the maturity stages and have been in existence long enough for others to critique the effectiveness of their health care plans.

Great Britain

Tim Ensor states in his article "Broadening the Market for Health Care" that Great Britain, which has had National Health Service since 194C, has changed some of the ways in which its National Health Service operates. Under the new method of managing capital spending, health service providers must pay a capital charge based on the value of their physical assets. A major effect of the internal market on health service purchasing patterns is that city centers, particularly London, will tend to lose out because of the higher capital and operating costs. Health authorities will prefer to contract with provincial hospitals which can offer an equivalent service at much lower costs. Now that purchasers are free to choose among providers, the higher capital charges in city centres are making the provision of hospital services in those areas look increasingly unattractive. This has given more of a reason for hospitals to close or merge. Reform may succeed in bringing about some long needed reorganization of London's hospital system. But concern has been expressed that, if a reduction in accident and emergency facilities is not accompanied by an improvement in primary health care, the population will suffer (19).

According to Ensor, another problem with the National Health Service involves the availablity of information on the costs, consequences and quality of treatments, and the adequacy of competition among providers. Although considerable investment in information technology has already been made, the contracting process is still at a relatively rudimentary stage. The cost of introducing the new procedures has been substantial, and there are claims that waste has occurred (19).

These pressures emanate from suggestions that the increase in funding is not sufficient enough to cover the needs of a growing elderly population and the increasing cost of medical technology. Current pressures to restrain growth in public expenditures makes further substantial increases in funding from central taxation unlikely. Future options for increasing the level of supplementary funding may include higher patient charges for non-medical services and voluntary insurance for non-core NHS services and referrals of private patients. While a more fundamental review of the way in which the National Health Service is funded at present appears improbable, Great Britian could revive debate on alternative funding mechanisms if strong budgetary pressures continue (19).

Germany

The German Government believes that it has found a solution to health care reform. In Germany insurance is mandatory and is paid equally by the employer and employee; all types of

services are available. Even if one is to lose employment, he/she would still be covered. One problem however involves rising costs, which continue to plague this system. Many of these costs have been attributed to unnecessary treatments such as a standard birth requiring ten days of hospitalization. Additionally, when East and West Germany combined, the health plan was unable to adapt to the addition of the less stabilized East Germany (Other Countries CG).

Canada

To date the Canadian single payer plan is commanding much attention from health care professionals and politicians in the United States. According to Lowther, the single payer system there has some attractive features including universality, choice, physician autonomy, and cost controls (Lowther 3C). However, in recent years this plan has suffered a tremendous amount of ridicule, especially in the Canadian Provinces (Lowther 3C).

The Congressional Budget Office states that a single payer system would cut spending substantially in the United States. Symonds in his articles "Whither a Health Care Solution--Oh Canada" suggests that the biggest savings could come from the elimination of all the private insurance companies, along with the mountains of paperwork and differing regulations. That alone could save nearly $100 billion dollars a year, enough to

provide insurance to the 37 million people who lack insurance today (Symonds 83).

Author William C. Symonds feels that all across Canada, a growing number of patients are finding that the medical treatment available to them is limited by a variety of factors, including hospital bed closures, long waiting lists for surgery, and shortages of expensive new medical equipment. The underlying problem creating this havoc is the dwindling supply of funds for health care (83).

The budget crunch facing Canada's $60 billion a year health care system is coming at a very bad time. Demand for increasingly costly medical services is growing as a result of population growth and the rising average age of Canadians. Forced to operate with less money, hospitals across the country have closed beds, reduced services, and made staff cuts. Typically, Newfoundlanders who require a hip replacement wait 18-24 months for an operation while the waiting time for cardiac surgery can be as long as six months. Indeed, there are times when wealthy people pay bribes to better their position in line for a procedure (Lowther 38).

According to Lowther, financial pressures have taken place since the mid-1980's when Ottawa (the Canadian version of Washington, D.C.) began limiting the growth of transfer funds to the provinces. Some provincial politicians and health care professionals say that by the year 2000 reductions in federal funding will leave Ottawa powerless to enforce national health care standards (38).

Although Ottawa's total payments to the provinces have continued to grow, they are increasing at a slower rate than in the past. Additionally, the portion of federal funds used to finance health care is actually declining. In 1989-1990, Ottawa contributed six point nine billion in cash to provincial health care systems. But in the fiscal year that ended March 31, 1992, Ottawa will have given the provinces only six point one billion, a decline of 12 percent. As a result, the provinces are being forced to pay a greater portion of health care costs through direct taxation of their own populations. Some experts warn that under existing funding formulas, federal cash transfers for health care may disappear altogether by the turn of the century (38).

Some politicians and health care experts contend that if Ottawa continues to reduce cash transfers to the provinces, the federal government will no longer be able to maintain its standards regarding the five basic principles of medicare which include: universality, accessability, portability, comprehensiveness' and public administration (38).

During the past four years, in order to cope with the financial shortfall, nine provinces (with the exception of Manitoba) have imposed ceilings on doctor's incomes and all the provinces have stopped paying the operating deficits that hospitals incur. Although no specific numbers are available, these government measures have angered doctors, causing some to abandon their practices and move to the United States (Lowther 38).

According to journalist William Symonds, for the United States to undertake an operation similar to the single payer system of Canada, federal spending and taxes would jump by over $500 billion a year and the government would gain new powers that would completely regulate the health care industry. Caps on government spending could produce waiting lines for some treatments, and squeeze research and the promotion of new technology, which would slow the adoption of new innovations (83).

Many policy experts and politicians feel that although this sytem is not completely flawless, it still should be viewed as an appealing option for the United States Legislature to consider.

