

A COMPREHENSIVE APPROACH TO
HEALTH CARE REFORM IN THE UNITED STATES:
TWENTY-FIVE KEYS TO UNDERSTANDING THE CHALLENGES

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ABSTRACT

No societal or political debate in the United States seems more ubiquitous than the reform of the nation's health care system, nor does any other issue seem to generate more public or private discussion among policymakers. Unlike most partisan or ideological debates, health care reform generates disagreement from multiple points of view and within circles of otherwise like-minded people. Consensus seems elusive.

Most health reformers point to systemic problems dealing with organizational functions, social interactions, and methods of payment for services. Evidence of the need for major reform of the United States' health system is couched in terms of the rate of uninsurance, spiraling cost of care, and access to health services, with some reformers expressing concern about the quality of care, and the job satisfaction of health care professionals.

This thesis contends that the answer to what ails the United States' health care system rests in the hands of its citizens and residents. It further contends that citizen and resident-driven health care is most often ignored by the preponderance of health reformers.

Chapter I

INTRODUCTION

“The United States faces a health care crisis of unprecedented Magnitude.” (Simmons, 2006)

“It won’t get much intelligent attention in the campaign, but health care is the single biggest threat to the fiscal underpinnings of the republic.” (Jenkins, 2008, p. A19)

I...believe that every American has the right to affordable health care. I believe that the millions of Americans who can’t take their children to a doctor when they get sick have that right...We now face an opportunity – and an obligation – to turn the page on the failed politics of yesterday’s health care debates. It’s time to bring together businesses, the medical community, and members of both parties around a comprehensive solution to this crisis, and it’s time to let the drug and insurance industries know that while they’ll get a seat at the table, they don’t get to buy every chair. (Obama, 2008)

John McCain Believes The Key To Health Care Reform Is To Restore Control To The Patients Themselves [sic]. We want a system of health care in which everyone can afford and acquire the treatment and preventative [sic] care they need. Health care should be available to all and not limited by where you work or how much you make. Families should be in charge of their health care dollars and have more control over care. (McCain, 2008)

Consider the number of people who simultaneously believe that medical spending is too high but managed care limitations on spending are too stringent, who believe that doctors as a whole make mistakes but their own doctor does not, and who think that the United States has the worst medical care system in the world – unless you are sick. We hold seemingly contradictory views about basic health issues. Is it any wonder that we have difficulty agreeing on appropriate reforms? (Cutler, 2004, p. ix-x)

Whether the 2009 health care crisis is unprecedented is a matter of opinion, scale, and context. That a serious quandary faces health care policymakers is without question.

Providing health care to more than 300 million people in a wealthy, modern nation with a diverse racial, ethnical, and cultural population is a challenge of immense complexity. Attempts to resolve a specific problem creates at least one other, metaphorically, like squeezing one end of a balloon compresses the balloon where the squeeze occurs, but causes the rest of the balloon to bulge outward.

The United States spent \$2.1 trillion on health care in 2007, amounting to 16% of the gross domestic product. (Centers for Medicare and Medicaid Services [CMS], National Health Expenditures [NHE], 2008) The United States Census Bureau (2008) reported that 15.3%, or approximately 45.7 million American residents, lacked health insurance at some point during the year. These two issues form the foundation of a debate that focuses on how to control spending without reducing access to health care, and how to find a way to pay for health care for uninsured people.

Health care as a domestic issue draws a large volume of input and opinion. Activist organizations with ideological agendas, professional groups representing doctors, hospitals, pharmaceutical and durable medical device manufacturers, charitable groups, employers, emergency responders, teachers, grass roots groups, government agencies that dispense health care, trial lawyers, insurance companies, an army of third party administrators, and elected officials populate the list of interested parties. These groups represent points of view diametrically opposed to the interests of other groups. Lobbyists for competing interests work against each other, attempting to influence members of Congress and state legislatures.

Resolving the health reform debate lacks broad public consensus. This thesis demonstrates that consensus is made more difficult as the adherents of conflicting points of view and their political allies fail to confront the fundamental issues threatening the system. Instead, reform proposals find their basis in symptoms and ideology. Legislative proposals dealing with health reform are rooted in political strategy

and tactics as a means of attracting voters, rather than a realistic consideration of human behavior and its impact on health care utilization.

During 2007, the health care system employed 14.7 million people, some 10% of United States' workers, with another 3 million workers employed in social assistance occupations related to health care. (Statistical Abstract of the United States, 2009, Table 600) Often, the largest segment of employment in any community is made up of those who work in health care related vocations.

A critical consideration of the health reform debate concerns practical applications of religious belief. Health care problems appear to be as intransigent among professing Christians as among non-Christians. There appears to be a lack of adherence by Christians to Biblical entreaties related to caring for one's body, serving the medical needs of others, and the stewardship of money related to health care expenses. When does trust in God give way to trust in technology? When is life long enough? What are the moral and ethical considerations of forcing taxpayers to pay tens of thousands of dollars to extend human life for a few additional weeks? Does a Christian society have a financial obligation to spend whatever it takes to prolong life, and to reduce pain and suffering? The spiritual roots of the health reform debate are discussed in Chapter IV, and that discussion will form the basis for future research.

This thesis addresses the various positions and assertions made by factions that are attempting to influence the health reform debate: The literature review facilitates this form of discovery. Chapter III considers 25 fundamental understandings necessary to finding realistic and effective reforms. As a set of comprehensive considerations drawn together, these 25 fundamentals appear to be absent from health care reform policy discussions. Chapter IV addresses three fundamental strategies that serve as a beginning point for the healing of the United States' health care system.

This thesis combines literature review, critical analysis of that literature, the author's informed assertions, and interviews with policy activists. It draws on the author's 30 years experience as a political strategist; 17 years as a health care reform researcher, writer, and speaker; and research that informed three published books by the author, and his ongoing daily writing and research about United States' and foreign health care.

Chapter II LITERATURE REVIEW

Introduction

The United States' health care system is highly complex, and attracts study from nearly every segment of society within the United States and across the world. It is one of few service delivery systems that, at one point in life, will touch everyone. Therefore, it has many constituencies and they are oftentimes in conflict with each other. As such, each aspect of health care has been and continues to be assiduously studied, from its most minute detail to the broadest implications of health care policy.

Health policy reform is vulnerable to ideology and partisan politics. The volume of health care reform articles, books, papers, forums, and speeches spikes during each electoral season. In recent years, however, the health reform political and policy debate seems not to have abated between elections as in the past, continues on in state legislatures and Congress, academia, and across a broad spectrum of health industry stakeholders.

The books and writings selected for this thesis included several written during the last 10 years. This allowed consideration of contemporary thinking into the information process so as to understand how "experts" view the primary issues facing health care reform.

Some older writings have been added as they identify previous predominant thought, and much of it seemed, in light of the contemporary debate, to have been prophetic in nature. The pathologies of the United States' health care system, these older writings indicate, have changed very little during the past two decades, except for continued tinkering by the political system as it attempts to fine tune or overhaul the system.

These writings cross the lines between those who advocate for a government-managed system, those who prefer a *laissez faire* free market system, and those who visualize a blended system including aspects of each. The writings also tended to reveal disrespect for fundamentals of human behavior, in that they proposed reforms that rely on a view of humans as manipulatable cogs in a large economic wheel, as opposed to volitional creatures that act in their own perceived best interest.

Since the study of health reform is so vast and complex, this literature review, as does the thesis, focused on that which stakeholders present as critical issues that need resolution. No claim is made that this review is an exhaustive attempt to explain all aspects of the health reform debate.

LITERATURE REVIEW

In *The Health Care Mess: How We Got Into It and What it Will Take to Get Out*, Julius Richmond, M.D., and Rashi Fein, Ph.D., (2005) explain that the United States has been a leader in medical innovation, but has been unable to achieve comprehensive health services for all citizens. The authors are optimistic based on the vigor and resilience of our health care institutions, and by the strength of our science and technology base and the opportunities it presents for future progress.

Richmond and Fein believe a government-managed universal health care system is the best answer to resolve issues relating to access to health care, and as a way to pay for it. Richmond and Fein define access as a means of providing everyone with all health services, regardless of individual economic status.

We believe that the most effective, efficient, and equitable health care insurance system would be what has come to be termed 'single payer...Such a program would embody a social insurance approach; its financing would rely on (general or earmarked) tax revenues. (Richmond, Fein, 2005, p. 243)

Rudolph Mueller, M.D., asserts in *As Sick as it Gets: A Diagnosis and Treatment Plan* (2001) that greed has triggered the "raging high costs" of U.S. health care. He assigns blame to the "health care industry's lobby." He shows that in foreign democracies, a "willing stream of [profits and private] money" pouring into health care is prohibited by law. Mueller asserts that although Americans spend more on

health care, they get less for their health care dollar than countries that spend less, and that preventive care is sorely lacking in the United States, driving up the long-term cost of individual care.

Mueller focuses on the challenges faced by people without health insurance. His statistical analysis of the makeup of this group is outdated, but his primary assertion, although open to various interpretations, still holds true.

As a practicing physician, I believe this is just plain bad medicine and exactly opposite of what any rational health system should provide. With our current system, [uninsured] patients in poor health see a doctor less often than those in good health [who are insured]. (Mueller, 2001, p. 6)

Mueller goes beyond the uninsured issue to what he terms the “underinsured,” meaning people who do not have broad enough coverage, and as a result, who pay more out of their own pocket than those with low deductibles and low co-pays. Mueller, however, also includes as underinsured those without dental insurance, long-term care insurance, or without prescription coverage.

Underinsured patients have insurance, but they still can't afford all of their needed prescriptions, tests, doctor visits, or hospital bills...Some [insurance] plans have unaffordable high deductibles or co-pays; some plans fail to cover important medical tests and treatments; and some plans use fine print too small to read in their contracts. (Mueller, 2001, p. 20)

Mueller asserts that relying on a market-based health system has led to our current dilemma.

In the name of the market-driven systems which supposedly bestows liberty and great benefits to all Americans unavailable in other nations, the industry struggles to control public opinion...Instead of a national health program providing universal care to all people, America has attempted a myriad of incremental programs: Medicare, Medicaid, commercial insurance, HMOs, self-insurance, MSAs, Worker's Compensation, Child Health and Family Health Plus, VA, etc. (Mueller, 2001, p. 189)

Mueller calls for a national health system to deliver universal health care. He asserts that no person should have to spend more than 10% of his or her income out of pocket for covered health services. He believes that health care is a human right, based on the concept of American equality. The model he proposes is a government-managed system somewhat similar to that of Canada, only more comprehensive, financed by taxation. Mueller makes no mention of the level of taxation required to fund a national, government-run health care system.

This national health program must provide universal insurance that is comprehensive, portable, non-discriminating, high quality, and affordable to all people. It must cover all people regardless of their ability to pay...[and] cover the majority of costs related to medical, mental, dental, prescription, and long-term health care needs. (Mueller, 2001, pp. 192-194)

Former United States Senator and Senate Majority Leader Tom Daschle, in *Critical: What We Can Do About the Healthcare Crisis* (Daschle, Greenberger, Lambrew, 2008), sees the problems of the United States' health care system as being made more complex by competition between interest groups.

Daschle focuses on the number of Americans who are uninsured, and compares the United States with other industrialized nations.

We like to boast that we have the highest standard of living in the world, and yet at the dawn of the twenty-first century, we are the only industrialized nation that does not guarantee necessary health care to all of its citizens. (Daschle, et al. 2008, p. 3)

Daschle blames the high cost of health care on Americans' desire to find a cure for every disease. He further suggests that advertising drives consumerism creating more demand than is necessary for good health. He identifies other cost factors such as lack of competition among insurance companies and providers, and uncoordinated care and payment systems that add to administrative expenses. (Daschle, 2008, pp. 11-13)

Daschle asserts that high deductible health insurance plans have motivated people to forgo “consistent” health care.

Eleven million people with health insurance have per-person deductibles of \$1,000 or more. One recent study found that 44% of adults with deductibles of \$1,000 or more didn’t fill a prescription, declined to see a specialist, skipped a recommended test or treatment, or didn’t see a doctor when they had a serious medical problem. About 22% of adults with deductibles under \$500 reported the same behavior. Forty-one percent of people with deductibles of \$1,000 or more said they owed money for medical bills. (Daschle, 2008, p. 27)

Daschle sees universal health care as a national priority.

Ensuring that all Americans have access to affordable, efficient, high-quality health care is absolutely essential to our country’s well-being...The consensus in the middle of the political spectrum, among both Democrats and Republicans, is that we should create a public-private hybrid that preserves our private system within a strengthened public framework. (Daschle, 2008, p. 41, p. 107)

Daschle recommends the creation of a “Federal Health Board” to oversee the management of health care. (The Federal Reserve Bank is a privately owned organization, whose Chairman and Board of Governors are appointed by the President of the United States.)

The Federal Health Board I envision for our country would be modeled on the U.S. Federal Reserve System, which has skillfully managed monetary policy for decades while earning a reputation for independence...Fed Board members are recognized experts, and they set policy based on data and analysis. (Daschle, 2008, pp. 129-130, p. 132)

Daschle supports maintaining Medicare, Medicaid and other state programs, plus the employer-based health insurance system, although he doubts the efficacy of consumer-based health insurance. The Federal Employee Health Benefits Program (FEHBP) he supports would allow private individuals to voluntarily enroll in a national insurance pool that would rely on competing private health plans. It would employ guarantee issue coverage (everyone, regardless of health risk, could receive insurance), and have within it a form of Medicare for everyone. To minimize excessive cost, Daschle would subsidize premium and individual out of pocket expense above a certain annual threshold through tax credits. (Daschle, 2008, p. 145)

David Cutler, in *Your Money or Your Life* (Cutler, 2004), became one of the most quoted of all reformers who lean toward a greater government involvement in resolving health care issues. Cutler believes that the United States’ health care system suffers from the way it is organized, and that every United States’ resident should be required by federal law to own health insurance. Health care reimbursements, he argues, should be based on the quality of care, not the quantity of times in which a person sees a medical provider. Unlike many other writers who advocate for a greater government role in the payment and delivery of health care, though, Cutler argues that overall health care spending is a good thing, and that Americans need to spend more on health care, not less.

Cutler’s introduction establishes the basic conflict faced by health reformers.

Consider the number of people who simultaneously believe that medical spending is too high but managed care limitations on spending are too stringent, who believe that doctors as a whole make mistakes but their own doctor does not, and who think that the United States has the worst medical care system in the world – unless you are sick. We hold seemingly contradictory views about basic health issues. Is it any wonder that we have difficulty agreeing on appropriate reforms. (Cutler, 2004, pp. ix-x)

Cutler focuses on the key issue facing health reformers: How much money is a life worth, and when has the system spent enough of it? Should people with more assets be able to enjoy better health care than those with fewer, or should everyone have access to the same level of care?

Valuing health is among the most difficult of all topics to discuss in polite company. It involves ethical, legal, religious, political, and economic values. There is no way to do it that does not give us at least some discomfort. (Cutler, 2004, p. 11)

Cutler asserts, "spending more over time was worth it." But the system's potential has never been met and serious problems remain to be resolved.

The fate of the uninsured is particularly problematic...Even among the insured, there are major failures. Some people receive more care than is appropriate. Others get the right care, but receive it from providers who are not sufficiently experienced. Still others get too little care, especially in the management of chronic disease. (Cutler, 2004, p. 61)

Managed care, in its most common forms, emerged with the introduction of the Health Maintenance Organization (HMO) in 1973. Cutler explains that other forms of managed care emerged, and defines them:

...[M]anaged care is a system in which insurers intensively monitor aspects of the care process. Traditional insurers did not [previously] meddle in care decisions. Managed care insurers, in contrast, approve tests and procedures, steer patients to some medications over others, and limit the use of hospitals and other expensive forms of care.

