

*Special Commentary*

**Health Care: A Governmental Duty**

**John Croley, JD, LLM**

## I. Introduction

A. Healthcare as a Governmental Duty. For years, healthcare in the United States has been debated as a basic right supported by the social arguments of need and justice, but with little agreement.<sup>1</sup> However, in the opinion of this writer, when a fundamental service such as healthcare is no longer readily accessible by a large segment of the general population it will become a prime duty of government to provide that service. Examples of other recognized prime duties include those powers specifically granted to the Federal government under the Constitution, Article I, Section 8, such as the power to declare war, raise and support armies, regulate interstate commerce and provide postal services and roads. Healthcare has become one of the most needed, least understood, complex, opaque, and expensive services that an individual citizen faces. One might liken today's healthcare to a world of unregulated interstate commerce where tariffs are levied on goods crossing each border and where each state regulates the health insurance within its borders, thus limiting the size of risk pools and increasing the costs of insurance<sup>2</sup> just as was provided by the McCarran-Ferguson Act (1945)<sup>3</sup>.

B. Converging Dynamics over Time. The evolution of healthcare and who bears the financial burden have moved in concert over time.<sup>4</sup> Traditionally, healthcare was rendered by individual providers in the patient's home<sup>5</sup>. Patients shouldered the financial responsibility for their healthcare services, negotiating payment arrangements (money or barter) with care providers.<sup>6</sup> Patients with no financial means were left to provide their own healthcare.<sup>7</sup> As societies grew, religious orders developed hospitals as part of their charitable missions, thereby assuming both clinical and financial responsibility for the care provided.<sup>8</sup> These communal hospital services provided care for individuals requiring the same types of treatment in confined areas. However, many of these services were as much about protecting the healthy, as curing the ill<sup>9</sup>. Over time medical practices became more sophisticated and complex, with more healthcare services being

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<sup>1</sup> ProCon.org, Background of the Issue, (Aug. 6, 2016)

<https://healthcare.procon.org/view.resource.php?resourceID=006590>

<sup>2</sup> Richard Cauchi, "Allowing Purchases of Out-of-State Health Insurance, NCSL Health Program (June 1, 2018)

<http://www.ncsl.org/research/health/out-of-state-health-insurance-purchases.aspx>

<sup>3</sup> 15 U.S.C. § 6701. <https://www.law.cornell.edu/uscode/text/15/6701>

<sup>4</sup> Kimberly Amadeo, "The Rising Cost of Healthcare by Year and Its Causes," The Balance (updated May 5, 2018)

<https://www.thebalance.com/causes-of-rising-healthcare-costs-4064878> , Noam N. Levey Noam N. Levey,

"Healthcare costs rise again, and the burden continues to shift to workers," Los Angeles Times (Sept. 22, 2015)

<http://www.latimes.com/nation/la-na-healthcare-costs-20150922-story.html> , Noam N. Levey Noam N. Levey,

"Healthcare costs rise again, and the burden continues to shift to workers," Los Angeles Times (Sept. 22, 2015)

<http://www.latimes.com/nation/la-na-healthcare-costs-20150922-story.html>

<sup>5</sup> Melissa Thomasson, "Health Insurance in the United States." EH.Net Encyclopedia, edited by Robert Whaples.

Apr. 17, 2003. URL <http://eh.net/encyclopedia/health-insurance-in-the-united-states/>

<sup>6</sup> The History of Family Medicine and Its Impact on U.S. Healthcare Delivery, a symposium paper presented by

Cecilia Gutierrez, MD and Peter Scheid, MD, at 4

[https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-](https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-are/cfhm/FMImpactGutierrezScheid.pdf)

[are/cfhm/FMImpactGutierrezScheid.pdf](https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-are/cfhm/FMImpactGutierrezScheid.pdf)

<sup>7</sup> Stan Leibowitz, "Cato Institute Policy Analysis No. 211: Why Healthcare Costs too Much," (June 23, 1994), at 5

<https://object.cato.org/sites/cato.org/files/pubs/pdf/pa211.pdf>

<sup>8</sup> G.C. Gosling, "Payment and Philanthropy in British Healthcare, 1918–48," Manchester University Press (2017)

<https://www.ncbi.nlm.nih.gov/books/NBK441620/>

<sup>9</sup> Barbara Mann Wall, "History of Hospitals," Nursing, History, and Healthcare University of Pennsylvania School of Nursing <https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-hospitals/>

provided in a hospital setting in lieu of the patient's or provider's home.<sup>10</sup> Hospitals also became teaching institutions for providing medical education to physicians.<sup>11</sup> This was the first step in the "professionalization of healthcare practices"<sup>12</sup> and delivery of care by a continuum of providers made up of individual specialists, specialty hospitals and other specialty service providers<sup>13</sup>. As healthcare services continued to evolve, they spawned multitudes of sophisticated health services and technologies, provided by specialists,<sup>14</sup> all with rising costs;<sup>15</sup> ultimately becoming the sophisticated, complex, profit-driven business that has evolved into the business of healthcare.<sup>16</sup>