The Clinton Plan

A great deal of controversy surrounds the Clinton Health Security Act in general and the initiation of managed competition. Specifically, managed competition relies on managed care networks- a system that most consumers find unappetizing in the extreme. The networks, as mentioned in Chapter Two, are formed by employers and individuals who banded together into health insurance purchasing co-ops. In theory they force the networks of doctors and hospitals to compete on price and quality, precisely the two areas requiring the most attention. However in a survey conducted by Louis Harris & Associates Inc., there were only 41% who favored

controlling health care costs through managed-care plans. "The majority of Americans are strongly opposed to anything that would limit their choice of physicians, " says Drew Altman, president of the Henry J. Kaiser Family Foundation, which funds health policy research and which commissioned the survey (Garland 35).

Managed competition serves a major role in this health care debate and is a primary issue in the Health Security Act. In a sense, these other parts serve as a catch 22 scenario because one part of this plan could not function properly if the other phases are not systematically intertwined.

One of these components, and possibly the biggest concerned with health reform, involves the actual care that patients will receive. Americans will have more of a choice in health care than ever before according to the Health Security Act released by Clinton. That point may not necessarily be true. No one will be able to choose whether to buy health insurance-which means that millions of young Americans will lose their ability to postpone buying insurance until they feel they need it. Also, while the bill states that people should have the option of paying extra to choose their doctors, it also gives states the right to eliminate such choices by offering residents a single health plan and a limited list of the doctors they may see. Millions of Americans could find that they could no longer see their physicians under their new insurance plan (Castro 22).

As the President explains in the Health Security Act, private insurance companies will be able to exist with less bureaucratic control from the government than they do presently. According to Janice Castro, in her article entitled "What you're not being told", a closer look at the plan actually reveals a vast, multilevel new federal and state bureaucracy with enormous power to regulate all areas of medicine. What benefits will be offered, which new technologies and procedures will be made available to Americans, and how many medical students can pursue each specialty are just a few of the things over which the federal government will have strict control. It is presumed that the majority of students will enter into primary care while the other specialty areas will be awarded based on racial quotas, depending on how underrepresented each ethnic group is in a particular field (22).

Castro makes mention of another questionable issue found in the Health Security Act involving care always being available regardless of rigid insurance caps being set into place. Doctors and hospitals say these caps would leave them short on funds to give patients the treatment they need. The plan also calls for the cutting of Medicare spending. However this would appear to be impossible considering the aging of the population and the dependence on the entire program. Castro states that the only way to make ends meet would be to cut back on medical services; ultimately patients might be denied critical help (Castro 22).

Price controls are yet another concern in Castro's eyes. There are three in particular which Castro illustrates including: the government being responsible for deciding how much the alliances could spend on health care through a system of tight controls on insurance premiums, setting prices for new drugs, and alliances having the power to slash doctor and hospital fees in order to meet the rigid new budget limits (23).

Many people worry about how any of the proposed plans will be paid for and the Clinton Plan would appear to be vulnerable in this area as well. For the first time in history employers will be required to pay for most of the cost of health benefits for their workers based on the benefits package established by the governement. Many feel it would be difficult to call the resulting payroll costs anything but a new tax. Employers currently deduct the cost of the coverage they provide their workers; employees do not have to pay taxes on this benefit. Passage of this bill might be simplified if: the employers were required to pay less than the 80-20 split that has been recommended by the plan: if businesses were gradually implemented over a longer period; and if small businesses were exempted altogether (23).

According to a study released by the conservative Heritage Foundation, an employer mandate such as this would cause employers to pass as much as $1,200 a year in costs to employees in the form of lower wages. Lower wages, when added to other changes in spending that would occur under the Clinton Plan, would mean that more than 53% of families

would pay more for health care. This figure is greater than what the Health Security Act figures have previously stated, that only one third of the families having to pay more (Weissenstein 34). Large companies that choose to operate health alliances for their employees will have to pay an extra payroll tax of 1% to support the benefits of other people who are enrolled in the local public alliance. Urban residents will be subsidizing the inner city poor, the unemployed, the elderly, the disabled and others through more expensive new private insurance premiums. Some economists agree that this program could very well run out of money and therefore affect U.S. citizens through rising taxes (Castro 23).

The Clinton plan calls for the creation of new jobs. However, it would appear that this plan gives employers more of a reason to fire workers than expand their employee base. Estimates run as high as two million jobs being lost if the Clinton plan is approved (See Figure 4). Indeed, small companies believe layoffs will be necessary if they are to succeed. With the federal government paying part of the cost of benefits for part-time workers, employers would benefit by replacing full-time employees with part-time help, and part-time employees with temporaries. Under the Clinton Plan, companies would not be held responsible for providing health coverage to temporary employees (23).

Figure 4

Estimated Job Losses Resulting from an Employer Mandate
(Full and Part-Time Workers in 1998)

Industry	Number Employed	Losses
Construction	6,645,856	5,229
Manufacturing	21,875,590	28,022
Transportation	6,931,161	6,078
Wholesale Trade	4,121,199	1,023
Retail Trade	16,664,639	30,627
Service	29,735,649	47,914
Finance	6,937,199	4,057
Federal Government	3,443,223	5,150
State Government	5,121,197	9,081
Local Government	10,052,903	11,532
Other	4,619,694	5,587
Total	116,148,310	154,570

Source: (Wagner 34)

Universal coverage through the Health Security Act may be more difficult to achieve than originally thought. In order for there to be universal coverage, everyone must buy insurance under the plan. Many of the uninsured have no jobs. To ask these people to contribute to a plan that would include coverage for themselves might create a difficult decision. Many of these people would ultimately have to choose between the health insurance or the food put onto their tables. A requirement that employers provide benefits will not reach those people. The federal government can require people to buy insurance, but no one knows how it can actually make many of them do it (Castro 23).