In some cases, managed care insurers place explicit limitations on what doctors can do, such as requiring approval before certain tests or procedures are performed and denying payment for care deemed unnecessary. (Cutler, 2004, pp. 87-88)

Cutler's proposal to resolve the issues facing the United States' health care problems is to provide health insurance to everyone. He turns to the Federal Employees Health Benefits Program as the best way to provide coverage, but while maintaining a private market for insurance. He proposes to pay for the increased cost of Medicaid and other public programs by shifting the burden to people with high incomes thereby rescinding the Bush-era tax cuts for the wealthiest Americans.

Cutler would require all health plans to be guarantee issue. Guarantee issued insurance means that which is issued regardless of health condition. Insurance companies would be required to issue policies to individuals who suffer from pre-existing or chronic health conditions. Detractors suggest that it would allow people to wait until they become ill before buying health insurance, in the same sense that guarantee issue auto insurance would allow someone to wait until the day after an accident to purchase auto insurance. "The government organizes the system [of insurance] but is not the insurer. Private insurers that want to cover federal workers submit rates to the government and (if they qualify) their plans are then offered to employers." (Cutler, 2004, p. 114)

In *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer* (2007), Shannon Brownlee sees the American medical system as filled with hypocrisies, that far too many people receive too much care while others receive too little, and that United States' doctors effectively kill 100,000 patients each year from medical errors. She believes that science is not what drives health care, but rather the interests of politicians and the "medical industrial complex." Economic incentives are "backward" and "American medicine is in desperate need of fixing."

Brownlee asserts that there is a disconnect between science and the practice of medicine. Rather than apply science according to reason or factual basis, physicians practice medicine based on hunches and suppositions. The results, Brownlee suggests, are a great deal of overtreatment and with it, unneeded expense.

...[S]tunningly little of what physicians do has ever been examined scientifically, and when many treatments and procedures have been put to the test, they have turned out to cause more harm than good. In the latter part of the twentieth century, dozens of common treatments...have ultimately been shown to be unnecessary, ineffective, more dangerous than imagined, or sometimes more deadly than the diseases they were intended to treat. (Brownlee, 2007, p. 27)

Brownlee blames some of the spike in health spending to a distortion of the market as the United States exponentially added more doctors into practice.

Boosting the number of doctors in a community did not lead to lower fees, because medicine does not function like other economic markets. If doctors found they weren't getting enough business, they didn't have to slash their fees in order to attract new patients; they could simply give more medical care to patients they already had, especially those who were now insured by Medicare and thus insulated from the price of their care. (Brownlee, 2007, p. 30)

Brownlee advocates for a universal health system. Beyond that, Brownlee asks that clinical research be removed from the auspices of drug companies, health care be coordinated and subject to scientific review, and that it should consume less of the United States' gross domestic product.

A rational system would cover everybody, not only because it's the right thing to do, morally...but also because the uninsured help distort our current system, pushing hospitals to shift costs to insured patients in order to cover their losses from the uninsured. (Brownlee, 2007, p. 267)

Brownlee sees patients as playing an active role in their own health care decisions, but not as it relates to paying for their own care. Brownlee disparages the idea of consumerism as it applies to individuals participating in paying for their own health care, asserting that the complexity and expense of hospital billings renders them undecipherable by the average patient. Brownlee, therefore, believes the health system is far too complicated to lend itself to any market constraints from patient participation in the financial aspects of making health care decisions. "Strengthening the patient's role in choosing a particular treatment or test is an important aspect of moving toward more efficient care...The good news for payers is that informing patients better will very likely decrease overutilization rates." (Brownlee, 2007, pp. 297-298)

Michael Fumento, in *Science Under Siege*, (1993) focuses on the micro issues related to science, or rather, "bad" science. He defines bad science as science determined by politics rather than honest research. Fumento cites panic over what appears to be bad health news that, put into perspective, is nothing more than probability theory resulting in predictable results. Fumento shows how popular media often drives people to assume they are sick, or dying. Unfounded health scares directly affects utilization of health care services.

In an effort to put science into perspective relative to health care, Fumento explains 15 tenets of epidemiology. The first of these is "Everyone dies." (Fumento, 1993, p. 82) Fumento reminds readers everyone dies of something. By this he asserts that if a number of people die from a similar disease in a certain defined geographical area, it does not force the epidemiologist to necessarily conclude that a mysterious cause lurks in that geographical area to explain the deaths and, therefore, find a way to mitigate them. No health system, scientific undertaking or discovery, or media report will alter the reality of human death.

In the 1993 book, *Medical Cost Crisis*, (1993) business writer Donald Larson saw the explosion in the cost of health care as the chief obstacle to reform. He posits a radical solution. He asserts that 10% of the population spends 90% of the health care dollar each year. He suggests that each resident should be liable for the first 10% of their own annual health cost. The federal government, Larson suggests, should fund the remaining 90%. Furthermore, Larson wants patients to know the price of health care services to make informed decisions.

John Goodman and Gerald Musgrave, in *Patient Power: Solving America's Health Care Crisis* (1992), champion the idea that, as it is in other economic segments of society, so it could be with health care.

Goodman and Musgrave believe that the key to reforming health care is to unlock the power of individual patients making decisions about their own health care, including how to pay for it. Goodman and Musgrave would reformulate and rethink tax policy to favor individual responsibility, and move away from institutional power over health care. Goodman and Musgrave sum up their view of both what ails health care and how to heal it.

What really matters is what is in the self-interest of the individuals who actively participate in the system.

Viewed in this way, it is obvious that we cannot solve America's health care crisis if 250 million [sic] Americans find it in their self-interest to act in ways that make the crisis worse. By contrast, the crisis will be solved if 250 million [sic] Americans find it in their self-interest to take actions that promote solutions. (Goodman & Musgrave, 1992, p. 37)

Patrick Rooney and Daniel Perrin, in *America's Health Care Crisis Solved* (2008), suggest the greatest peril to the United States' health care system has to do with how much money we spend, and its source and control. Rooney and Perrin see the United States' current health system as in a crisis of spending and cost, which they assert without substantiation, that Americans can no longer afford. Rooney and Perrin ask tough questions in the context of asserting that America cannot afford the \$4 trillion expense of health care they claim is projected for 10 years hence.

Unfortunately, Americans can't afford to pay \$2 trillion a year for health care...If American health care truly is not sustainable, what then do we do about it? And perhaps a better question is, how do we pay for it? (Rooney & Perrin, 2008, p. 4, p. 7)

Rooney and Perrin believe that hospitals gouge patients, and offer as proof the hospitals' practice of marking up bills three to five times above the Medicare reimbursement rates they receive from the government when those services are billed to patients with private insurance or who are uninsured. The key to resolving health care dilemmas, Rooney and Perrin assert, is to follow the money that has distorted the health care marketplace, and taken advantage of patients.

Jesus would not tolerate "Christian" hospitals that plead for mercy from the government to get generous tax relief and then turn around and seize ...[patients]... by the throat, demanding payment in full when the money isn't there...For those who want to make a lot of money, health care is a great place, because very few people are willing to say no when it comes to their health, regardless of the cost involved...Health care companies keep coming up with new procedures, products, and pills – and they keep persuading us we have to have them. So we keep buying them. (Rooney & Perrin, 2008, p. 10, p. 12)

Rooney and Perrin explore the notion of "managed competition" – the attempt by some health reformers to create competition between health plans. The authors show that the health plans themselves, however, are anti-competitive, so that the efforts to have them compete is, in fact, no competition. "If we were to make this kind of managed health care compulsory for all Americans, the 'competition' would arise when the HMOs compete with one another for an employer's business." (Rooney & Perrin, 2008, p. 28)

Rooney and Perrin believe that people can spend their money more wisely than can a government agency, or a large health plan or insurance company. The authors recommend a health plan based on that assumption, that they label "Fair Care." The idea is based on this premise:

Health care is all about money, who controls it, and who has access to it...This financing mechanism would give a refundable tax credit to every American who is not on a government-run or government-sponsored health care program. The Fair Care refundable tax credit is tax-free money, just as the employer's payment for health benefits is tax free. (Rooney & Perrin, 2008, p. 43)

Rooney and Perrin devote a chapter to showing consumers how to purchase health care less expensively. The authors point to a variety of innovative, preventive care facilities, such as retail store walk-in clinics instead of physicians in their clinics, and urgent care centers instead of emergency rooms. Rooney and Perrin suggest that when patients spend their own money, they will seek out less expensive forms of health care providers, and thereby reduce overall and individual health care cost. (Rooney & Perrin, 2008, pp. 127-134)

Wellness consultant Michael Framberger, in *Get Happy, Get Healthy, Be Wealthy* (2005), sees that health, wealth, and happiness are linked together. He seeks to see people live balanced lives, taking responsibility for and care of themselves, rather than turning to a health plan or government program to correct what only individuals can resolve.

Framberger quotes author David Solie, who writes about "enhanced longevity." By this, Solie refers to living a long life of high quality health, and dying after a short illness, in contrast to a long life lived with chronic and expensive illness. Framberger makes common sense recommendations to achieve "enhanced longevity," which he identifies as 100 or more years of life. "Check-ups, vaccines, screening tests, and preventative [sic] medicine are the first things on the list if you want to live a long and healthy life...Centenarians always live active lives. Consistent physical activity and exercise are well-established ways to add years to your life." (Framberger, 2005, p. 170, p. 175)

Michael Cannon and Michael Tanner, in *Healthy Competition* (2005), argue that what is most lacking in the provision of health care is real competition, at many levels. Consumers do not have enough information, whether it includes quality, availability of alternatives, and especially, the real cost of care. Instead of having multiple choices, consumers are locked in by few choices, whether it means insurance plans or health providers. This is detrimental to quality and serves to drive cost higher.

Cannon and Tanner dispute the notion that spending a great deal on health care is a negative economic concept.

Health care is considered a "normal good," meaning that spending is positively correlated with income. As income rises, people tend to demand more health care. The amount Americans spend on health care is to a large degree a reflection of America's wealth. (Cannon & Tanner, 2005, p. 20)

Cannon and Tanner discuss the assertion by others that the health care system is not subject to the same market exigencies as are other forms of trade and commodities. The authors explain why they believe health care markets are, in fact, subject to market forces, and their understanding is central to their ideas of how to reform the system.

Consumers who must weigh different options against one another tend to focus on getting the highest value per dollar spent, and they reward producers who provide it...On the [health care] consumer side, government promotes excessive levels of health coverage. On the producer side, it imposes excessive regulation, which dampens competition...[but] government inhibits the competitive discovery process and most often leaves consumers worse off. (Cannon & Tanner, 2005, p. 45)

Cannon and Tanner assert that because state and federal governments pay for or administer health care for "77 million Americans," it has had the effect of distorting the price of care. "Government health programs exhibit all the negative effects of overreliance on health coverage, including moral hazard, reduce sensitivity to price and quality, and less competition. In addition, government sets payment rates for providers who treat beneficiaries in these programs." (Cannon & Tanner, 2005, p. 75) Essentially, government exerts price controls that affect the broad range of health services, including those paid by private insurance or cash.

Cannon and Tanner concede that the health care economy is different in some aspects from that of other forms of trade, such as hard goods, banking, or communications.

However, we do not see the gravity of these matters as a reason to divert power away from individuals and toward government. Rather, we see the special nature of health care as all the more reason to increase each consumer's sphere of autonomy. (Cannon & Tanner, 2005, p. 147)

Regina Herzlinger, in *Who Killed Health Care?* (2007), highlights the changes in culture from Permanente, the California-based Health Maintenance Organization, in its earliest iterations, to its successor, the Kaiser-Permanente of today, and asserts that those cultural changes are what has created today's crisis. Herzlinger claims the operating and leadership culture of Kaiser-Permanente has resulted

in a profit-first, business model, rather than a care-first model. This cultural shift, Herzlinger asserts, has infected the delivery of health care across the United States. Herzlinger states that the health system needs a complete restructuring based on consumerism.

Consumer-driven health care empowers individuals and brings their force to bear on the offerings of doctors, hospitals, and insurance and pharmaceutical companies. It converts the entire system to one that is responsive to you and me as the ultimate consumers of its goods and services. (Herzlinger, 2007, p. 16)

Herzlinger sees many forces working against the best interest of patients. She lays much of the blame on hospitals.

The killers work in insurance and hospital firms that have lost their souls, firms that have become more interested in money and perpetuating themselves than in providing health. Employers, as well as the U.S. Congress and a bevy of health policy academics, are also implicated. They were satisfied with substituting simple, utopian abstractions, like the idea that an insurer or a government can "manage health care" cheaper and better than your doctor, for the thousands of complex interactions that should guide the practice of medicine. (Herzlinger, 2007, p. 18)

Herzlinger reports on studies about the ability of high-deductible health plans to restrain health care spending, and attempts to dispel some of the fears reformers associate with individuals exercising self restraint.

Separate analyses revealed that enrollees in such plans – called "high-deductible health plans" – used health care resources in significantly different ways, when compared to their usage patterns before they were enrolled in a high-deductible plan and to a matched control group: they used less of the emergency room and hospital and fewer drugs and yet engaged in more preventive care, such as yearly physical examinations. Those who had chronic diseases complied more with the drug regimens that are key to their health status. (Herzlinger, 2007, p. 54)

The key to innovation and reforming health care, Herzlinger concludes, is consumer-driven services, products, and medicines. People with an ideological bent, or who are trying to hold onto destructive but profitable structures that fail to meet patient needs, Herzlinger asserts, create too much health care policy,

Ideology does not transform how markets operate. Entrepreneurs and consumers do. Consumer-driven health care will work only if it makes basic economics happen – if it affects both supply and demand –and alters the way that consumers demand and providers supply. (Herzlinger, 2007, p. 158)

Robert Shupe, in *The Bitter Pill* (2006), focuses on the problem of reduced or eliminated benefits that result from ever-higher medical costs. He suggests that to find solutions, the researcher needs to track how the money is raised and spent.

Shupe contrasts his own experience as a child with that of a modern-day child. Shupe explains that his mother took him to the family doctor for earaches, not to the emergency room, as do some modern mothers. The difference, Shupe says, is the money.

My mother paid cash, the other had insurance. Today most people do not equate the two as having anything to do with each other. Paying cash for medical services is rarely, if ever, thought to be an option for most Americans...Having insurance has created a feeling of entitlement for some people who do not realize the cost for these services and products must eventually be paid by someone. (Shupe, 2006, p. 7)

Shupe reported on numerous studies, and saw where they placed blame for the woes of the United States' health care system. Many institutions, including providers, payers, and employers, are cited. One group, Shupe noticed, is nearly always left out.

We, the consumers, are missing from the list. The ones who spend every health care dollar. We are told what we can buy, how much we can buy, where to buy, from whom to buy, or how often we can buy. (Schupe, 2006, p. 23)

Schupe points to the amazing successes of modern medicine as a negative incentive for people who refuse to take care of themselves. Schupe uses the experience of his friend, who had recently suffered a heart attack, to provide the setting for this assessment. Schupe's friend survived the heart attack, and within weeks of receiving extensive medical care and surgery, felt better than ever.

What does this tell me, a forty-something, overweight, non-exercising, junk food consuming, stressed out insurance consultant? It tells me that I don't have to change a thing I am doing. I might have a heart attack. It will hurt a bit, and I will be inconvenienced, but I will be up and walking around in a couple of weeks. (Schupe, 2006, pp. 62-63)

Richard L. Reece, M.D. writes in *And Who Shall Care for the Sick? The Corporate Transformation of Medicine in Minnesota* (1988), that the delivery of health services should be about caring for sick people. Instead, he saw the system as moving more toward power struggles between corporations and physicians, leaving sick people vulnerable.