The Cooper Plan

Wofford identifies a major problem with the Cooper plan in that, although Cooper promises universal coverage, his plan appears to lack a viable process for this to be achieved. Indeed, the Congressional Budget Office has stated that the plan would leave 22 million people without coverage (Wofford 20). Changing certain insurance industry practices might improve the availability of coverage and portability of coverage from job to job, but would not guarantee universal coverage. Health plans must also be required to "community rate," that is charge all enrollees in a certain area the same amount. Without this step, insurance companies could still discriminate against people, not by excluding them, but by charging them outrageous premiums (20).

It would appear that the Cooper plan would be very expensive to implement. It would increase the deficit by some $70 billion dollars over five years, according to the CBO/Joint Tax Committee estimates. Additionally, the plan would create a new layer of government. paperwork for every employer by having the agency enforce the cap on tax deductibility (20).

In addition, it would appear to do nothing to reverse the present trend toward limiting people's choice of their own doctors and pressing them into low-cost HMO's. By making the employers pay taxes on any health premiums higher than those of the lowest cost plans, it would speed up the process of restricting choice (20).

Cooper also wants to reduce the rate of growth for Medicare and Medicaid. However, he wants to accomplish this goal without controlling spending on the private sector side, resulting in health care providers shifting costs by charging their privately insured patients more. In addition, there would be no protection for early retirees, the very people who are increasingly seeing their coverage cut off by former employers. Furthermore, the plan fails to address any conventional way of dealing with long term care or prescription drugs for the elderly (20).

Malcolm S. Forbes, Jr. feels that the Cooper Plan is a worthy attempt at getting health care reform started in the United States, but that it would appear to be as far as this effort will get. He feels the plan has defacto price controls, which, no matter how contructed, will invariably destroy innovation and degrade the quality of product and service. Cutting corners to contain costs will matter more than quality (Forbes, 27)

The Gramm Bill

The Gramm Bill introduces a measure offering portability so that employees do not lose their insurance if they lose their jobs. This would prevent insurance companies from cancelling coverage if individuals become ill, enabling people to get coverage through a high risk pool even if they have pre-existing conditions. There would also be tax credits for those

who cannot afford insurance. Forbes believes that such a practical and sensible approach does not attract those in Washington who think government can handle health issues better than individual Americans can (27).

Clearly the biggest question here involves the choice Gramm proposes for employees, that is, the choice of having a comprehensive benefits package or a catastrophic benefits package. The comprehensive package would have the employee paying monthly to a fund and if the person or his/her family needed medical attention, they could receive it immediately. The catastrophic insurance package would include medical savings accounts in which people would more or less save for a rainy day or put the savings toward retirement. However, if someone were to become ill, it is not clear what would happen if the individual on the catastrophic plan depleted their funds or where additional monies would come from. This is clearly a difficult situation to deal with.

The Chafee Plan

Roger Thompson, a writer for Nation's Business, believes there is a major incentive to adopt a plan such as the one Chafee is proposing because it does not mandate that employers share the cost of health insurance with their workers. It favors regulation of health insurance premiums and allows individuals to choose medical IRA's combined with catastrophic-insurance plans. It would phase in by the year 2000 and

utilize a voucher system for purchase of health insurance to help all of those with incomes below 240% of poverty level (an income of $33,000 for a family of four). In addition, he feels the plan also could achieve huge savings through limiting the growth of Medicare and Medicaid spending (Thompson 28).

However, the author does feel that a major problem with this plan concerns universal coverage being provided by the year 2005, if savings are achieved. Does this mean that if the plan is adopted and we do not have savings by the year 2005, that the health debate will once again take national precedence? It would be difficult to rely on such a plan that has as its main promise taking place only "if" this or that happens. Also, setting a target date so long after Clinton leaves office could be politically risky for the President.

Rich Lowery, a writer for the National Review, identifies another complication stemming from the formation of a National Benefits Commission which Chafee proposes be appointed by the President and Congress. A commission that is answerable to Congress and guards such a special interest bonanza could ratchet up benefits and increase government control, eventually creating something close to Clinton's scheme (43).

Even more troubling to Lowery is the fact that Chafee does not believe in crucial supervision of his own bill. Although there is an ongoing effort to convince him that voluntary alliances are better than mandatory ones, Chafee has been heard saying behind closed doors that he actually prefers an employer mandate (43).

The McDermott Proposal

The McDermott Plan is the Canadian version of health care reform. This plan allows for universal coverage, people having a choice between physicians, and the provision of long term care.

According to Susan Dentzer in her article, "Sizing Up the Other Plans", the plan's taxing schedule will be a serious problem. The plan calls for individuals to be required to pay a 2.1 percent tax on all income. Firms will also have to pay a tax rate of 4-8.4 percent, depending on the company's size and average wage. In addition, new taxes on handgun sales and higher tobacco taxes will also be implemented. This amounts to a large amount of money that would be literally taken away from the American people. No one, including politicians, is ever in favor of more taxes which is why this plan is so unappealing (32).

Let the Waiting Game Begin

It is certainly difficult if not impossible for anyone to predict which, if any of these proposals, will be selected for the American people to live by. One thing is certain; not everyone is going to be happy with the final results. Although it is extremely difficult to describe just how difficult it really is to create a plan that will offer a little of something for

everyone, perhaps that is just the problem. Perhaps the health care professionals and politicians are being too naive in believing that a compromise can be reached.

Chapter IV

The Experts Speak Out

The efforts for creation of a national health care plan are catching the attention of virtually every American citizen. Although disagreement exists regarding what a national plan should include, it appears that there still remains a general belief that some type of reform is necessary.