Reece's 1988 comments are particularly apt, given their prophetic nature and the dilemmas faced in 2009 and beyond. Reece warned about the change of culture in the provision of health care from doctor and hospital management to a corporate management structure.

This struggle is mainly between the management of corporations and physicians. It is a struggle for power. To be effective in the marketplace, corporations have to harness physicians to corporate goals, thus creating internal discipline and compliance; to be independent professionals, physicians have to be free to choose what they want for their patients. The government, economists, and leaders of large organizations favor the corporate strategy because it is a way of making physicians behave economically. (Reece, 1988, p. 4)

After 1988, Reece often wrote about the changing nature of younger physicians. In this 1988 book, he points specifically to the viewpoint of physicians and the nature of their work as complicating factors in dealing with the corporatization of health care. Reece contrasts the physician's nature with that of hospital or large clinical organizations that rely on trustees, careful planning, and the luxury of time. "Physicians are, in short, no-nonsense people who want things done immediately in black and white terms." (Reece, 1988, p. 90)

Hospital administrators, Reece asserts, think differently from physicians. While physicians eschew hierarchical control, administrators require it. Reece explains that hospital administration might be the most difficult management job in the world, and suggests three significant traits of the administrator.

So how do hospital administrators think?

- Like businessmen, of course...
- Administrators must also think like managers of limited resources...
- And finally, administrators think like business realists – they put their money where they think the economic results will be. (Reece, 1988, pp. 97-98) [Bullets in original]

Reece's 1988 book covered a wide range of subjects, including foreign health care systems. Reece reaches for answers and "the" resolution, and concludes that it is chasing after the wind.

The answer, of course, is that there isn't any perfect single kind of care for any single country. Every Western country not only has a mixed economy – part public and part private – but a "mixed" medical system as well. The system depends on the culture and politics of the country. In most countries, the government pays 75-90% of health care costs, while in the United States, government pays [46]%. (Reece, 1988, p. 258)

In *Voices of Health Reform* (2005), Reece reports on interviews with 40 health reform leaders from across industries, representing a divergence of points of view. Here Reece follows trends in health reform that he discussed in his 1988 book, and which he continued tracking during the interim.

Reece summarizes the interviews by describing them in a functional sense. He found that unlike earlier reform efforts, the reforms that characterize the modern era cross professional boundaries, with disparate groups trying to find common ground. Reece identifies two main crises: the cost of health care, and "a growing number of people with no health insurance."

[The Center for Practical Health Reform]...seeks to rein in costs, improve quality, and assure wider coverage, while warding off an economic death spiral of the health and general economies...Diverse interests now seek common ground for the common good. Reform has become not simply a matter of social justice, but of economic survival. (Reece, 2005, pp. ii-iii)

Reece is a believer in consumer-driven health care models, but does not see them as reform; merely repackaging. Reform relates to the delivery of health care. He provides this example:

I regard the farming out of disease management to squads of nurses focusing on home care as fundamental reform. The caregivers are different, nurses rather than doctors, and the setting is different: the home rather than the physician's office, the emergency room, or the hospital. (Reece, 2005, p. iv)

Reece quotes E. Thomas Wood from *Healthleaders Magazine*, who categorized the four "top power struggles" involved in health reform.

- Providers Vs. Payers (Pin the tail – and horns – on the health plans),
- Physicians Vs. Hospitals (Marcus Welby dukes it out with Gordon Gecko),
- Free-Marketers Vs. Universal-Health Advocates (Harry and Louise, meet Karl and Vladimer),
- Employers Vs. All of the Rest of Healthcare (If the HMO takes a pound of flesh out of each employer, is it at least covered by bariatric surgery). (Reece, 2005, p. v) [Bullets in original]

Michael Porter and Elizabeth Teisberg, in *Redefining Health Care* (2006), point to unacceptable quality, high cost, and the elevated number of uninsured in the United States as primary concerns. Porter and Teisberg assert that the system is unsustainable, and must refocus on delivering value rather than gross revenue, defining value as gross outcomes per dollar spent. Porter and Teisberg want to create real competition among players in all sectors as a partial curative for what ails United States' health care.

Porter and Teisberg see three key components of health care, each needing critical reform. One, however, stands out.

The first is the cost of and access to health insurance. The second is standards for coverage, or the types of care that should be covered by insurance versus being the responsibility of the individual. The third is the structure of health care delivery itself...we believe that the structure of health care delivery is the most fundamental issue...The fundamental problem in the U.S. health care system is that the structure of health care delivery is broken. (Porter & Teisberg, 2006, p. 3)

Porter and Teisberg believe that health care competition, as structured today, results in a zero-sum game. One faction of the system works to redistribute money to another, and so forth, without regard to value. The nature of competition in the delivery of and payment for health care must be reformed.

The way to transform health care is to realign competition with value for patients. Value in health care is the health outcome per dollar of cost expended. If all system participants have to compete on value, value will improve dramatically. (Porter & Teisberg, 2006,

p. 4)

Porter and Teisberg differentiate between "positive-sum" and "zero-sum" competition. Positive-sum competition results from entities competing against each other on the basis of providing value, and value accruing to the benefit of those who access the products and services those entities produce.

Value-based competition is the type of competition we see in virtually every field...Such competition has transformed previously regulated fields, such as telecommunications and trucking, as well as sclerotic economies, such as those in Eastern Europe, with extraordinary benefits. (Porter & Teisberg, 2006, p. 33)

Porter and Teisberg indicate the entities participating in zero-sum competition do not compete on providing value. Rather, zero-sum competition serves only to redistribute dollars.

Zero-sum competition in health care is manifested in a number of ways, none of which creates value for patients:

- Competition to shift costs
- Competition to increase bargaining power
- Competition to capture patients and restrict choice
- Competition to reduce costs by restricting services

Each of these dysfunctional types of competition has unhappy consequences. (Porter & Teisberg, 2006, p. 35). [Bullets in original]

Porter and Teisberg see that health care competition, as it currently exists, is wrongly focused in part because of the levels at which it competes.

Competition is both too broad and too narrow. Competition is too broad because much competition now takes place at the level of health plans, networks, hospital groups, physician groups, and clinics. It should occur in addressing particular medical conditions. Competition is too narrow because it now takes place at the level of discrete interventions or services. It should take place for addressing medical conditions over the full cycle of care, including monitoring and prevention, diagnosis, treatment, and the ongoing management of the condition. (Porter & Teisberg, 2006, p. 44).

Porter and Teisberg identify eight observable factors that constitute a positive-sum, value based system of health care competition.

- The focus should be on value for patients, not just lowering costs.
- Competition must be based on results.
- Competition should center on medical conditions over the full cycle of care.
- High-quality care should be less costly.
- Value must be driven by provider experience, scale, and learning at the medical condition level.
- Competition should be regional and national, not just local.
- Results information to support value-based competition must be widely available.
- Innovations that increase value must be strongly rewarded. (Porter & Teisberg, 2006, p. 98) [Bullets in original]

Porter and Teisberg conclude that there is no need for the United States to adopt government-managed health care. Foreign nations that rely on government-managed care are, Porter and Teisberg suggest, moving toward competition and reduced government management. Competition needs to be redefined, resulting in practitioners that focus on a cycle of care, and on mastering a segment of health care versus trying to service a broad range of health issues. Porter and Teisberg believe that value must

be rewarded, and that comes from producing better health results. "Ironically, the solution to the crisis lies in refocusing the health care system on health." (Porter & Teisberg, 2006, p. 381)

Alan Press, a veteran health insurance agent from New York City, in an article in *The Insurance Forum* (2008), charges the health insurance industry with failure to find ways to reduce the number and rate of uninsured and underinsured United States' residents. Press suggests that the health insurance industry has an "ethical obligation to contribute its leadership and expertise to help solve the problem of delivering quality health care to all Americans." (Press, 2008, p. 21)

Press alleges that the insurance industry fans the emotions of Americans by insinuating that government-provided health insurance for the uninsured would be a socialist approach. Press contends that the American people have already accepted a number of federal programs to provide for citizens, including Social Security, Medicare, and the Federal Employee Health Benefits Plan (for government workers). Furthermore, Press contends that the United States' health care system carries inordinate administrative expense, primarily because of the disparity and sheer number of private insurance programs. Press refers to a study by Professor Arnold J. Rosolf, of the Wharton School of Business. "For every dollar spent on private health insurance, 30 to 40% goes toward administrative costs and investment returns to shareholders." (Press, 2008, p. 21)

Press' primary assertion, however, is that a civilized society government's first obligation "is to provide security for its citizens," and when private industry fails to do so, government ought to step in and fill the void. Press proposes that government ought to do this by providing health insurance and health care to "all who participate in our society," if those same people cannot get private health insurance elsewhere, or afford to purchase it themselves. (Press, 2008, p. 23)

Lee Kurisko, M.D., in *Health Care – The End of the American Revolution?* (2009), identifies himself as a Canadian expatriate physician living and practicing in Minnesota since 2001. Kurisko compares and contrasts the Canadian government-managed health system with that of the more market-based United States' health system. Kurisko, a diagnostic radiologist, focuses on the attitudes and economic theories that underlie both systems.

Born, raised, educated, and formerly in practice in Canada, Kurisko asserts that individual Canadians have become powerless to deal with their own health pathologies as the result of a violation of the universal economic principles upon which the United States built its world-leading economy. Kurisko, writing from his practice experience and his personal study of economics, asserts that the key element of universal health care provided by governments is constraint of services.

When a government is the sole payer of health care, inevitably that government will control the availability of resources to constrain costs. Since health care recipients [presently] pay none of the cost of care directly, it results in unrestrained demand, and it is inevitable that government will end up running it all. It is a fantasy on par with Santa Claus to expect that government will restrain itself in paying for care without also controlling it, and the "it" here translates to people. Government controlling people is an anathema to the goals and values of the American Revolution. (Kurisko, 2009, p. 2)

Kurisko identifies areas of functional and structural limitations common to governments, among which are being too distant from where decisions need to be made, the delay in time necessitated by negotiating with slow-moving bureaucracies, and the political and financial limitations of taxing sufficiently to meet the needs of everyone on an equal basis. Kurisko sees the common element in the latter; people's insatiable demand for care, especially when it appears to be free. "The Canada Health Act gave the government a monopoly to provide health care. The government tries to fill the need as cheaply as possible, but people demand more care than what the government can afford to provide." (Kurisko, 2009, p. 6)

Kurisko sees strength in the values that shaped the United States as expressed in the Declaration of Independence, specifically pointing to the idea of unalienable rights granted by the Creator. Kurisko believes the key to the United States' success lies with its commitment to these unalienable rights, and

labels this idea as "rights theory." He contrasts "rights theory" with the idea of building a society based on the "common good." Kurisko believes the advance of national health care is aided by the misunderstanding of United States' residents about their own rights, and the concomitant responsibilities they bear as a result of those rights. "Rather than seeing themselves as autonomous sovereign beings with inalienable rights, many Americans want the government to take their money and decide what type, amount, and quality of health care they should receive." (Kurisko, 2009, p. 16)

Using personal reflection and anecdote, Kurisko describes Canadian citizens' character as one of passivity and acquiescence, to the point of ignoring threats to their own lives that result from the problems associated with Canadian health care. Kurisko asserts that Canadians passively accept the lack of timely health care that is characteristic of their health system that too often results in needless pain and suffering, and often hastens death. Unlike Americans, Kurisko asserts, Canadians will not, as a matter of culture, hold their medical system accountable since they see it as benevolent.

Harold D. Kletschka's biography, *To Change the Heart of Man* (Racer, D., 2009), addresses the moral implications of the United States' health care system, or more directly, the implications of the evolution of an immoral society. Kletschka spoke often¹ of the abrogation of human life in the form of legalized abortion that he addressed in more detail in his own book, *A Treatise on Human Life* (2003). Health reformers who agree on the need for moral reformation as an adjunct to health reformation might disagree with Kletschka's strong assertion concerning the immoral nature of elective abortion that he added to his biography (in a chapter he personally authored), yet they may embrace his moral edict.

First, the people will have to convert and return to living under the moral code whereby God and His laws are recognized and obeyed. This first step is absolutely imperative, and without it all other remedial measures will be of no avail, because it was when this protective mantle of Divine Providence was cast aside that the disease process now infecting America was allowed to gain its foothold, and then to spread, unleashing its destructive consequences. Each individual can make this personal commitment, and, hopefully, by example and enlightening others, lead them to join in the rehabilitative process. (Racer, 2009, p. 377)

Kletschka, long a student of the march of international communism, also feared the onset of government-managed health care as a door opener to such a system. He labeled socialized medicine as the keystone to the imposition of communism. Kletschka strongly asserted:

Attention has to be directed at controlling any further expansion of government controls which would deprive patients of their fundamental right to choose their own physician, and physicians from using their independent judgment in managing and treating their patients. The current march to forced medicine by which the government, by edict, dictates what appropriate treatment of each patient is, must be halted. (Racer, 2009, p. 378)

Summary

Health reform writers profess common themes. Health care is expensive and growing more so. The uninsured rate is too high. Private corporate medicine, driven by greed, is a threat to citizens' health and finances. A few refer to the role and power of individuals to change the balance from payers, doctors, hospitals, and other providers, and government, to individuals, but most writers look to find ways to change institutions or methods of organizing the delivery or payment of health care from the top down.

Chapter III KEYS TO HEALTH CARE REFORM

Introduction

The literature review and common positions expressed by leading health care reformers indicate a point of view that appear to be bereft of real world considerations. Points of view are predetermined, partisan, and act as blinders or distractions that prevent the reform advocate from looking beyond his or her predisposition to other mitigating factors. The impact of partisan politics impinges on a frank and open discussion; political advantage trumps sound policy.

This section of the thesis lists 25 keys to understanding the United States' health care system from a macro-perspective. These keys relate to real world conditions that should inform any debate, discussion, or resolution of how to reform the United States' health care system. These keys run from the simple to the complex, yet all are interwoven into the fabric of what we call the United States' health care system. The author does not contend that these 25 keys are an exhaustive list. As such, additional keys are listed briefly at the end of the discussion section.

The Population of the United States: Key Number One

Population demographics are key to determining any evaluative or reform process. The United States has the world's third largest population, currently at 305 million. (United States Census Bureau [USCB], 2008) United States' residents were projected to spend \$2.4 trillion on health care during 2008. (USCB, 2008) The United States Census Bureau reports that approximately 45.7 million United States' residents are without health insurance at any point in time; a number that has held firm at 15-16% of the population during the past decade. (USCB, 2008)

Subtracting the total number of uninsured individuals from the total U.S. population indicates that the United States' health care system currently provides health coverage for more than 258 million people.² The United States provides coverage through a combination of public and private health plans. In perspective, the total number of United States' residents covered by a government or private health plan exceeds the combined populations of Canada, France, the United Kingdom, Germany, and Spain. (Organization for Economic Cooperation and Development [OECD], 2008) Each of these other countries has health systems controlled by national governments.

In light of ethnic and racial composition, the differences in population between the United States and other countries become more definitive. The United States is a nation of nations, with wide racial differences, and it is home to immigrants from across the world. The heterogeneity of United States' residents, along with the physical and behavioral pathologies inherited by various diverse racial and ethnic groups, is unlike any other nation. United States' residents do not look like, act like, or conduct their lives in the same manner as the residents of other nations.

We Live in the Richest Nation in the World: Key Number Two

The United States' health system is often compared to those of foreign nations. Commonly mentioned are Canada, the United Kingdom, France, Germany, Spain, and Japan. In 2007, the gross domestic product (GDP) of the United States approached \$13.9 trillion, an amount equal to the combined GDPs of the aforementioned nations. (OECD, 2008)

Although oil-rich nations have more per-capita income than the United States, the United States has long led the world as an economic powerhouse. Except during periodic recessions, as a nation of people, United States' residents enjoy more disposable income than those in other nations. Americans spend more per capita on health care than those in other nations because Americans have more to spend. (Cannon & Tanner, 2005, p. 20)

Since United States' health care is primarily provided by non-government entities, people are free to spend as much as they wish for alternative and optional health services. Medicare and Medicaid

recipients, however, face legal restrictions on their freedom to purchase health care to spend their own money as they wish.

As disposable income shrinks or in the absence of disposable income, health spending is less than when disposable income is greater. Vanessa Fuhrmans, writing in *The Wall Street Journal*, explains that as a result of economic pressure on household income during 2008, and increased cost of consumer goods, health care providers have witnessed a noticeable cutback in patient spending.

In a survey by the National Association of Insurance Commissioners last month, 22% of 686 consumers said that economy-related woes were causing them to go to the doctor less often. About 11% said they've scaled back on prescription drugs to save money. Some of the areas being hit include hip and knee replacements, mammograms, and visits to the emergency room... (Fuhrmans, 2008)

A good deal of the health care services Fuhrmans discusses in the article are optional and not life threatening. In this sense, reduced spending on health care does no harm and may, instead, be the first indicator of defining need versus want or desire.

Public Health Systems Result in Cost Shifting to Private Health Care: Key Number Three

Every United States' taxpayer directly helps support government-subsidized health care. In addition, each person with a non-government health insurance plan, and the uninsured, pay more for health care, as costs are shifted from those on government plans to those not enrolled in a government plan. Milliman researchers quantified the cost shift at \$88.8 billion in 2006 for hospitals, the last year for which they had hospital data, and 2007 for physicians' services, the last year for which they had physicians' data. (Fox, W., & Pickering, J. 2008, p. 2)

When a health care provider bills Medicare for services, the government reimburses the provider, using the services of a third party administrator. The rate at which Medicare reimburses providers is far less than that which is billed by the provider. (CMS, 2007)

Doctors routinely complain that Medicare payments are often less than they need to meet their practice overhead costs. They make up for the Medicare under-payment by shifting those costs to people who have health insurance, or who pay for their own health care. (Fox, W., & Pickering, J. 2008, p. 2)

In most jurisdictions, Medicaid (the government's health plan for low income residents) reimburses doctors at rates below Medicare reimbursements. These low Medicaid reimbursement rates require that providers shift costs to those with private insurance, or who pay their own health care bills (often, those without insurance pay the most).

United States' residents pay Medicare taxes to underwrite the cost of Medicare, other taxes to underwrite the cost of Medicaid, and pay higher prices for their own health services as a result of low Medicare and Medicaid reimbursements. Attempts to increase the number of residents enrolled in government health plans will result in a subsequent increase in health care cost for those with non-government health plans, as well as pressure lawmakers to increase taxes.

Wasteful Health Spending: Key Number Four

As a whole, physicians complain that patients often – even most often – do not follow through on the doctor's advice. Petrilla, A., Benner, J., Battleman, D., Tierce, J., & Hazard, E. described this in their 2005 study:

In actual practice, however, long-term compliance and persistence are rare. Fourteen percent of all written prescriptions are never filled; another 13% of prescriptions are filled but never taken. Among patients who actually begin therapy with 3-hydroxy-3 methylglutaryl coenzyme A reductase inhibitors (statins), observational studies have reported 1-year discontinuation rates of 15–60% and 5-year persistence rates of only 52%. Only 26% of patients are both persistent and compliant 5 years after initiating statin therapy. Similar trends have been observed with

antihypertensive medications.

During the first year of treatment, the average patient has antihypertensive medications on hand less than 50% of the time. Twenty-one percent of patients never obtain a refill after starting antihypertensive therapy, and only one patient in five has sufficiently high compliance during the first year of therapy to receive the benefits observed in clinical trials. (Petrilla, et al, 2005, p. 2)

Patients' failure to follow through creates waste in the health system and reduces the effect of individual treatment. The cost of never-used prescription drugs, reduced medical outcomes, and the increase in need for remedial treatment contribute to the waste of health care dollars.

The doctor will recommend losing weight, quitting smoking, getting more rest, or dealing with stress, but patients make no effort to change behaviors. Instead, patients expect health insurance to pay for treatment that will give them relief from the suffering caused by their destructive behaviors. When the condition flares up again, doctors perform another examination, order new diagnostic tests, and perhaps write a new prescription.

Health care providers' records do not communicate with each other across health plans, and this results in two primary and wasteful dangers: First, physicians might order tests for patients that have previously been ordered by other doctors, but are not in the prescribing physician's records. Second, physicians prescribe medicines or procedures that are harmful to patients because they do not have the patient's complete medical history. To be successful, the health reform effort must address each individual's willingness, or lack thereof, to change wasteful behaviors, and a patient's entire health history must be available to each health care provider with whom the patient becomes engaged.

We Are a Compassionate People: Key Number Five

The United States' Congress passed the Community Health Center Act in 1964. The act created a federal government incentive for local citizens to establish non-profit health clinics across the country to serve the needs of low-income people. Today, Community Health Centers are "Spread across 50 states and all U.S. territories, more than 1,150 community health centers provide vital primary care to more than 17 million Americans with limited financial resources." (National Association of Community Health Centers [NACHC], 2008)

Community Health Centers charge low fees for health services provided to people without health insurance; or provide services free of charge. Financial support comes from foundations, individuals, government reimbursements, and government grants. Community Health Centers claim to save the United States' health care system as much as \$17.6 billion a year for services the CHCs provide to clients. (NACHC, 2008)

Those who cannot or will not pay for their own health care are also able to receive care from a variety of charitable medical resources. Local and national charities provide financial and staff support for clinics, hospitals, hospices, durable medical equipment, and prescription medicines.

Much debate focuses on the abuse of emergency rooms by people without health insurance.

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented. (CMS, Overview, 2008)

While current federal law protects health providers from being forced to treat illegal immigrants, it does require provision of maternity care to them. Beyond these requirements, providers are under no legal obligation to provide services to illegal immigrants, although they are free to do so, and many do.

Recent legislation introduced in Minnesota, California, and other states that promote “universal health care” do not exclude illegal immigrants from receiving coverage currently available only to citizens and legal residents. The 2009 expansion of the State Children’s Health Insurance Program (SCHIP) waives the prohibition that previously denied SCHIP benefits for children of illegal immigrants. As a rule, in the United States, there are programs and facilities to provide basic and or life-saving health care to everyone who needs it, even if they cannot or will not pay.

As a People, We Are Growing Older: Key Number Six

Supported by modernization of the nation’s infrastructure, medical advances have allowed Americans and citizens of the world to live longer. Life expectancy, a measurement of expected longevity for babies born today, now extends to 78 years in the United States, despite the country’s racial and ethnic diversity. (Heron, M., Hoyert, D., Jiaquan, X., Scott, C., & Tejada-Vera, B., CDC, 2006, p. 3) Clean water and air, safer highways, air-conditioning, an abundance of frozen and fresh foods, computerization – all these have added to extending human life.

Medicines, surgeries, and medical devices serve to alleviate suffering and extend life, but this often requires ongoing, expensive health services for those who live longer. People 65 and older spent 25.5% of total health care expenditures and constitute 12% of the population. (Statistical Abstract of the United States, 2009) Considering that nearly all people aged 65 or older are enrolled in Medicare, and that Medicare reimbursements are less than those paid by private insurance, the actual share of health care use by seniors may reflect a far larger number.

Nearly 77 million “Baby Boomers” will be entering retirement years starting in 2011. (Dattilo & Racer, 2006, p. 83) The number of Americans over age 85 will double by 2030, and Gammick and Morley (2006) show that 40% of the population will be older than 50 by 2050. The proportion of the population older than 50 will grow as a result of the number of people that will live longer lives. (Gammick & Morley, 2006) The aging of populations is common among all advanced nations and as a consequence, as in the United States, other nations also struggle with rapidly increasing demand for health services and face increases in overall spending.

We Embrace and Protect the Life of our Tiniest Infants: Key Number Seven

From its conception as a nation, the United States has fostered a culture of life. This is seen in the United States’ Declaration of Independence (and other official documents): “We hold these truths to be self-evident; that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty and the pursuit of happiness.” (Jefferson, T. et al. 1776) As a nation that, in theory, continues to assert that the rights of every human being are God-given, it has also been the practice of our medical system to do whatever it takes to save life, and to reduce pain and suffering: The Hippocratic Oath, to which physicians still subject themselves, requires it.

According to Marcus Merz, President of PreferredOne Insurance Company in Golden Valley, Minnesota, the average cost of a neonatal intensive care unit amounts to \$9,000 to \$10,000 a day.³ Scott Reid,⁴ sales director at Medica Insurance Company in Golden Valley, Minnesota, confirmed Merz’ assertion. A tiny baby may spend a few days, a month, or longer in such a unit. The average total cost among Twin Cities’ insurers to provide Neonatal Intensive Care Unit (NICO) care for one tiny infant approaches \$40,000 per month. (Merz & Reid, emails, 2008) This charge is exclusive of physician services, and other support services. According to Merz and Reid, it is not uncommon for the cost to provide care for a premature infant to exceed \$250,000.

Premature infants generally face health challenges greater than those of full term babies, both during their first year of life, and during a lifetime. The average cost of providing the first year of care for a premature infant exceeds \$41,000, compared to less than \$3,000 for a full term infant. (Merz & Reid, 2008)

United States’ hospitals are prepared to provide services for premature babies. By comparison, during August 2007, Karen Jepps of Calgary, Alberta, Canada, gave birth to Autumn, Brooke, Calissa, and Dahlia: identical quadruplets. Jepps gave birth in a Great Falls, Montana hospital, since Calgary did not

have the resources to care for four premature babies at one time. (Simnett, C., 2007) That a smaller city of the nature of Great Falls had such a facility is an indicator of the investment made by United States' hospitals in facilities ready to meet extreme needs, and an indicator of the difficulty of a centrally planned health system such as that of Canada to provide adequate health care infrastructure for out-of-the-ordinary medical experiences.

The University of Iowa Department of Neonatology tracks the birth of the world's tiniest infants, born at weights below 14 ounces. Fully 70% of those births recorded since 1936 have been in the United States. (Bell, E., 2008)

We Spare No Expense to Extend Human Life as Long as Possible. Key Number Eight

The United States' Centers for Medicare and Medicaid Services estimates that 27.9% of Medicare's annual budget is spent caring for patients in their final year of life. (Calfo, S., Smith, J., Zezza, M., 2008) The majority of dollars spent for end of life care are spent on people aged 65 or greater; hence, much of the cost of this care is paid from Medicare. In 2004, 1.7 million Americans receive long-term care paid from Medicaid funds totaling \$51 billion. (Dattilo & Racer, 2006, p. 168) Both programs, Medicare and Medicaid, reimburse providers at a rate less than what they are able to receive from people who have private insurance, or who are uninsured. A portion of the loss attributed to Medicare and Medicaid patients is captured by shifting those costs to those with private insurance and those who pay for their own care. (Fox & Pickering, 2008, p. 2) As a result of cost shifting to private health insurance and the uninsured, the true cost of caring for those approaching the end of life potentially consumes a greater share of health spending than that defined by the Centers for Medicare and Medicaid Services.

As a result of extended lifetimes, more people living longer means they require more care for a longer period of time. Dr. Ted Loftness indicated that spending per capita per year for those aged 35 to 44 was \$2,144, those aged 65 to 74 was \$5,172, and those aged 75 or older was \$6,108. (Loftness, 2008, p. 15)

This analogy describes the common development of life for an older resident: The person who undergoes coronary bypass surgery at age 70, who otherwise may have died from a heart attack, now lives to 85, and spends his or her last six months dying from cancer, while receiving expensive corrective and palliative care. The aging person that suffers a debilitating injury, who in past years would have been confined to home, is able to gain mobility through medical intervention, thereby becoming reinvigorated and able to sustain a longer life than would otherwise be possible. This may result in that person living with chronic illnesses, often compounded upon each other, and spending of health dollars for therapy, surgery, and prescription medicines.

Patients and their families often demand that doctors and hospitals do everything possible to save and extend life, without regard to cost. As a result, United States' health services spend more and do more of the most costly of services, and many of these services are hospital-based. Samuelson wrote, "...10% of patients account for two thirds of spending. People in this unfortunate group, regardless of income, get thrust onto a conveyor belt of costly care: long hospital stays, many tests, therapies and surgeries." (2008) Yet, it is in the nature of the United States' culture to preserve and extend human life, even when it makes no medical sense to do so.

We Provide Long Term Care for Aging and Infirm Residents: Key Number Nine

The United States has embraced the idea of providing long term, skilled residential nursing home care for those who are unable to care for themselves. The most recent statistics suggest this trend may be slowing as fewer people are opting for long term nursing care facilities.

The number of elderly long-stay nursing home residents (90 days or longer) declined from 1.21 million to 1.06 million between 1999 and 2004, while the demographic profile of these residents changed little during the time period. Only a small percentage of Americans take care of aging parents or family members at home... Medicaid is the main payer for elderly long-stay residents, accounting for 68% of these residents in 2004. (Kaspter, J., O'Mally, M. 2007)

The 2007 average annual cost of a semi-private room in a nursing home was \$69,000. The average cost of a private room was \$77,750. The cost of providing nursing home care for a single Alzheimer's patient averaged \$72,000. (MetLife Survey, 2007)

While home hospice care offers great advantages and cost-savings in many cases, few families are willing to make the sacrifice necessary to provide it. In many cases, patients in home hospice require the help of professional attendants, and in some cases, 24-hours per day. When home care involves employing skilled nurses, the cost may exceed that of skilled residential care, as evidenced by the State of Tennessee's decision to reinstitutionalize some of its homebound patients. In Tennessee, the monthly cost of caring for a chronically ill or debilitated patient at home averages \$26,000 a month, compared with \$4,200 to \$4,600 a month in a nursing home. These funds are paid from Tennessee's Medicaid programs, as is common to all states. (Schrade, 2008)

We Refuse to Say "No" to People that Abuse Themselves: Key Number Ten

The United States is not only the wealthiest nation, it is also the most generous when it comes to helping hurting people. Public and private largesse extends beyond the provision of health services to the subsidization of low-income residents for food, housing, clothing, transportation, schools, and a myriad of other necessities.

When someone in the United States fails to plan for financial security by buying health insurance, they still receive health services. More than 18 million of the nation's uninsured earn in excess of \$50,000 a year, and many far greater than that. (Herrick, D., 2008) When wealthier uninsured people fall ill or suffer an injury, they still receive care, though they may be hounded by bill collectors or be driven to bankruptcy. Their cost is absorbed by society through the underwriting of provider losses, higher taxes, and the increased cost of private health insurance. (Fox & Pickering, 2008, p. 2)

According to the Centers for Medicare and Medicaid Services (CMS), as listed on its website, those who qualify for and enroll in Medicaid are provided a comprehensive health benefit set. Low-income residents without health insurance can receive an abundance of high quality health services from physicians in private practice, public and private hospitals, Community Health Centers, charitable care centers, and in government health facilities.

Medicaid enrollees are not denied care if they habitually practice destructive and unhealthy behaviors. Taxpayers pay for the care and treatment of drug addicts, the promiscuous person, smokers, and those who are morbidly obese, from taxes and through cost shifting to those who own private health insurance.