This chapter will dicuss the issue of reform as viewed by three health care professionals in the St. Louis Metropolitan area. These people have been chosen for several reasons. Their viewpoints and opinions are based on education, experience, and personal feelings gained during the years of working within the health care environment. Additionally, they are involved in the day to day operations of their respected institutions and are highly regarded by their peers. The author has chosen this diverse group of panelists which includes an ethicist, a chief financial officer, and a health care consultant to participate in this discussion to provide insight from a wide range of health care professionals. Again, each has a considerable amount of experience and in the author's view is well qualified to speak on this topic.

The author's interests revolve around the opinions of these experts regarding the approval of any health care reform bill and how it could affect the field in which these professionals are employed. Additionally, the author will seek their views on

topics including: universal coverage, single-payer systems, pre-existing condition clauses, employer/employee mandates, and capitation. Although the focus of this paper has predominantly been on the business issues concerning reform, this chapter will attempt to provide some scope on the personal effects that reform may have in the United States.

Thomas H. -Ethicist at a Local 900 bed Hospital in St. Louis County

There are two primary concerns in the mind of Mr. H. that he feels must be addressed before any reform is passed. The first is the issue of the lobbyists. Mr. H. believes that for years these people and groups have been paying money to politicians for the protection of their beliefs, and to believe that all of this is going to be forgotten is absurd. He believes that health care is a public good that everyone is entitled to have, and there should not be anything or any reason to prevent people from getting the care that they need. Mr. H's. tone dictates that even with reform, corruption may still succeed because money speaks loudly in our society. "We have lost track of the original idea," Mr. H. states, while adding, "this debate has become a financial debate, not a reform debate." He suggests that the politician's greed in accepting this PAC money is only going to hurt the American people in the long run.

Mr. H.'s second major concern regarding the passage of a health care reform bill is capitation, that of the setting of a maximum amount of dollars to be spent on health care per year. He states that a cap will not work because it brings about rationing. He points to Oregon as an example, stating that they have attempted this process, but it did not work because it marginalized the poor. He does say that capitation is possible because families do it all the time, but explains that the government will cut all Medicare and Medicaid to the providers in order to control budgets. In turn, the hospitals will be forced to pass on cuts to consumer's care and/or cut programs much more noticeable than what has already occurred. This will aggravate many people because we also live in a society in which we often are spoiled and do not like it when our choices are limited. Mr. H. believes that since the people of this country have never been turned away when they have sought out health care in the past, there is no reason to think that they will begin to accept capitation in the future. He adds that even if a cap were set, there is no way to tell if the amount budgeted would be enough. If it was not enough, Mr. H. feels that the government would borrow money and add to the deficit because people simply would not allow a limitation on the health care services that are available.

He feels very strongly that universal coverage should be made available to all, even to the Cuban refugees who are escaping their country and coming to the United States for political asylum. He thinks that we, as a nation, have the

resources which can make insurance more affordable, but feels that choices must be made between limiting care at the end of one's life or draining so much money into the high-tech support systems that breathe life into people. He adds that a futility definition must be made regarding life so that we can have universal coverage, and the funds needed to provide this care "are not completely drained by those people who are hanging onto life by a thread."

When asked about his feelings on catastrophic health insurance, Mr. H. feels that this will not work. "The Congressional Budget Office says that it will provide only for the healthy and wealthy. These people will ultimately leave the insurance pools, stranding those who are sick and forcing these pools to raise premiums for everyone who remains in that pool," says T.H..

On the issue of employer/employee mandates, he states: "Historically, employers giving employees health benefits came from the end of World War II. I do not feel that it is the responsibility of the employer to provide insurance, but rather it is the community. The only reason Clinton chose this is because a broad based tax just will not fly--but neither will this."

Mr. H. is in favor of a single payer system, but feels that the only way that corruption will not play a part in this is if a two tier system is set into place.

Our conversation concluded with Mr. H. making several final suggestions. He believes that preventative medicine is a key

component to health reform. He emphasized that emergency medicine is the most ineffective way to deliver medicine from a financial standpoint, but this is the way so many Americans choose to be treated, even if they are only needing care for a minor abrasion. He also feels that even though there will always be a need for acute care hospitals in the area, there will be a drastic reduction in the number of these institutions during the next 10-15 years. Finally he believes that, from an HMO standpoint, hospitals are a failure. He stated that HMO's are able to treat patients for a fraction of the cost of what a hospital normally charges, but by the same token there appears to be a conflict of interest. Even though an HMO is supposed to give a person the best care, they tend to undertreat people, and therefore it is hard to measure if they are really doing as effective a job as they could.

Ms. S. -Hospital Chief Operating Officer at a Private, 300 Bed, Catholic Hospital in St. Charles, MO.

Ms. S. has three concerns regarding the establishment of health care reform in the United States. The first concern deals with how uninsured parties would be addressed. She feels that it would be difficult to balance a budget when there are so many indigent people that need to be cared for. Her worry revolves around the discussion about significant cuts and/or completely eliminating the Medicare and Medicaid programs. Ms. S. feels that this type of action would not in the least bit benefit the indigent people in our country.

Ms. S. is also concerned about whether the funding that would be set aside would actually be enough to provide quality care. As a COO, Ms. S. feels that rationing could work, provided that the payments from third parties were not reduced so low that it would affect the actual care that would be given to patients. "There are tradeoffs that need to be considered", Ms. S. said, "depending on how far the dollar actually stretches is what I am most concerned about."

Her third concern was just how effective a government regulated plan would work. She is skeptical that the government is competent enough to take on such a challenge and fears that they really have no idea what they are getting into. She states, "a privatized system would be more efficient."

Ms. S. believes that universal health care coverage is the right thing to do, if it can be accomplished. She believes that health care is a right, not a privilege and that everyone is equal. She believes that universal coverage will occur, but not as soon as everyone is saying it will. "It may be ten years before we actually see this take place, and I believe that it will cover only a certain set of benefits."

Ms. S. believes that reform will cause hospitals to trim excess capacity and staff, including doctors and nurses. At her particular facility, Ms. S. says there are fewer full time employees than average around the country for a hospital of equal size. She does not know if this trend will continue and sees the next positions in jeopardy at the administrative level.

She also feels that all management will be cut, and those who survive the cuts will be responsible for two to three times more work while supervising more employees.

A single payer system would be good in her eyes, but she does not think a system like that would work in the United States because it appears too complex. She believes that Clinton and the other plans that lean toward this system demonstrate naive thinking, in that the government could handle an operation as large as a single payer system. When asked if a two tier system might work, she responded no.

She appears to be in favor of an employer/employee mandate stating, "I realize the cost associated with health care, but increases in minimum wage have been fair to the worker and have not broken the employer."

On the issue of catastrophic health insurance, Ms.S. responds by saying, "If people have incentives not to use doctors, that would be great. Catastrophic insurance does just that because if you do not use the money on health care, it can be applied to one's retirement which is a great idea."

She said that if she had the power to submit a bill of her own for approval it would contain the following items: universal coverage, no pre-existing condition clauses, punishment for abusing the system, elimination of a lot of non patient care, no rationing of health services, and requiring people to have advance directives. Ms.S. would also have her plan financed through sin taxes and income taxes because she feels that "people really do not pay that much in income taxes, and by

asking for them to pay a small amount more, really would not be that terrible if it meant that everyone could have equal care. The wealthy, however, should have a responsibility to pay more that the low or middle income person, although not so large that it would significantly break them."

JSB-Health Care Consultant in the St. Louis and Kansas City Areas

JSB has been involved predominantly with the pharmaceutical/medical equipment side of health care. She formed her own health care consulting practice several years ago and provides another perspective on reform.

JSB's primary concern regards the capping of dollars allotted for new drug compounds, ultimately this will affect the amount of money that will be available to conduct research. She points out that considering that 92% of all research is performed by private companies, this could be a very large problem. She believes that research must continue to be conducted, although she agrees that the money could be allocated differently so that it could stretch further. "A lot of money is spent in the research process because the drug companies pay the doctors to test the drugs on their patients. The doctors charge the drug company a lot of money to do this, but then ask for even more money to actually treat the patient and record results, not to mention getting the free drugs for the patients to use in the first place. Surely there

is a better way to allocate these funds so there isn't so much money being spent."

Another potential problem is the reimbursement issue for pharmacy services. JSB has read that some bills say they will reimburse for drugs only, and not for the consulting work that needs to be provided simultaneously. These consulting services involve talking to patients and their families about the effects the various drugs can have on them, their psychological state, and the drug reactions that could occur if a drug is not properly taken.

The third concern she has involves universal coverage which is listed in many of the plans on Capital Hill. She is uncertain about exactly what this will mean for Americans and more importantly who will pay, because this information up till now has been very sketchy and could wind up costing a lot more than originally thought. JSB thinks that the concept of universal coverage is an interesting idea. "Some people say that universal coverage will lessen the coverage that people have now so that everyone can have equal, but less in the future, and I am not sure this is the best idea." PI

She appears skeptical that a single payer system can work in this country because she feel the task would be immense and too difficult for just one group to handle. She does not completely rule out the possibility, but feels that more information is needed.

Regarding employer/employee mandates, JSB believes that telling the employer they have to pay is almost an ethical

question. She agrees that it would be good if the employer could help get a better insurance rate for a full-time employee. She also feels that everyone should not have to pay the same amount for health care. Instead payment should be based on income and number of dependents that would need coverage. For example, if one man has a wife and two children to support, but makes the same amount of money as a man with one wife and no children to support, the first man should be responsible for paying more in health care, but not twice as much.

JSB makes reference to the decline in jobs within the health care field, but said that the impact is especially being felt by pharmaceutical companies. "Just within the infectious diseases divisions of pharmaceutical companies around the country, it is estimated that nearly 60,000 management positions will be eliminated," JSB said. She did feel however, that once health care reform emerges, some jobs will be created and others will drop out, based upon where the needs will be concentrated. It was her opinion that more consulting and education positions would grow in the future regardless of any outcome.

JSB feels that prevention is very important and would save a large amount of our health care dollars, just as people who take the initiative to develop their set of advanced directives. "Eighty percent of health care dollars are spent during the last two weeks of a person's life," according to JSB. She believes that by making these important decisions early on in an individual's life, it would make things much easier for the

family, physicians, and person's wallet, and the country as a whole. "People on life support are not able to make decisions about themselves while in that condition. Letting their desires be known ahead of time would resolve a lot of confusion." JSB also believes that the family should be educated on what to expect should a person be at the end of his/her life, whether it be due to a tragic situation or caused by the aging process.

Summary

Health care reform should have maximum input from everyone. Indeed, based on the opinions expressed by the three health care professionals in this chapter, it is easy to see that much time is needed to put reform into practice. Although there is some general agreement among the three about the philosophies of health care reform, each of their ideas vary enough nonetheless to create a considerable amount of debate. Within a short period of time decisions will probably be made regarding exactly what health care reform will consist of and how it will best serve the people of the United States. This should truly be one of the most exciting times that this country will experience.

Chapter V

Discussion

Prior to initiating this project, I was unsure what my feelings were regarding health care reform. I was "young and innocent," living each day as it came, and not interested in hearing about the troubles of others. Only after engaging in countless hours of research, interviews, and the actual writing of this piece, have I come to realize that I am equally frustrated with the issue of health care like so many of the health care professionals, politicians, and citizens of this country.