We Will Pay Whatever It Costs to Provide Care to Those With Chronic Illness: Key Number 11

According to the Centers for Disease Control (CDC), in 2005, 133 million Americans lived with at least one chronic unhealthy condition. (CDC, *Obesity*, 2008) Common chronic pathologies include hypertension, diabetes, osteoarthritis, stroke, coronary heart disease, respiratory disease, cancers, and childhood disabilities. Many people suffer from multiple conditions. The CDC states that providing care for these people accounts for more than 75% of the nation's medical care costs.

In 2008, the CDC projected the cost of health care for those with heart disease and stroke at \$448 billion. (CDC, *Obesity*, 2008) No other nation spends as much in aggregate on health care as the United States spends just to treat heart disease and stroke.

What makes people healthy or unhealthy are personal habits, good or bad (diet, exercise, alcohol and drug use); genetic makeup, lucky or unlucky, and age. Health care, no matter how lavishly provided, can only partially compensate for these individual differences. (Samuelson, 2008)

In 2000, the estimated cost of treating disease related to obesity reached nearly \$117 billion. (CDC, *Obesity*, 2008) This amount exceeds the total outlay of Canada to provide health services for its entire population during 2006. (Dattilo & Racer, 2006, p. 207) Since 2000, Americans have grown more obese. (CDC, *Obesity*, 2008) In the United States, our health system provides a nearly unlimited

quantity of health care for ailing people, and does so without regard to disability or chronic disease, no matter the source or cause of those diseases.

We Demand the Latest and Best Services: Key Number 12

It takes an average of 14 years for a breakthrough prescription medicine to make it to market from the time of its first patent. (Dattilo & Racer, 2006, p. 147) The cost of developing that new name brand medicine, according to pharmaceutical industry data, averages \$900 million; and only three of ten medicines under development ever make it to market. (Dattilo & Racer, 2006, p. 148) The overwhelming burden, 79.8%, of the cost of developing new name brand drugs is borne by United States' drug manufacturers. (Staff, Pharmaceutical Research and Manufacturers of America, [PhRMA]. 2008) Congress has extended 20-year patent protection to pharmaceutical companies for new name brand medicines. As a result, United States' residents pay more for new name brand medicines than other countries do. Other countries are not bound by U.S. patent concerns, and can license domestic manufacturers to produce patented name brand drugs if they choose to ignore U.S. patents.

As with new name brand medicines, so it is with new medical and surgical devices. New devices require long and costly research, development, and animal and human experimentation before they receive government approval. The cost associated with the entire cycle of a new name brand medicine or a piece of durable medical equipment directly affects their initial high cost to patients.

When a person is beset by pain or suffering or the threat of death, physicians frequently offer patients relief using recent medical breakthroughs or technological advances. Physicians do this because patients ask for the latest and best treatments that science can make available. Even when experimental care or cutting-edge procedures are not covered by insurance, public pressure is brought to bear on an insurance company to pay the cost, or patients turn to charitable foundations or governments to fund such procedures. Medical schools may provide services without reimbursement when they involve new technology, but those costs must be borne either by taxpayers or through tuition, or both.

We Want to Live Pain Free, but Do Not Want to Pay for it Ourselves: Key Number 13

Americans count on their health care system to provide help to numb or remove physical pain and expect the health insurance system to spend whatever it takes to do so. However, Americans do not want to suffer a loss of their financial assets as a result.

During the early 1900s, the most common painkiller was whiskey. Thankfully, medical researchers have found many better treatments; modern-day anesthetics, and for common pains, a bevy of over-the-counter and prescription painkiller choices available at local pharmacies. Seemingly miraculous surgery can remove the source of pain, and improve human life.

There appears to be a medicine, salve, surgery, treatment, or device to relieve almost every human pain. If there is not, patients and their physicians will let the market know that it needs to be created. Americans want relief from pain no matter the cost, and demand a health system in which someone else pays the bills attendant to the reduction of their pain.

We Want Immediate Emergency Care: Key Number 14

Americans want emergency rooms to be minutes away. Nearly every United States' community maintains a corps of highly trained paramedics outfitted with modern life-saving equipment, ready to rush to save the life of someone in distress. Paramedic crews are well trained and well paid. Americans expect paramedics to arrive in fully equipped ambulances within five minutes of a distress call. When a patient requires extraordinary emergency care, he or she expects a helicopter to be ready to provide an airlift to the emergency room or to a specialty care center.

Americans expect the emergency room to be fully and professionally staffed and stocked with the latest technology, supplies, and medicines. If it is not, and a patient suffers as a result, the patient will sue the hospital and medical staff. Emergency rooms in U.S. hospitals, therefore, are stocked to meet unexpected needs on a small or large scale, and this creates immense expense.

We Expect Immediate Access to Doctors: Key Number 15

United States' patients expect to be able to see a doctor right away, on the patient's own terms, to fit the patient's schedule. Patients expect that no matter their condition, they will be able to quickly access type of doctor necessary to treat their ailments and injuries. This is one reason why more than 900,000 doctors practice in the United States, at a ratio of about one doctor for each 335 residents. (Smart, D., 2007)

The continued need to train physicians is complicated by an explosion in knowledge and technology. Tomorrow's practice of medicine could be far more complicated than that of today; technology could also make it far less complicated. Physicians will adjust, and it may be that the United States will need more of them, or it may need fewer. "A newly trained physician will spend many years in practice in a field that surely will not remain static." (Richmond & Fine, 2005, p. 203)

Average wait time to see a doctor in the United States varies by specialty and location. In major cities the average wait to see a cardiologist ranges from nine days (Seattle) to 37 days (Boston). (Merritt & Hawkins, 2004) Dermatologists have the longest wait times; orthopedic surgeons have the shortest wait times.

United States' patients are used to immediate access to preventive, corrective, maintenance, and emergency health care. Americans expect to see a doctor in days, or perhaps a few weeks and refuse to tolerate longer wait times.

We Live Risk-filled Lives and Expect Health Care to Fix Us: Key Number 16

Americans want to be able to practice risky behaviors, and when they get sick or injured, they expect the health care system to heal them. Risky behaviors include voluntary actions that place the human body in peril and habitual consumption or lifestyle behaviors that tend to render the body less healthy.

When a middle-aged man damages a knee playing softball, he expects a sports medicine specialist to treat him, or an orthopedist to replace his knee. When thrill seekers skydive, bungee jump, or parasail and are injured, they expect an ambulance staffed by skilled paramedics to rush them to a nearby emergency room. When drinkers become intoxicated, or addicts ingest hallucinatory drugs, and cause an accident to themselves or others, our health system will do everything possible to save their lives or cure them of their addiction. Smokers put themselves at risk for many diseases. American executives and professionals push themselves to the brink of exhaustion, and suffer strokes, heart attacks, or stress diabetes.

The United States' health system treats the results of risky behavior, but seldom the cause. Often, America's cultural sensitivities preclude an honest discussion about risky behavior. Young sexually active girls, for instance, are at greater risk of developing cervical cancer later in life. (Gostout, B., 2009) These young girls can avoid this risk by not having sex. Instead, states are establishing programs to vaccinate them under the compulsion of law as early as nine years of age. (Gostout, 2009) Authorities assume that girls will be sexually active, and therefore, need the vaccine.

We Are a Society of Overweight People: Key Number 17

United States' residents overeat, eat the wrong kinds of foods, and lack proper exercise. As a result, the Centers for Disease Control warned the country that it is experiencing an epidemic of obesity. The CDC reported that in 2006, more than 25% of Americans were obese. (Behavioral Risk Factors, 2007) Obesity is a root cause of hypertension, Type 2 diabetes, osteoarthritis, stroke, heart disease, gallbladder, sleep apnea and respiratory issues; even some cancers.

The growth of obesity in the United States has been most profound during the past 20 years. The CDC reports that obesity rates during 1986 averaged less than 15% across the country. (Behavioral Risk Factors, 2007) By 2006, in some states, the rate of obesity exceeded 30%. If Americans continue to eat this way, and refuse to exercise, there will be no way to control health spending, unless providers

deny health services to obese people, or insurance companies and government refuse to pay for their health care.

We Take Advantage of Health Plans: Key Number 18

Since the middle 1970s, the United States has embraced European-style health plans. (Dattilo & Racer, 2009, p. 15) European plans are governed by federal agencies, and in general, remove most or all direct financial burden from the citizens. Rather than pay premiums to an insurance company, citizens in a European-style government plan pay the cost through taxation and in some countries, supplemental insurance. Countries with government health plans tend to feature quite high tax rates and economies that struggle to maintain growth.

According to professional health agents interviewed during the past 30 months, traditional United States' health plans require policyholders to pay a co-pay for health services and medicines that range from \$2.00 to \$5.00 for union-negotiated plans, to \$25.00 or more for the most common of employer-based health plans.⁵ Usually the patient also pays a deductible amount, and commonly, less than \$500.

Since the patient's personal expense is low for each encounter, patients tend to use health plans more than they do when they pay for their own care. Whether a patient suffers from a cold or the flu, or needs a serious clinical or scanning procedure, his or her cost per encounter remains the same. Insurance agents report that they have clients who no longer own a home thermometer, but go to the doctor when a child has a fever in order to have a doctor or nurse take the child's temperature.

Richard L. Reece, M.D., reports that the two most common reasons Americans go to doctors are for respiratory problems and low back pain, neither of which the doctor can cure.⁶ Reece says the reason a doctor tells a patient to come back in seven days if a cold persists is that most colds run their course in seven days, with or without a doctor's help. Patients worry, however, and ask for penicillin, an X-ray, or a battery of tests.

Sixty percent of Americans receive health insurance through their employer's insurance plan. (Kaiser Foundation, 2008) They may pay none or only a limited portion of the actual insurance premium, usually less than 50%. The insured person's perspective is that they pay a good deal for insurance, and feel entitled to use it often, and when they please.

We Pay Health Professionals High Incomes: Key Number 19

Health professionals in the United States earn incomes between \$135,000 and \$450,000 because they are entrusted with human life. (Dattilo & Racer, 2006, p. 65) There are a limited number of doctors, and doctors require years of expensive education and training. Someone other than patients pay their bills.

Hiring a doctor is far more expensive than for any other service for which citizens' pay, with the exception of attorneys. Health care practitioners work under immense pressure and in a risky profession, trying to protect patients' health and a lack of tolerance for mistakes. Since insurance or government pays most of a health professional's bills, patients do not know if the professionals are paid too little or too much. When a patient's life is threatened, how much their attending doctor earns is of little importance.

We Sue Doctors: Key Number 20

Health professionals carry malpractice insurance to protect their assets from patient lawsuits. There is nothing unusual about professionals or any organization carrying liability insurance; it is prudent to do so. Two factors make health professionals especially sensitive to the potential of a malpractice lawsuit: (a) the unique physical nature of each individual, affected by a myriad of unpredictable factors; (b) the personal and professional degradation felt by doctors who are sued.

Although the human anatomy is consistent in nature, each human body is unique. Body chemistry, configuration, experience, exposure to elements, mental condition; all of these vary from person to person. It is not uncommon for a surgeon to discover that a body organ is positioned

differently from what the anatomy book described. Different humans respond differently to the same medicines because body chemistry varies from person to person. That is why health professionals call the practice of medicine an “art.” Doctors have to adjust to what they find when they examine a person, and often rely on deductive reasoning that eliminates various factors before discovering a successful treatment regimen. The only factor predictable about the nature of humans is that they are not consistently predictable.

Every human is frail, subject to illness, and eventually will die. When a patient sees a doctor and is not healed or dies, oftentimes the patient or the patient’s survivors believe it is due to doctor error, and sometimes it is. Doctors own malpractice insurance as a result of the likelihood that they will be sued sometime during their careers. Doctors’ malpractice insurance is expensive. Those costs are passed on to patients in the form of higher fees. Malpractice insurance cost is small, however, compared to the ramifications of defensive doctoring.

The Insurance Institute reports:

That fear of litigation has also caused many [doctors] to practice defensive medicine, which in turn increases healthcare costs. Nearly four out of five doctors (79%) surveyed said they have ordered unnecessary tests, while 74% have referred patients to specialists more often than they would have based solely on professional judgment. (Hartwig, R., 2003)

Dr. Charles Fazio, Chief Medical Officer for Medica Insurance, speaking at a 2008 brokers’ forum (2008), stated that each family practice doctor’s pen controls \$5 million worth of spending. He referred to the cost of tests and procedures ordered by the family practice doctor. An unknown portion of this \$5 million cost results from defensive doctoring by physicians who fear a lawsuit.

The threat of medical malpractice claims differs from state to state, depending on the nature of tort laws written by various state legislatures. In states with restrictive laws that demand a high standard of proof of damage and with severe limits on financial awards, the threat of lawsuit is diminished. Conversely, in states with a low standard of proof with few or no limits on financial awards, the threat of a malpractice lawsuit is great.

The potential for a medical malpractice claim is a major reason that health care spending in the United States is greater than it needs to be. The predicament is further complicated by political factors related to the influence of strong interest groups, such as the American Trial Lawyers Association and the American Medical Association.

We Expect Others to Pay Our Health Care Bills: Key Number 21

In 1960, United States’ residents directly paid 48% of their health care cost from their own pockets. (CMS, NHE, 2008) Their insurance only paid major, catastrophic costs. Health care and insurance remained affordable for most Americans.

By 2006, Americans paid less than 12% of their health care cost from their own pockets. (CMS, NHE, 2008) The primary reason for the difference in the rate of out of pocket payments is the adoption of European-style health plans, the type of “insurance” that prepays most health care services, or that pays the largest portion of the cost of health services as they are accessed. (Dattilo & Racer, 2009, p. 15)

Prepaid health care, administered by a Health Maintenance Organization (HMO) or designated as managed care, is the most common form of health plan. HMO and managed care adherents believe that a business-oriented administrator can manage a doctor who is managing the health of each patient, encouraging preventive care, and thereby, reducing lifetime health expenses. From the inception of the Medicare and Medicaid Acts of 1965, and the HMO Act in 1973, health care spending has spiked higher each year, often by double-digit rates. (CMS, NHE, 2008) There are two primary reasons for the spike in spending, and many subordinate reasons.

First, insured people (with prepaid health care) began going to the doctor more often, having more tests, and consuming more health care. Second, rather than pay their own health care bills, or even a

reasonable portion of their own health insurance bills, the patient's employer-supplied prepaid health care plan paid the bills. No longer did patients know how much their own health care cost. Patients, instead, began to feel entitled to as much health care as they wished to consume. Instead of hoping never to use their health insurance as a result of becoming ill or injured, policyholders began to think they were not getting value for their insurance dollars unless they saw a doctor, or received many tests. The cost of prepaid health care (that is, health insurance) soared, and today, has become very expensive and to many, unaffordable. (Kaiser, 2008)

Compounding the increase in utilization of health services is the ongoing explosion in medical technology, pharmaceutical breakthroughs, and the ability to perform ever-increasingly delicate and expensive medical and surgical procedures. Loftness asserted, "Technology drives 50% to 66% of cost increases above inflation. (Loftness, 2009, p. 22) At each juncture of new technology and procedures, cost of care collides with insurance coverage issues, and eventually, additional mandates for insurance benefits issued by state legislators. More health care, covered by more insurance, resulted in more expensive coverage.

States have further complicated this predicament by forcing insurance companies to cover procedures under approved health plans. These are called mandates, and average 36 per state. Minnesota leads the nation with 64 mandates. (Bunce, V., Wieske, J., Prikazsky, V., Council for Affordable Health Insurance, [CAHI], 2207)

United States' residents have become comfortable with the idea that someone other than them should pay their health bills and provide them with comprehensive health insurance.