In the author's view, the United States is currently suffering the effects of the skewed health financing policies of the past thirty years. The Reagan/Bush era saw the economic route of everyone but the very rich, and in health care the dismantling of programs, preventive care and basic physician education and training, as well as the failure to oversee private insurers. Today only a small amount of doctors choose to provide primary care-family practice services, internal medicine, obstetrics/gynecology--and only a small percentage of those will treat the poor. Public entitlements are so poor in the coverage and meager in their payments to physicians that many who do provide basic care are opting out of Medicaid altogether as well as parts of the Medicare program. Health care is truly in the crisis stage.

This health crisis, however, could almost be termed a social crisis. Social pathologies such as drug abuse, teen pregnancy, and family breakups have nothing to do with the flaws in the medical system, but they do show up as medical costs. Many other health problems reflected in poor diet, lack of exercise, self-inflicted damage from smoking and drinking, and gross income inequality create a society with many heartaches. The time has come when Americans must do what they can, in an effort to salvage what is left of this society in which we live.

Reform simply adds fuel to the fire. The issue itself is very involved, evidenced by the number of different bills currently proposed on Capital Hill. To complicate the matter, there are many different options from which this country can choose in order to form a national health care reform plan. It would appear to the author that there has never been a big hurry to actually establish what has been needed for so very long. The United States has been spending so much on health care over the years, that it would seem foolish for the large health care corporate giants to admit anything other than their positive contibutions made to society during this time period. By the same token, there has been so much money paid out by these industry leaders to some of the most powerful individuals in this country-- the politicians, encouraging them not to make this issue one of our nation's most important priorities. Although it has taken years, and has occurred predominantly

at the expense of the American people, change in health care in the author's opinion will revolutionize America.

To be candid with the reader, the author has a difficult time understanding why there is so much "dissention amongst the ranks," regarding the various political parties decision on a bi-partisan plan. This entire topic should involve compromise, a word that is often misunderstood in Washington, D.C.. To resolve an issue with this much importance, an aggressive approach should be taken immediately. Understandably there is a range of feelings regarding the urgency of this health care dilemma; however the majority of politicians agree that something must ultimately be rearranged so why delay any longer? These people should also remember that they are representing the people, in many instances the same individuals who elected these officials to office. The author believes that if the public were to take a stance on health care reform and scare the politicians into taking swift action (or not be provided the electoral support), the pressure would be too much for the politicians to avoid.

For many years the health care industry has been extremely profitable. In the author's opinion, the many health care insitutions and companies have attempted to take advantage of the sytem and would continue to carry out this practice if allowed. Unfortunately for them, the funds are simply not available as they once were and this kind of activity must be regulated. In my estimation, the health care industry as a

whole may have ignored to the fact that all good things (excess profits) must surely come to an end. They were protected by some politicians in high places so that something like this would not occur, but the pressure generated from other political counterparts was too great. Had the health care industry been successful at regulating itself rather than allowing the government to become involved, chances favor the health care industry, that they would have been able to maintain a higher profitablity margin than they can expect with government involvement. Many politicians do not have the business background to understand how the health care industry operates and will be looking to rectify the entire picture regardless of drawbacks. This is not what companies or institutions want because they will be hurt in the long run, and will therefore not be able to generate the large amounts of money that they have in the past.

All efforts set forth to develop a national health care plan should be applauded. The wide range of opinions is good in that it allows for more open-mindedness, ultimately enabling us to have the best health care system possible. Many hours have undoubtedly been spent in developing the structures of these plans. Additionally, each plan has used the expert opinions of many professionals both in and out of the health care industry. The Health Security Act is no different. Both Bill and Hillary Clinton claim to have gathered opinions of over 500 health care officials. The author however is hesitant to give credit just yet. Based on the format of the Health

Security Act, it would appear in the author's opinion, that too much emphasis has been placed on determining the feasibility of the program based on its' financial makeup. All of the political, business, insurance, and lawyers involved in the development of this plan seem to have overshadowed this program, rather than allowing more of the "health care experts" to have a fair say regarding patient care. The alternative plans also fail to achieve support from the author in that they too do not give people confidence that everyone will be offered equal health care access at the same price. Legislators are attempting to sell the point that the financial backing will be available, but are not specific enough regarding actual care. This puts fear into the author, who feels it should do the same to the rest of the American public. It seems as though the government appeared to do its homework in a haphazard style, attempting to make the people feel that if the financial figures sounded good, so too would the actual care that went along with them.

The author sees many cutbacks being needed to begin the process of turning this whole situation around so that everyone can have the same health care at an affordable price. Furthermore I believe that the health care officials around this country should band together to make an eleventh hour attempt at forming a health care plan that will benefit the American population. These are the people who know where the cutbacks can be made and the best way to go about achieving these results. A government agency should then in

turn be given the limited responsibility of formulating the means to finance this plan. What does the government know about something as simple as a stress test or as complex as a double by-pass operation?

Although the author does not necessarily agree with the ways in which health care reform proposals have been established, he is not saying that a plan could not work. After gaining some insight on the reform issue there are indeed several ideas which the author feels are essential to a successful reform bill.

I am deeply in favor of universal coverage and feel that it is a right of every American citizen to have access to health care; whether it be a non-emergency or a life threatening situation I believe that people should be treated. I worry that universal coverage could be abused in a society such as ours. There are countless times throughout the year when emergency rooms are used in non-emergency instances, such as for minor abrasions and the 24 hour flu. People need to become more aware of the costs of care and I feel the only way to do this is to make them pay for part of the bill. I have never been an advocate of deductibles, or for that matter monthly premiums. These payment methods have proven to be ineffective. Once a person or the family pays the deductible, they are usually asked to pay twenty percent of the actual bill. In some cases depending on the insurance coverage, there may not even have to be any payments made by the individual or their family because their employer will subsidize

the cost. Although theere is no simple solution, an answer surely does exist.