We Have No Idea How Much Health Care Costs: Key Number 22

A typical United States' resident with a traditional health insurance plan knows nothing about the true cost of health care services. The same is true for Medicare recipients, and more so, for Medicaid recipients. The only cost of care about which a person covered under traditional health plans or a government plan is aware is their co-pay.

Weeks after a patient uses a health care service, the insurance company sends the health provider a reimbursement in payment for that service. This is a payment negotiated between the insurance company and health care provider that pays the balance of the bill after the patient has paid the co-pay. Depending on the type of provider and the services rendered, the additional payment could be hundreds or thousands of dollars.

Hospital charges often total thousands and tens of thousands of dollars for a single incident. The patient does not know, nor does the patient have reason to care, about the actual cost of services. Patients directly pay only a fraction of the real cost of health care; insurance pays the greatest portion.

In reality, every taxpayer pays the cost of everyone else's health care, plus they pay indirectly or directly through increased insurance premiums. Employers that provide health insurance to their employees pass along those costs to consumers in the form of higher prices for goods and services, and restrict the level of wages and salaries they might otherwise pay to employees. There is truth in the adage that there is no such thing as a free lunch, nor is there any such thing as free health care. Someone always pays, but the true cost is hidden from the patients.

We Tolerate a Dishonest and Misleading Health Care Billing System: Key Number 23

United States' residents not only are shielded from the real cost of health care, the billed charges they *do* see are dishonest and misleading. These billed charges serve to further confuse and cloud the true cost of health services.

The United States' system of determining health reimbursements is almost entirely based on the amount that the federal government reimburses doctors for Medicare services. Medicare uses a system of determining the cost of each health care service known as the Resource Based Relative Value Scale (RBRVS). From the RBRVS for each service, Medicare determines a level of reimbursement it will pay to a doctor or hospital for each specified service.

Related to the RBRVS, the American Medical Association further developed the reimbursement system by implementing use of Current Procedural Terminology (CPT) codes. Over time, other forms of codes have been developed to deal with specific or unusual medical, surgical, hospital, and other health related services and products. The coding system is highly complex, constantly under review, and changes over time as the delivery and breadth of health care evolves. Each health service corresponds, theoretically, to a code that is used to bill Medicare for services rendered. Hospitals further bundle services into Diagnostic-Related Groups (DRG), and use them to bill Medicare and insurance companies for services.

From the original purpose of using RBRVS and CPT (and other) codes to facilitate payment for Medicare, their use has been extended. "Many of the nation's payers, including Medicaid, are implementing variations of the Medicare Resource-Based Relative Value Scale (RBRVS) to pay physicians for the provision of health care services." (American Academy of Physicians [AAP], 2008)

In effect, the charges levied by health providers (doctors, clinics, hospitals and their integrated health systems) are directly or indirectly based on how much Medicare reimburses providers for each service, even if those services are provided to a person with private insurance or who is uninsured. The billed rates generated by providers are, however, contrived and distorted compared to what providers accept for payment. For the top 31 DRGs performed by hospitals during 2005, the hospitals billed Medicare 308% more than what Medicare actually paid for those services. (CMS, Top 31, 2007) The data set compares Medicare payments in every hospital across the United States at which those hospitals perform Medicare-reimbursed services.

Insurance companies base their provider reimbursements on a multiplier above the Medicare reimbursement rate and as much as possible, use the same CPT and DRG coding system as does Medicare. Providers sign a contract with each insurance company that pays a "discount" from the billed rate, the rate that averages 308% more than Medicare pays for a hospital procedure. The amount that providers accept varies, based on competitive factors in each community.

Health care providers bill the full price to the insurance company. The insurance company pays the provider the negotiated "discounted" rate from the billed price. Physicians' bills often show a lower discount than those for diagnostic services. Hospital bills typically show the largest discounts – these are the billings that average 308% more than Medicare reimbursements. The price actually paid by insurance companies varies depending on their privately negotiated, contracted rates with each health care provider, and the contracted rates are not publicly revealed prior to services being rendered, unless required by state law. Weeks after health services have been rendered, the insured patient receives an Explanation of Benefits (EOB). The EOB shows the billed rate, and the allowed rate, leaving the patient astounded at the high cost of health care, but thankful that the insurance company negotiated a lower price. The most pernicious aspect of this dishonest billing system is the way it treats uninsured people. The only individuals who are billed at the full price and expected to pay it are those without insurance, and who are unable to negotiate a discount.

The billing system creates mass confusion, and the illusion that insurance companies are saving their clients a good deal of money. This furthers the idea that without health insurance, no one could pay his or her health care bills.

We Abuse High Deductible Health Insurance Plans: Key Number 24

Prior to 1980, most United States' residents who owned health insurance had "major medical" or "catastrophic" health insurance. This form of insurance covered major medical and hospital expenses, and featured "high" deductibles, at that time on the order of \$50 or \$100 a year. (Dattilo & Racer, 2009, p. 24)

In recent years, health insurance agents, health reform advocates, and insurance companies have been promoting high deductible health plans, sometimes called consumer-directed health plans. These health plans typically pay 100% of preventive and health screening costs, and after the deductible

is met, either 80% of all remaining covered expenses, or 100% (depending on the plan), with a maximum out of pocket limit per year.

According to professional health insurance agents interviewed during the past 30 months, the deductibles are at least \$1,150 per person, but often \$2,500 or higher. Family deductibles are commonly \$5,000 or higher.⁷ This allows the policyholder to control the cost of insurance premiums, which professional health insurance agents report are often 20-60% below a traditional health plan. The premium spread between a traditional health plan and a high deductible health plan depends on the state in which the plan is offered and the level of competition among insurance companies that offer consumer directed health plans in each state.

While these high deductible plans often reduce the overuse of health services, once a person has a serious illness or an injury, and their health spending exceeds their calendar-year deductible, the incentive to save money has been lost. It is common during the balance of that calendar year for the insured person to schedule as many health services as possible, and the chief motivation is that someone else will pay their bills – everyone who owns insurance and pays into the pool of money.

Politicians: Key Number 25

Since Congress passed the Medicare and Medicaid Acts in 1965, Congress has increased its oversight and micromanagement of health care. State legislatures, likewise, have increasingly micromanaged the delivery of and payment for health care services.

Politicians directly or indirectly set the price of health care based on the dollar amount that Medicare would reimburse doctors and hospitals for services. (Dattilo & Racer, 2006, p. 120) This is due to the fact that medical providers and insurance companies base their negotiated charges and payments on Medicare reimbursement rates.

Politicians write the laws from which government bureaucrats write the regulations that define how doctors and hospitals must practice medicine and provide care for patients. Politicians write the laws that tell insurance companies which benefits must be covered under their health plans. Politicians write the laws that tell employers the conditions under which they must operate if they choose to provide a health benefit to employees. Since 158 million Americans and their families receive health insurance through employers (Kaiser, 2008), legislation and government regulations affecting employer-provided health benefits play a significant role in determining the nature and cost of insurance plans.

The United States' health care system stands alongside, or ahead of other issues in which politics plays a role. The personal nature of the services delivered by health care providers, and the threat of financial ruin faced by patients has endeared Americans to the protective hand of elected officials. In the manner of modern civic issues, health care has become an extremely partisan issue, used for electoral advantage, and subject to promises common to election contests. Few politicians grasp the complexity of the health system economy. Rather, they focus on issues that fit their worldview and that will win them votes.

Health care is subject to political activist influence due to its ubiquitous nature and the sheer number of dollars it generates in the economy. Rather than find solutions, interest and pressure groups employ public relations tactics to bring their message to the public to win votes. The politicization of health care has shackled progress in resolving the serious issues the delivery and cost of health care faces.⁸

Subjected also to the system of compromise common to politics, government health care policy seldom reflects the realities faced by the people it is to serve. As political as has the United States' health care system become, it is not surprising that it is characterized by waste and inefficiencies.

Additional Key Concerns

Health care reform is impacted by far more than the 25 key issues discussed so far in this thesis. An attempt to list all issues related to health care reform would render this document impossible to

complete during a lifetime. A handful of issues that deserve further intense scrutiny are included herein for future consideration.

Congress created Medicare and Medicaid in 1965, and federal officials launched the two programs in 1966. Congressional adherents of Medicare predicted that Part A spending would total \$9 billion a year by 1990; spending for Part A totaled \$67 billion during 1990. (Dattilo & Racer, 2006) In 2006, Medicare spent \$401 billion caring for enrollees. (CMS, NHE, 2008) Beginning in 2011, Baby Boomers will begin enrolling in Medicare. As a result, the Medicare fund is unsustainable over the long term without tax increases on working people, rationing of care, or establishing means testing of enrollees' assets to create more income for the program.

The impact of technology on the practice of medicine is known best by new surgical and diagnostic techniques. Less known is the impact technology might have on recordkeeping, billing, and ensuring that health care providers can access the most accurate and up-to-date medical history of patients. The movement toward individualized electronic medical records is thought to be a panacea for much that ails the health care system, but it is in its infancy, is very expensive, and physicians have shown they are averse to it.

Heredity may play a great role in determining health outcome statistics. There is a need to study racial and ethnic differences and how they affect the pooled statistics dealing with infant mortality, maternal mortality, and life expectancy. The United States Census Bureau releases these statistics each year, but they appear to receive very little notice among health reformers. Combining statistics that may be influenced by heredity may mask cause and effect and hinder proper health protocols to develop treatment for various racial groups.

Defining the terms of evaluating the efficacy of health care makes it difficult to draw concrete solutions. This author polled a number of doctors, asking them to define "preventive care," and found a lack of agreement about this simple question. Preventive care is often confused with health screenings. It is likely that doctors seldom prevent illness from occurring, but often, through screening, can discover existing conditions that would lead to a worsening of a condition, or that can be healed through medical intervention.

Professional organizations that are stakeholders in the multi-layered aspects of the United States' health care system fight to hold onto power, and protect territory. Greed, pride, fear of change, power, prestige, ignorance, close-mindedness, professionalism, and any number of influences restrict reformers' vision of what needs to be done. As Rooney and Perrin wrote, sometimes it is simple to understand basic motivation: Just follow the money.

Fear plays a central role in the stubborn nature of reducing the cost of health care. By fear, the author means a fear of nearly everything. The United States, and perhaps most of the civilized world, seems obsessed with fear of a long list of potential disasters, most of which never will occur. Humans desire an answer for every predicament, demand that someone must pay for every mistake or accident, and seek a solution for every perplexity. The drive to live without risk, or with reduced risk, or to have all risk indemnified, is pervasive.

Emerging science about personal and community health plays a central role in what lies ahead for the United States' health care system. One consideration alone could upset the entire system by its profound potential implications. Dr. David McCarthy addressed this issue at the O'Fallon Forum, O'Fallon, Illinois, on May 14, 2008. (Dr. McCarthy hosted The O'Fallon Forum that featured Gov. Mike Huckabee, LaVar Burton, Dave Racer, and himself.) During Dr. McCarthy's presentation, he demonstrated that Americans suffer from a serious Vitamin D deficiency. McCarthy reported that by correcting this deficiency a great many chronic and life-threatening diseases can be completely or nearly eliminated. McCarthy estimated that correcting this deficiency by using inexpensive doses of Vitamin D-3 could save \$800 billion a year in health spending for corrective and palliative care in the United States.

People of faith, in particular those that claim a personal and intimate walk with Jesus Christ, seem to have adopted the world's values in the way they view the provision of and demands upon health

care. Rather than use their God-given resources to care for themselves, or to relieve the suffering of others, they turn to governments or institutions to provide medical relief at the expense of others. When the end of life appears near, either they cling to it as if gripped by fear of the eternal, or their loved ones refuse to give them into God's hands. Instead, they spend copious amounts of other peoples' money (most often through Medicare or private insurance) to extend life by a few weeks or days.

Chapter IV

THREE FUNDAMENTAL STRATEGIES TO MITIGATE HEALTH SYSTEM PROBLEMS

The purpose of the United States' health care system is to provide preventive, corrective, and palliative health care to a broad spectrum of people of diverse races, ethnicities, cultures, and faith systems in locations all across the country. Racial, ethnic, and cultural diversity adds to the complexity of providing health care in the United States. Finding a common solution for a health care system that is applicable to the entire population may, in fact, be an impossible task; certainly, a single solution is impossible.

The author suggests three strategies that individuals can adopt to mitigate their own use of the health care system. Acting alone, in families, communities, and through their institutions, each individual's actions will impact the broader system, and can serve to mitigate issues affecting the overall national cost, access, and quality of care. (a) Individuals can reduce their own health spending cost by taking better care of their bodies by practicing healthy behaviors. (b) Individuals can reduce the cost of health care by exercising control over how their health care dollars are spent, and thereby, impose financial discipline onto the health care system. (c) Christian individuals, in particular, can practice what the Scriptures teach about personal stewardship as it regards personal health and finances and Christian compassion for others. They can work together to serve the health care needs of others, relieve financial pressure on public systems, and thereby provide opportunities for presentation of the Gospel.

Healthier Behavior

Dr. Charles Fazio, Chief Medical Officer for Medica Insurance, speaking at a brokers' forum about the evolving nature of health care, stated, "It can't be about fixing people anymore." (Fazio, 2008) By this Fazio indicated an emerging trend in the way his company views the provision of and payment for health care in the United States. Fazio explained that his company has shifted its focus to begin actively and aggressively engaging members (people insured by Medica) in wellness coaching, in a concerted effort to help them stay healthier. Medica, by this action, joins other health plans and insurance-related organizations in a well-organized and funded assault on ill health.

The United States' Centers for Disease Control states that obesity directly and negatively affects seven critical health conditions. The CDC indicates that 33% of Americans aged 20-74 are obese (2003-2004), and that at least \$78.5 billion was spent during 2007 treating diseases directly related to obesity. (CDC, *Obesity*, 2008) Fazio quoted other CDC statistics indicating that 32% of children, and 67% of American adults are overweight or obese. (Fazio, 2008)

Obese and overweight people with chronic negative health conditions spend more money on their health care during their lifetimes than do people with normal weight. (CDC, *Obesity*, 2008) Their behavior further results in increased spending on health care as their health diminishes, and death draws nearer.

Losing or maintaining a healthy weight has been thought to be subject to individual volition, not to external pressure. Trends indicate that governments, health plans, and employers are beginning to impose incentives onto Americans to lose weight. Health plans for as many as 35 years have been relying on managed care constructs to force physicians to reduce spending. The newest trend is for the health plans to append managed care by insinuating the health plan directly into individual wellness case management. (Fazio, 2008)

Obesity is not the lone culprit contributing to ill health and higher expenditures for care. Smoking, drinking to excess, lack of adequate rest or exercise, stressful behavior, sexual practices, and other human behaviors that, when not controlled, can lead to illness or injury each add to the complexity of providing and paying for health care. All of these require individual behavior change that is held hostage to personal volition. Individuals must be convinced one by one that it is in their best interest to take better care of themselves.

Americans who suffer from health pathologies related to birth, heredity, accident, illness, acquired diseases, or other exigencies beyond individual control, and who are not near to death, nonetheless are often able to, at some level, still have a positive impact on improving their own health. Small efforts to improve health can reduce the need for or frequency of health services. Closely following treatment and therapy recommendations may mitigate other health complications, reduce cost, and alleviate unnecessary suffering. State and federal governments are adopting a managed care concept to help contain these costs, known as health care homes using professional care coordinators.⁹

United States' residents, on an individual level, must become convinced to become healthier. That task is made more difficult by the way most Americans pay for health care.