I would propose that there be a federal employer/employee mandate to begin within one year of the passage of a given plan. Any person unemployed or in-between jobs would be covered by an emergency fund developed by the state at the beginning of each fiscal year. The mandate would require everyone to purchase insurance through their employer. The payment for this coverage would be based on two factors: the age of the individual and salary. This plan would include all part time and temporary employees as well. The plan would call for payroll deductions to occur automatically during each pay period. Just as with taxes, there would be an additional, automatic ten percent deducted from everyone. I feel ten percent is a good figure because that is close to what Americans wind up spending on health care (insurance, office visits, prescriptions, etc.) for themselves each year. To account for inflation, during each of the next five years this figure would rise one percent each year until it reached fifteen percent; the following year it would again be reduced to ten percent and the scale would climb to fifteen percent once again, and so on. Audits would be necessary for this idea to work, so full time bookkeepers would be responsible for keeping track of these deductions through documents sent out by the federal government. These sheets would have carbons between them so a copy could be sent to the state health department for review and the other copy could be retained by

that company. An incentive program that would be introduced through a public awareness campaign would then be instituted. If a person and his/her family were to only file one incident report during the year, the state health department would reimburse that family 25% of what it had paid into the fund at the state health department. For instance, if a family made $60,000 per year and only filed for one doctor's visit, it would be given a check for $1,500 at the end of the year. If the family filed for more than one office visit, the family would forfeit their $1,500 and would have another chance during the next year. If a family wanted to seek medical attention more than once, but only file one claim, the family would have to pay for the expense from their own pocket. This amount represents more than what it would cost to see a physician, and would provide plenty of motivation from having a family lose out on such a great offer. The major strong point of this idea would be that the patients would be free to see any doctor they wished, rather than being told what physician they were able to visit.

Physicians would profit from two sources: those people who paid on their own and decided not to file a claim with the state health department and by the reimbursements made from the state health departments. The physicians would be compensated based on the number of patients they see. This would create a competitive atmosphere among physicians, which in my opinion, is an already oversaturated profession. Those unable to attract enough patients would not succeed and would

have to find other means of employment. I do not believe that just because a person makes it through medical school, they are automatically given the right to collect a salary of six digits. Many others who graduate from college often must find career opportunities in what are considered difficult times. These people often settle for less than they are actually worth, yet at far less than the salaries that physicians command. In the author's opinion, many physicians who have graduated in the past two decades give me an unsettling feeling. Now more than ever, stories are heard about doctors and their medical inabilities. The author's personal experience would even favor a big city over a small, rural, general practitioner even if that practitioner were the last doctor on earth. I am uncertain whether the criteria for entering a medical graduate program has declined or if the various study programs are not up to the standards that it was at one time. Although there are many doctors who are extremely capable working in the medical field, one "bad" doctor can leave a lasting impression on the entire profession.

There should also be a requirement for each state to be responsible for developing a task force that would look into raising the standards to enter medical school within that state and furthermore, reducing the tuition required from those students eligible for education. This task force would also be responsible for developing a plan to reduce the pressure of malpractice and the the high cost of insurance which

accompanies it. A federal plan would then be adopted and all fifty states would participate.

Regarding the costs for various procedures, physician visits, and drugs, the government would develop a new, more generous fee schedule and cost of materials list that will focus on quality care at low prices. Tax breaks would be imposed for all health care professionals, facilities, and manufacturers who abided by these schedules and costs. A measure such as this would provide incentive for a company to run a cost effective business and in turn would be favorably approved by the government through a lower tax rate. A more lenient form of liability insurance would also need to be developed so that cost would not have to be used to subsidize this coverage. The amount of money required for this protection appears much too expensive and should be adjusted.

Any fraudulent practices discovered by the government officials, regardless of the size of that particular entity, would result in severe financial penalties and possible jail terms to top executives. Fraud has gotten us as a nation into the pathetic state we are in now, and if things are to change this will surely have to be conquered.

Since the state health department would be responsible for regulating and reviewing all records of companies within its state, I believe that it too should be responsible for collecting the money paid into the insurance coverage. There would no longer be a need for private insurance carriers. Any claims that need to be paid to doctors would also be the

responsibility of the state health department to oversee. The governor of each state would be responsible for providing a system of checks and balances so that there is no temptation by any person within the state health department to embezzle funds.

In a sense this system could be considered a single payer system, although each independent state would ultimately be responsible for making sure that everything is functioning accordingly.

The author is admittedly opposed to capitation, for I feel it is no one's right to say, "Well, we are down to the last $15,000 and Al needs a angioplasty before you get your corrective eye surgery". Likewise, there would be no preexisting condition clauses either. Neither of these two things is acceptable to me; I feel health care is a moral right.

Finally, I would like to hear some type of feedback, positive or negative, regarding the system and its effectiveness. I recommend that a report card be attached to everyone's W-2 form sent out in January or February. Perhaps a rebate could be made upon receipt of that card. Simple multiple choice questions could be asked of the public and a number could be given out that would allow a citizen to discuss any suggestions they may have, via a toll-free hotline. In order for any system to improve, it is vital to gain as much feedback as possible.

There is no telling that a health reform plan such as the one just proposed or any plan for that matter, will actually

work. The key thing that must be remembered however is that we as a country have our backs to the wall. The situation could probably become a lot worse, but why let it. There is no reason why a plan should not be attempted in the not too distant future; but the longer we wait, the longer it will be before we can actually determine if it will work. I strongly believe that a national health care plan is just what the doctor ordered. However, without any action taken shortly, the prognosis for the future looks extremely bleak.