A Personal Financial Stake in Health Care

Nearly 258 million Americans' health care is paid either by a government, or non-government health plan. (USCB, 2008) Across the United States' population, 34% of Americans spend nothing on health care each year. Another 34% spend an average of \$500 on health care each year. Another 24% of Americans spend an average of \$1,000 on health care each year. This translates to 92% of Americans during any given year spending an average of \$1,000 or less on health care. The remaining eight percent spend an average of \$12,000 a year on health care. (Hopper, 2007)

The average cost across the United States of insurance premium for a single person with private insurance who owns a traditional health plan during 2008 is \$4,754, and for a family, the average premium is \$13,122. For those who own a high-deductible health plan, the average single premium is \$3,922, and the average family premium is \$10,121. (Kaiser, 2008) No data is provided for the range of premiums used in this calculation, an omission that is especially critical while evaluating the range of premium savings for high deductible health plans (HDHPs). HDHPs commonly range in deductible amounts from \$1,150 to \$5,000 for single coverage, and to as much as \$11,000 for family coverage. Given the available data set, the average saved on premium between a traditional health plan and an HDHP is \$832 for a single (17.5%), and \$3,001 (22.9%) for a family plan.

As a calculation of a mean premium this data tells only part of the story. In Minnesota, professional health insurance agents interviewed during the past 30 months indicate that the premium differentials between traditional health plans and HDHPs exceed 40%. California insurance agents interviewed during the past 30 months report the same results, while Michigan health insurance agents see an average 10% differential. New Jersey health insurance agents report average premiums across all types of plans that are 200-400% or more of those in moderately priced states.¹⁰

These deviations from the mean are mentioned to put in context the advantages offered in premium savings by high deductible health plans, and the impact it can have on controlling health spending. When 92% of Americans spend an average of \$1,000 or less per year on health care, and when premium savings from the purchase of high deductible health plans are \$1,000 or more per year, prudence dictates the purchase of HDHPs over traditional health plans. (Hopper, 2006, p.68)

The Federal government and most states encourage the purchase of high deductible health plans by offering a significant tax break to those who purchase them. Funds eligible for the tax break are deposited in a Health Savings Account (HSA). The law limits the maximum amount of annual deposits. The funds deposited in an HSA are owned by the person or family that deposits them, are fully tax deductible when deposited, investment or interest income gained on the deposits remains fully tax deductible, and there is never a tax on any of the funds if they are used to pay qualified health expenses. The money belongs to the individual's estate, and if left unused for health purposes, will follow all other estate assets at the time of the individual's death. (HSA Coalition, 2008)

In 2009 the maximum HSA deposit allowed will be \$3,000 for an individual, or \$5,950 for two spouses. People 55 or older can add another \$1,000 a year, in what U.S. treasury officials label a catch up deposit. (HSA Coalition, 2008)

Those who own HSAs and HDHPs use their premium savings to fund their HSAs, and often, their employers help fund them (employer deposits are also tax deductible to the employer and cause no tax gain to the employee). People who own these plans are spending less on health care.

...[T]he state report also showed a 14% increase in out-of-pocket medical expenses for Minnesotans...With Minnesotans bearing more of the cost, [Health Commissioner] Sonier said, it's equally possible they are cutting back on their use of health care services. (Olson, J., 2008)

Research reveals near unanimous agreement exists among health care commentators, writers, providers, payers, politicians, and patients, that health care spending must be harnessed. One way to do this is by combining HSAs with HDHPs, so that patients will have a sense of ownership of their health care dollars, and spend them more carefully.

Some suggest that people will forgo necessary health care services if they are free to use their own money. Typical of this sentiment is a *Washington Post* article that quotes data from several studies. The writers indicate that these plans result in people with less coverage and facing more personal cost: "Embarrassed by unpaid bills and fearful of accruing more, many such patients postpone care until they are sicker and their illnesses are more difficult and expensive to treat." (Staff, *Washington Post*, 2009)

Other HDHP/HSA researchers point to studies indicating that there is little difference between those with HDHPs and those with standard health plans as it concerns obtaining necessary care. (HSA Bank, 2008) The primary difference is the behavior of those with HDHPs as it concerns less essential health services.

A joint study by the Employee Benefits Research Institute and Commonwealth Fund purportedly found that people with higher deductibles are twice as likely to delay or avoid care as those with comprehensive plans. But this is precisely what we should expect of people who are spending money out of pocket rather than someone else's money. A survey by McKinsey & Company found that people with extremely serious health conditions did not forgo care, whether covered by CDHC [Consumer Directed Health Care, which rely on HDHPs and HSAs] or traditional health plans. Those with very serious health conditions were more likely to forgo care if they had a traditional health plan compared with those in CDHC plans. Those with CDHC plans were more likely to forgo care than those in traditional plans for conditions they considered not very serious or only somewhat serious...Reducing one's health consumption for less serious conditions is not injurious to one's health...

Lumenos found that when its CDHC plan replaced traditional health plans, there was an 18% reduction in outpatient visits. The rate of generic drug substitution for more expensive brand name drugs rose to 92%, and total pharmacy costs fell 15%. Aetna found that, compared with individuals in traditional plans, CDHC enrollees reduced outpatient visits by 14%, primary care office visits by 11%, hospital admissions by 5%

and emergency room visits by 3%. (Goodman, J.; Herrick, D., 2006)

The federal Health Care Modernization Act of 2003 established the Health Savings Account, and it is unknown as yet the impact it will have over an extended period of time. What is known is that decades earlier, when the common health insurance plan covered only major health and hospital costs, Americans spent 48% of all health care dollars out of their own pockets. By 2006, that number had shrunk to 12%. (CMS, NHE, 2008) During the 1950s, health care consumers hoped they would never have to use their health insurance, because if they did, it meant they faced a serious health predicament. During the modern era, health care consumers feel cheated if they do not use services, even when they are unnecessary. This shift in attitude from the 1950s to today is a key element in why health care costs have spiked.

In 2008, when the price of a barrel of oil topped \$140, and the price of gasoline approached or exceeded \$4.00 a gallon, the American people cut back on travel. This helped force down the price of oil, and consequently, gasoline prices fell back below \$1.60 in several states by December 2008. As with health care, the price of oil and gasoline is complicated, and prone to effects not directly related to the

commodities themselves (such as the strength of the dollar, speculation, storms, international politics, or war), and still, when consumers put pressure on the price by using less gasoline, the price fell.

The idea of health care consumers playing a role in paying their own health bills and having their own savings at stake opens the door to patients having an extended conversation with a medical provider. "How much does this cost?" A simple question asked of a doctor can help determine the need to spend money for a health care procedure, as the patient wants to know whether it is of value to spend their own money.

Health consumers look for values in somewhat the same way as people will drive around the block to save three cents on a gallon of gas. Shopping for values is easiest to observe in the way consumers purchase prescription medicines. When a patient has a traditional health plan, his or her share of the bill might be a \$25 co-pay for a name brand drug. When the patient spends his or her own money, and learns the actual cost of the drug is \$200, he or she will ask about generic alternatives. When a patient learns that he or she can purchase a generic drug and save 98% or more by doing so, they buy the generic. (Dattilo & Racer, 2009, p. 49)

Rather than go to an emergency room for the sudden onset of a non-life-threatening ailment, the patient that is concerned about cost chooses to go to an urgent care center and saves 25-75%. Rather than see a doctor at a health clinic as the result of suffering a sore throat, the health care consumer sees a nurse practitioner at a retail walk-in health clinic, and saves \$50 or more on a single visit. (Dattilo & Racer, 2009, p. 54) When a serious illness or injury occurs, the health care consumer has major medical and hospital insurance to cover the big expenses. The purpose of tying health care consumers to the first dollars they spend on health care is to inject dialogue, reason, logic, and self-responsibility into the purchase of health care. Patients that spend some of their own money in a health care treatment have been shown to follow through more often than those with low co-pays.

Common criticisms about consumer-driven health plans include the idea that only wealthy people can afford to use them, that they are for healthy people, and that low-income people could never afford to put money in an HSA. It is true that these plans are very attractive to wealthy people who can easily deposit 100% of allowable funds into their HSA, and who relish saving money on their premium. As well, they are more likely to find ways to invest their HSA money and seldom, if ever, tap it for health expenses. It is also true that wealthy people abuse traditional health plans as often as those of lesser income. There is no downside to wealthy people using these plans.

Numerous case studies prepared by health insurance agents for their clients that use High Deductible Health Plans (HDHPs) have shown premium savings of more than 40%. Typical of these studies is one prepared by a California health insurance agent that demonstrated a 44.8% premium savings averaged across five of his clients (Weber, 2008). The annual savings for these five firms totaled \$458,000, and reduced the average out-of-pocket premium cost to employees by \$3,295. The reason they save so much is that the insurance premiums are far less.

Hopper demonstrates that individuals suffering from chronic illness are also likely to save money with an HDHP if combined with an HSA. He provides a case study of a woman with chronic arthritis who must spend more than \$12,000 a year on medical care and insurance premium. Her cost not covered by insurance or her employer's contribution to premium each year amounted to \$1,700. With a High Deductible Health Plan and an HSA, her net out-of-pocket cost was reduced to \$800. Hopper indicated that she could save more by shopping for value, using generics, avoiding unnecessary tests, and taking better care of herself. (Hopper, 2006. p. 68)

Middle income and low-income Americans, likewise, benefit from these plans. The advantages of an HSA are, however, enhanced if an employer participates in funding it. A large number of employers willingly make these deposits, and they do so out of the premium savings they enjoy from purchasing high deductible health plans. The same motivations entailed in providing a health benefit (recruitment, retention, morale, better health, and fewer sick days) are in play for an employer by making contributions to employees' HSAs.

Faith and Health Care Reform

Changing the attitudes and habits required to positively affect personal health and finances requires strong motivation. For many, that motivation is too often created by an immediate physical crisis that results in the need for intense medical care and immediate lifestyle changes. For Christians, the motivation for how one ought to live should be the result of walking in the Spirit and the Light, and this sort of motivation ought to result in a reduced incidence of a physical crisis (this is not to say that Christians strong in their faith will never become ill, or need health care, but it does speak to how they interact with the health care system).

The overall delivery and financing of modern health care in the United States generally follows a secular construct. This construct focuses on doing everything possible to alleviate pain and suffering and extend human life, but at the expense of others. That the U.S. should look to a secular solution is understandable, given that there does not seem to be a ubiquitous, national comprehensive Biblical construct that relates to modern health care. Society has turned to secular providers for delivery of health services, to governments as the primary payers of care for 92 million people, and moreover, to governments as the ultimate provider of care, if all else fails.

Lacking from the public and political discourse about health care reform has been a concise, cogent, and Bible-based apologetic dealing with the responsibility of individual Christians as it regards their own health and that of others. The health reform debate has not considered how Christian faith ought to inform believers to be stewards of their bodies (the temple of God), of their finances, and serve their communities.

A faith-based discussion would be as complex and all encompassing as is the broad, general discussion about health care reform considered above. A discussion of faith and the delivery of health care could result in a powerful movement toward personal, community, and church responsibility to care for others and away from dependence on government programs. Adding an evangelical aspect to the practice of faith in the delivery of and payment for health care could serve to advance the Gospel to those who may be tender toward its message of hope and delivery.

Examples of the powerful effects of Christian compassion for those who are sick and distressed still resonate throughout America. These are most often small, local clinics, where a nexus of individuals who are driven by faith come together to meet the needs of those who are most unable to care for themselves. Moreover, these institutions are motivated by a purpose far greater than treating and healing physical ailments; they are pointed specifically to ministration of the Gospel of Jesus Christ, to bring eternal healing to sin-sick souls. A comprehensive health redesign strategy would turn to these institutions as a central point of contact to reach the chronically uninsured population and low-income residents.

Saint Paul, Minnesota, like many other cities, houses a Union Gospel Mission. For nearly 100 years, the St. Paul mission has provided shelter, food, safety, and presented the Gospel to thousands of men, women, and children. The St. Paul mission building features a fully equipped medical and dental clinic, staffed by volunteer doctors and nurses, who touch people that would never be seen in their professional practice facilities. When these individuals require more care than is available at the mission facility, they can be referred to Community Health Centers, or to hospitals that are specifically designed to serve their needs.

First Baptist Church, Leesburg, Florida, invested in the Leesburg community, rather than expanding or improving its impressive church edifice. The church created a ministry village on its property that provides care for unwed mothers, alcoholics and drug abusers, battered spouses, homeless families, and others in distress. In recent years, the church added a Community Health Center to its ministry mix. These ministries are housed in buildings on the church property. God has used this ministration to those in distress to bring His Gospel to many, who see their temporal and eternal lives transformed. Truly, "Christ was a holistic healer." (Schmidt, A., 2004, p. 152). So, too, ought we to follow in His footsteps.

The Swedish Covenant Benevolent Society has built senior housing complexes all across the country. Their effort goes far beyond providing a nice home, good food, fellowship, and field trips. The institutions are supported by a comprehensive approach to ministry to residents, from time of entry, through assisted living, and to their last days of life in an skilled care facility.

The history of institutional health care finds its roots in the transformational power of the Christian faith. Jesus Christ came to bring life, but not life as usual; transformed life.

The [individual] lives that He transformed in turn changed and transformed much of the world: its morals, ethics, health care, education, economics, science, law, the fine arts, and government. These changes, though often not recognized...are still largely operative in the West, continuing to produce many positive effects that are also present in some non-Western areas of the world. (Schmidt, 2004, p. 16)

Dionysius wrote of the unselfish nature of Christians in A.D. 250, as they cared for the needs of those who were dying from the Alexandrian plague. Emperor Julian lamented the attitude of Romans, who fled from the sick and dying, as he contrasted their actions with those of Christians, "who believed they were not only serving the sick, but serving God." (Schmidt, 2004, p. 153)

There is scant proof of medical facilities of any kind in pagan societies that were available to the general population prior to the concerted effort of Christians to create them. Health care institutions that preceded these were established only to provide care for soldiers. "Charity hospitals for the poor and indigent public did not exist until Christianity introduced them...if the Greco-Romans had some kind of hospitals that preceded Christian hospitals, none of them ever became institutionalized." (Schmidt, 2004, p. 155)

The Council of Nicaea ordered that wherever a cathedral existed, a hospice should be established. Hospices cared for the sick, provided shelter for the poor, and a place to live for Christian sojourners. St. Basil directed the building of the first hospital in Caesarea in Cappadocia around A.D. 369. Another soon followed in Edessa. Fabiola, "a wealthy widow and an associate of St. Jerome, [spent her own money and] built the first hospital in the west...in the city of Rome in about 390 A.D." (Schmidt, 2004, p. 156) Working with others, Fabiola founded another hospital in Ostia. St. Chrysostom ordered the building of hospitals in Constantinople during the fourth and fifth centuries, and St. Augustine oversaw the building of hospitals in the west.

It is important to note – and the evidence is quite decisive – that these Christian hospitals were the world's first voluntary charitable institutions...And it is these Christian hospitals that revolutionized the treatment of the poor, the sick, and the dying. (Schmidt, 2004, p. 155-157)

The practice of Christians building hospitals to care for the general public continued to grow, spreading from the European Continent to England. "And by the mid-1500s there were 37,000 Benedictine monasteries that cared for the sick." (Schmidt, 2004, p. 157)

Muslims copied this Christian charitable movement during the Eighth Century, as they began building hospitals in their countries. During the Crusades, even while Christians committed atrocities, "Crusaders also founded health care orders, providing health care to all, Christians and Muslims alike." (Schmidt, 2004, p. 158)

In the New World, Cortes founded Jesus of Nazareth Hospital in Mexico City in 1524, and it is presently still in operation. "And by 1583 every principal town in the archdiocese of Mexico had a hospital, each with a priest who cared for the souls of the patients." (Schmidt, 2004, p. 159)

The early American colonies, however, had few hospitals. During 1801, there may have been only two in the United States and its territories. Yet, as settlers spread across the continent, they built hospitals and clinics, as they had in other countries. These institutions bore names that reflected their denominational foundation: Lutheran, Baptist, Presbyterian, Catholic. Others bore the name of Saints: St. Johns, St. Mary's, St. Joseph's, and so forth. "The Christian identity and background of many American hospitals is now being erased, however. In recent years, as health maintenance organizations

(HMOs) have been purchasing more and more private Christian hospitals, their Christian names are being replaced.” (Schmidt, 2004, p. 160)

Nursing emerged and grew as a result of Christian compassion. “...[W]idows, deaconesses, and virgins commonly served as nurses in the Christian hospitals.” Monks and nuns provided care and became known as “infirmarians.” The Crusaders recruited women to serve as nurses, and in the Thirteenth Century, “the order of Augustinian Nuns arose. This group is the oldest nursing order of sisters,” (Schmidt, 2004, p. 163)

Florence Nightingale traveled to Kaiserswerth, Germany, to learn from Pastor Theodor Fliedner. Fliedner had begun his health care charity work by caring for an ailing prisoner, and later, built a hospital, recruiting peasant girls to serve as nurses. Nightingale, driven by faith and compassion, became the symbol of Christian charity in action, and inspired the creation of a new profession – the nurse. (Schmidt, 2004, p. 164)

The early days of charity had its roots in the teachings of Jesus Christ. Early Christians practiced charity in their homes as individuals cared for each other, and in their communities, as they built community care centers. Modern Americans, with passive or active ascent by Christians, moved toward secularization of its health care facilities during the last three decades of the 1900s. Non-profit and for-profit corporations purchased institutions that had been faith-affiliated. There is a danger in the secularization of health facilities that had previously been faith-based: The United States’ courts have demanded the separation of overt demonstrations of faith from civil governance. This contributed to the willingness of citizens to turn to government institutions to resolve their weightiest problems, and in particular, health care. The willingness to expect secular and government institutions to provide financial relief while delivering the world’s best health care leaves Christians at risk of forgetting Who is the source of life.

Two things I request of You (deprive me not before I die): Remove falsehood and lies far from me; give me neither poverty nor riches – feed me with the food allotted to me; lest I be full and deny You, and say, “Who is the lord?” Or lest I be poor and steal, and profane the name of my God. (Proverbs 30:7-9)

As government becomes a primary provider of life’s essentials, it may make recognizing God’s hand of provision more difficult. As a result, people may suffer needlessly, but more importantly, lose the chance to experience the Gospel in the actions of others, and discover God’s power to transform lives. Instead, they may come to see government as the primary institution responsible for their care and keeping.

In Germany, during the 1960s and 1970s, the government shut down charitable-based health care in an attempt to better control the supply of care and its cost. (Dattilo & Racer, 2006, p. 251) As governments increase their influence in the provision of health care, they strive to systematize the services. When nonconforming entities, such as faith-based or charitable institutions, provide those services, governments have a hard time accomplishing their own mission. It seems inevitable that if the United States turns more of its health care system funding and management over to government, it will also move further away from Christian charitable care. In its 1947 landmark First Amendment ruling, the United States Supreme Court indicated that Congress could make no law encouraging religion. (*Everson*, 1947) Subsequent courts have used *Everson* as a precedent to establish the modern court’s construction of the theory of separation of church and state, and to forbid the use of public funding for any institution that establishes or encourages religious faith. *Everson* and the cases that have followed could easily be applied to faith-based health care facilities, especially if they receive government funds.

It is the author’s intention in the next few years to evaluate how Christian faith relates to the way individuals interact with personal and community health care. The results of this study will form a unique and potentially useful and effective doctoral dissertation. This immediate thesis lays a foundation for that future study, which will attempt to answer these questions:

- (a) What does the Bible teach about personal health?

- (b) What does the Bible teach about financial stewardship?
- (c) What does the Bible teach about responsibility to family members, to neighborhoods, and to government?
- (d) How ought a Christian (or in a corporate sense, a group of Christians) best provide care for those who are closest – parents and other aging people, children with disabilities and chronic illness, and church or community families under stress from health-related problems?
- (e) What responsibility do Christians, acting in concert, have toward providing health care for the general population?
- (f) As a Christian evaluates the health care system, what kind of services and results ought he or she expect?
- (g) How does health insurance fit into the life of a Christian, and what should a Christian expect it to provide?
- (h) The ultimate question deals with the greatest expectations a Christian should place on a health care system. In modern societies, residents expect health care providers to reduce individual pain and suffering, and prolong life for as long as is possible, but do it at the expense of others. How does this view relate to what the Bible teaches about temporal and eternal life?
- (i) How do Christians' attitudes and actions positively or negatively affect the challenges of the health care system, both today and in the future?
- (j) What attitudes do Christians need to change, and what actions ought Christians to have regarding the United States' health care system?
- (k) How can the answers to these questions be interwoven into a strategy for effecting change in the way that Christians approach and bring change to the United States' health care system that results in the reduction of pain and suffering, extending life (as understood in a Biblical context), maximizing financial resources, and advancing the Gospel of Jesus Christ?

The monumental task of studying, analyzing, and writing about how faith interacts with the health care delivery and finance system must, by its nature, touch every aspect of human life. "And these words which I command you today shall be in your heart. You shall teach them diligently to your children, and shall talk of them when you sit in your house, when you walk by the way, when you lie down, and when you rise up." (Deuteronomy 6:6-7) For the Christian life is a "24/7" construct, in that every moment, awake or asleep, relates to faith in Christ and trust in God for life itself. Studying, writing, teaching, commenting, and building institutions to support Christian faith in proper interaction with the delivery and payment of health care as a lifetime passion that produces results would be world changing.

Chapter V

CONCLUSION

The United States' health care delivery and payment systems need reform; about this there is broad consensus. The loudest voices for reform point most often to a "crisis" in quality, access, cost, and the number of people who go without health insurance. Because these concerns are the most accepted, they also receive the most attention by reformers. Based on an effort to assuage these concerns, reformers from a broad range of worldviews and diverse economic and political leanings have recommended reforms that range from turning the entire system over to the federal government, to sending the government to the sidelines while employing a *laissez faire* approach to providing and paying for care.

Especially since 1965, when Congress created Medicare and Medicaid, health care has become a premiere political issue. A political solution is always driven by reelection politics, and as such, seldom lends itself to realistic and long-term solutions. In the United States, where the concept of separation of church and state has also been politicized, politicians often ignore the role that personal and corporate faith can and should play in reducing the stress on the health care system. The secularization of United States' health care could not have happened without politicizing the system, and the politicalization of the system will make it more difficult for Biblically based reforms to take effect.

Analyses of the problems facing health reform ignore key elements that directly and indirectly affect the system, and these elements are critical to understanding the difficulty and complexity of effective reforms. The size of the United States' population, its wealth, and the acquired health and financial behaviors of its people, must be factored in to any successful reformation.

Forty-seven percent of United States' adults attend Christian churches each weekend, and 101 million Americans are self-described "born again Christians" (Barna, 2008) Barna adds:

Notional Christians represent 39% of the population where notional Christians are those who describe themselves as Christians, but do not believe that they will have eternal life because of their reliance upon the death and resurrection of Jesus Christ and the grace extended to people through a relationship with Christ. (Barna, 2008)

Schmidt describes how Christianity changed the way health services were delivered across the world, and in the New World. (2004) How the United States used to provide health care is evidenced by the many Christian names attached to hospitals and clinics. Modern Christians, however, seem not to recognize the relationship of their faith to the provision of health care and have adopted the secular system as normative, outside the reach of active faith. Reversing this belief, and turning it toward active faith, could be among the most significant reforms to bring positive change to health care. The motivation for Christian action can be found in the words of Jesus Christ as He described the end time's judgment:

...for I was hungry and you gave Me food; I was thirsty and you gave Me drink; I was a stranger and you took Me in; I was naked and you clothed Me; I was sick and you visited Me; I was in prison and you came to Me... (Matthew 25:35-26)

A successful health reform strategy must be honest. If it relies on institutions to manage and control care, it will fail, and result in the dual evils of increased cost and reduced services. An honest approach requires that individuals take more responsibility for their own health and their own money, and act on their Christian duty to care for others through Christian charity. Taking personal responsibility means changing negative behaviors to new, positive behaviors. Changing behavior requires strong motivation.

Money is a motivator toward choosing financially appropriate health care. When a health care consumer sees a direct relationship between having money in an HSA and spending money more carefully, the HSA owner decides his or her purchases based partially on cost. Over time, it is likely that the combined efforts of millions of HSA owners will serve to stabilize or reduce the combined cost of care.

HSA Bank found:

Of all respondents considered for treatment, 33.8% chose to take a lower cost option, as compared to 33.4% of respondents who chose the more expensive option, when given a choice. 32.8% [sic] report no treatment or no option recommended. Of all respondents who were considered for treatment and also have an HDHP, 69.6% chose a lower cost alternative compared to just 61.2% of respondents with any other type of health plan. (HSA Bank, 2008)

Better personal health provides multiple positive results, including the reduced cost of care. (CDC, 2008) As individuals choose how to spend more of their own money for health care, they learn that losing weight, exercising, and quitting or curtailing destructive behaviors, not only improves health, but also reduces their cost. Therefore, they get to save more of their own money.

No motivation is as powerful as an honest commitment to follow Jesus Christ. "Your attitude should be the same as that of Christ Jesus..." (Philippians 2:5) He shows us the supreme value of individual commitment, service, and sacrifice. "...I have come that they may have life, and that they may have it more abundantly." (John10:10b) He is the source of the abundant life. "For the grace of God that brings salvation has appeared to all men, teaching us that, denying ungodliness and worldly lusts, we should live soberly, righteously, and godly in the present age..." (Titus 2:11-12) The abundant life results in what Paul calls sober living. This portends a healthier life for a longer period time, a life in which the Christian acts to relieve the suffering of others through the voluntary use of time and personal financial resources.

"So let each one give as he purposes in his heart, not grudgingly or of necessity; for God loves a cheerful giver." (2 Corinthians 9:7) In God's economy, we meet the needs of others from our abundance. If Christians do not take control of their own health care concerns, and leave the provision of health care to others, their abundance will be used to pay for that care, through higher insurance premiums, more government programs and taxes to support them, and eventually, health care that is rationed by a statutorily godless system.

Motivation driven by Christian faith can overcome negative behaviors, create positive behaviors, and move individuals to provide health care solutions for themselves, their families, and their communities. Of greater importance, however, is fulfilling the Great Commission to go into the entire world and preach the Gospel. "But you shall receive power when the Holy Spirit has come upon you; and you shall be witnesses to Me in Jerusalem, and in all Judea and Samaria, and to the end of the earth." (Acts 1:8)

And Jesus came and spoke to them, saying, "All authority has been given to Me in heaven and on earth. Go therefore and make disciples of all the nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, teaching them to observe all things that I have commanded you; and lo, I am with you always, even to the end of the age." Amen. (Matthew 28:18-20)

By shirking their duty to manage personal health care and finances, and by leaving the care of others to secular institutions, Christians lose their money, health, and rob themselves of enjoying the abundant life.

A test of the strength of Christian faith would include trusting God with the decision about when life should end. The Psalmist wrote, "The days of our lives are seventy years; And if by reason of strength they are eighty years, Yet their boast is only labor and sorrow; For it is soon cut off, and we fly away." (Psalm 90:10) "Remember how short my time is; For what futility have You created all the children of men?" (Psalm 89:47) In the modern, expensive health care era, this might be the most difficult of all issues to address. When have we lived long enough, and when it is time to return to dust?

A Biblically based apologetic on the Christian and his or her relationship to the health care system is an urgent issue, requiring immediate, thorough study. That is my intention.

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ENDNOTES

¹ In the writing of *To Change the Heart of Man*, Racer interviewed Dr. Kletschka during a period of time that spanned 10 months, from November 2000 to August 2001. As an essential part of the research support for the book, Racer read more than 7,000 pages of letters, reports, legal documents, news articles, books, and viewed hundreds of historical photos. Dr. Kletschka freely discussed a wide range of issues related to his views about health care, to life, and to politics. As a widely read medical innovator, published academic, and with nearly 52 years in medical practice, Dr. Kletschka's views were informed by rigorous study and practical experience.

² The United States Census Bureau reported the total United States' population as of January 2009 to equal approximately 305 million people. Subtracting 45.7 million, the number of uninsured people, from 305 million, the total number of residents, indicates that 258 million residents are covered under a health plan, either government or non-government in nature.

³ Merz, M. (July 13, 2008). Mr. Merz is the President of PreferredOne, Golden Valley, MN, a regional health insurance company. Merz responded to my direct question about the cost of providing care for a premature birth, and for the follow-on cost of care. As an insurance provider, PreferredOne constantly reviews and updates its data concerning cost of providing all kinds of covered health care procedures.

⁴ Reid, S. (July 17, 2008). Mr. Reid is a Regional Sales Manager for Medica Insurance, Golden Valley, MN, a regional health insurance company. Reid responded to my direct question about the cost of providing care for a premature birth, and for the follow-on cost of care. As an insurance provider, Medica constantly reviews and updates its data concerning cost of providing all kinds of covered health care procedures.

⁵ The author has traveled extensively to speak about the origins and effects of health care reform on the insurance industry. These travels began in October of 2006, and have continued since. The author has spoken in 22 different states, to more than 5,000 professional health insurance agents during this time. It is the author's practice to discuss the local characteristics of and obstacles faced in each market he visits. It has been during these discussions that specifics concerning deductibles, co-pays, co-insurance, unusual problems and hurdles, and other affects of health reform on local health insurance markets have surfaced. It is from these informal discussions that the author makes this report.

⁶ Richard L. Reece, MD, is a retired pathologist, who has written about health care reform for more than 45 years. He served as editor of *The Minnesota Medical Journal* during the 1960s and 1970s, publisher of the *REECE REPORT*, Editor of the *Oklahoma Medical News*, and has authored seven books about health care reform. Reece continues to write a daily blog at <http://medinnovationblog.blogspot.com/>. The author and Reece speak by email and telephone at least 10 times a month, discussing Reece's observations and study of the health reform debate. Comments recorded here were gathered from these discussions.

⁷ See note 5.

⁸ Since 1978, the author has been engaged in political research, strategy, commentary, candidacy, and management of political campaigns. This political engagement has included his own candidacy, as a gubernatorial and national presidential campaign manager, a columnist, paid political consultant, and a radio talk show host. To fulfill his responsibilities, and to advance the causes for which he worked, the author has had firsthand observation of nuances of politics, made more manifest during the 1996 Presidential Campaign staff forum held at the Kennedy School of Government, Harvard University, Boston, MA, during December 1996. During these experiences the author has come to understand the inner workings of political strategies and how tactics are applied to secure money and win votes. It is from these combined experiences that he draws conclusions concerning the effects of politics on the health care debate.

⁹ Health care reform is a moving target in that at any given time, legislation is being introduced in Congress, and each of the 50 states. These potential new laws, should they survive the legislative

process, each have the potential to change the way health care is delivered and how its costs are paid. A prime example is the inclusion of Health Care Homes as a concept of delivering health care. This concept passed the Minnesota legislature in 2008, and the governor signed it into law. See Minnesota Statutes 62U, 2008. The Health Care Home concept has, since then, been introduced in a number of state legislatures as well as the federal Congress.

¹⁰ See note 5.