Works Cited

Anderson, Odin W.. Health Services as a Growth Enterprise in the United States Since 1875. Michigan: Health Administration Press, 1990.

Armey, Dick & Gingrich, Newt. "The Welfarization of Health Care." National Review 7 February 1994: 53-56.

Barnes, Fred. "Second Opinion." The New Republic 20 December 1993: 12-13.

Beck, Merlinda. "Doctors Under the Knife." Newsweek 5 April 1993: 28-33.

Beck, Merlinda. "The Next Bite: Paying for Health Care." Newsweek 1 March 1993: 28.

Blankenau, Renee. "Reform Contenders Argue the Merits of Alliance Models." Hospitals & Health Networks 20 February 1994: 14-16.

Castro, Janice. "What You're Not Being Told." Time 14 February 1994: 23-23.

Clinton, Bill. Health Security; The President's Report to the American People New York: Simon & Schuster, 1994.

Coughlin, Kenneth M.. "Jackson Hole Plan Gaining Support." Reforming Health Care Special Issue No Date Cited 8-13.

Dentzer, Susan. "Sizing Up the Other Plans." U.S. News & World Report 7 February 1994: 30-37.

Dowd, Ann. "Congress's Fight Over Your Future." Fortune 18 October 1993: 59-60.

Dowd, Ann. "Fixing Clinton's Health Care Plan." Fortune 4 April 1994: 83-85.

Ensor, Tim. "Broadening the Market for Health Care." World Health November/December 1993: 18-19.

Faltermayer, Edmund. "Health Reform: Let's Do it Right." Fortune 18 October 1993: 54-56.

Fineman, Howard. "Health Care's War of Words." Newsweek 14 February 1994: 26-28.

Fineman, Howard & Thomas, Richard. "A New Generation." Newsweek 21 February 1994: 20-22.

Fishman, Steve. "In Sickness and in Debt." Vogue May 1991: 277+.

Forbes Jr., Malcolm S.. "The Clinton Health Plan May Be Dead." Forbes 28 March 1994: 27.

"For the Cooper Plan." The New Republic 6 December 1993: 7-8.

Francis, Diane. "Expensive and Dangerous Myths." Maclean's 2 September 1991: 13.

Fuchs, Victor R.. The Future of Health Policy. Massachusetts: Harvard University Press, 1993.

Garland, Susan B. "Managed Care: Dr. Clinton has Grim News." Business Week 18 January 1993: 35.

(GDR Fact Sheet) Health Insurance in the Federal Republic of Germany. Washington, D.C.: Embassy of the Federal Republic of Germany, 1993.

Goldberg, Joel H.. "National Health Insurance: Still a Bitter Pill." Medical Economics 21 September 1992: 76-85.

Harper, Timothy. "German Medicine-Through a Doctor's Eyes." Medical Economics 6 January 1992: 156-159.

Health Care in Canada. Washington, D.C.: Canadian Embassy, 1993.

Herrmann, John. "Health Care Reform-Focus on the Hill." Health Systems Review November/December 1993: 22-30.

Kinsley, Michael. "GOP Rx." The New Republic 18 October 1993: 6+.

Lowry, Rich. "Chafee's Political Prescriptions." National Review 24 January 1994: 42-44.

Lowther, William, "Facing Radical Surgery: Budget Cuts Threaten Canadian Medicare." Maclean's 13 January 1992: 36.

Marmor, Theodore R.. "Canada's Health-Care System: A Model for the United States?" Current History December 1991: 422-427.

Meyer, Harris. "Clinton Plan Backlash could revive Canadian Model." American Medical News 19 April 1993: 1-3.

Mulcahy, Colleen. "Doctors Debate Health Care in U.S. and Canada." National Underwriter Life & Health-Finanacial Services Edition 22 June 1992: 16-18.

"Other Countries- How Do They Pull it Off?" Health July/August 1993: 66-67.

"Other plans cover the Spectrum." Nation's Business November 1993: 28.

Reagan, Michael D.. Curing the Crisis-Options for America's Health Care. Boulder: Westview Press, 1992.

"Reforms Help Some and Hurt Others." Nation's Business May 1994: 59.

Roberts, Marc J.. Your Money or Your Life; The Health Care Crisis Explained. New York: Doubleday, 1993.

Samuelson, Robert J. "Don't Be Afraid of the Health Debate." Newsweek 25 October 1993: 47.

"The Search For Solutions." Consumer Reports September 1992: 579-592.

Smolowe, Jill. "He's the Man with the Too Popular Plan." Time 13 December 1993: 39-40.

Social Welfare. Washington, D.C.: British Embassy, 1993.

Starr, Paul. "For the Clinton Plan." The New Republic 6 December 1993: 28-31.

Stevens, Carol. "Does Germany Hold the Key to U.S. Health-Care Reform?" Medical Economics 6 January 1993: 148-156.

Symonds, William C. "Whither a Health Care Solution? Oh Canada." Business Week 21 March 1994: 82-85.

Thompson, Roger. "Small Firms' Stake in Health Reform," Nation's Business November 1993: 18-28.

Wagner, Lynn. "Healthcare May Cost $1 Trillion in '94-Report." Modern Healthcare 3 January 1994: 2.

Weissenstein, Eric. "Clintn Plan Employer Mandate Hit." Modern Health care 21 March 1994: 34.

Wofford, Harris. "Cooper Pooper." The New Republic 7 February 1994: 19-20.

Woolsey, Christine. "Play or Pay May Not Pay Off." Business Insurance 3 August 1992: 1-2.