Concurrent with the growth of healthcare services, the individual's financial responsibility for such services has given way to collective risk sharing in the form of health insurance. However, with collective risk sharing becoming unavailable to ever increasing numbers of people due to either the high cost of insurance or stringent insurance underwriting criteria, the financial burden has and should, in this writer's opinion, become the government's responsibility. Performance of this duty may be accomplished either by amendment to the Constitution or broader judicial interpretations of the Constitution as was demonstrated by the Supreme Court in *Helvering v. Davis*.<sup>17</sup> In particular, the Supreme Court found the benefits created by the Social Security Act were within the power of Congress and were not limited by the Tenth Amendment's reservation of powers to the states. The Court concluded that "Congress may (levy taxes) and spend money in aid of the 'general welfare'" of the people, citing the U.S. Constitution, Art. I, section 8, *United States v. Butler*<sup>18</sup> and *Steward Machine Co. v. Davis*.<sup>19</sup> The Court further stated that the concept of the general welfare is not static and the "needs that were narrow or parochial a century ago may be interwoven in our day with the wellbeing of the Nation. What is critical or urgent changes with the times."<sup>20</sup> Additionally, the Court noted that Congress has wide range of discretion to spend in aid of the general welfare, subject only to it being "clearly wrong, a display of arbitrary power, not an exercise of judgement."<sup>21</sup> More recently in 1965, Congress exercised its taxing and spending

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<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> Connie Evashwick and William Aaronson, "The Continuum of Care Today," Health Progress Journal of the Catholic Health Association of the United States (Sept.-Oct. 2006) <https://www.chausa.org/publications/health-progress/article/september-october-2006/the-continuum-of-care-today>

<sup>14</sup> George Weisz, "The Emergence of Medical Specialization in the Nineteenth Century," Bull. Hist. Med., (2003) 77:536-575. <https://www.mcgill.ca/ssom/files/ssom/MedicalSpecialization.pdf>

<sup>15</sup> Peter B. Bach, "Medicare Start the Bidding," The New York Times (June 3, 2009).

[https://www.nytimes.com/2009/06/04/opinion/04bach.html?\\_r=2&partner=rss&emc=rss&pagewanted=all](https://www.nytimes.com/2009/06/04/opinion/04bach.html?_r=2&partner=rss&emc=rss&pagewanted=all)

<sup>16</sup> Daniel Callahan, "Healthcare Costs and Medical Technology," in From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns, ed. Mary Crowley (Garrison, NY: The Hastings Center, 2008), 79-82.

<https://www.thehastingscenter.org/briefingbook/health-care-costs-and-medical-technology/>

<sup>17</sup> *Helvering v. Davis*, 301 U.S. 619, (1937).

<sup>18</sup> *United States v. Butler*, 301 U.S. 619.

<sup>19</sup> *Steward Machine Co. v. Davis*, 301 U.S. 548.

<sup>20</sup> *Helvering*, 301 U.S. at 641.

<sup>21</sup> *Helvering*, 301 U.S. at 619.

discretion as part of the Social Security Act<sup>22</sup> to fund a fragment of healthcare with Medicare<sup>23</sup> being a prepaid entitlement for certain beneficiaries and Medicaid<sup>24</sup> a grant for others.

Even with government intervention, the costs of healthcare continue to rise at uncontrollable rates,<sup>25</sup> which has been exacerbated by certain portions of the Patient Protection and Affordable Care Act (ACA).<sup>26</sup> Two ACA directives that openly affect the increase in insurance premiums are the (1) minimum Medical Loss Ratio and (2) the required adjusted community premium rating method to determine premiums<sup>27</sup>. The Medical Loss Ratio is the legislated minimum percentage of health insurance premiums (income) that must be paid out by an insurance company for healthcare expenses, thereby restricting the maximum administrative costs and profit.<sup>28</sup> Community rating is a method of establishing health insurance premiums based on risk pools that should normally include low risk younger people together with high risk older people resulting in disproportionately higher premiums for the younger healthier participants and lower premiums for the high risk older members.<sup>29</sup> As younger low risk participants elect not to buy insurance due to the high cost,<sup>30</sup> the remaining health insurance premiums are insufficient to sustain the program as the available insureds are predominately high risk, high users of healthcare services which will cause commercial private insurance to falter.<sup>31</sup> In this writer's opinion, the only vehicle capable of sharing these risks across the country is a national health insurance plan, funded by a viable tax base that spreads the risks.<sup>32</sup> To maintain the status quo will merely delay the inevitable, accomplished through inefficient and costly piecemeal legislation<sup>33</sup>.

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<sup>22</sup> Thomasson, Melissa. "Health Insurance in the United States." EH.Net Encyclopedia, edited by Robert Whaples. April 17, 2003. URL <http://eh.net/encyclopedia/health-insurance-in-the-united-states/>

<sup>23</sup> Social Security Act, Volume II, Title 18, codified at 42 U.S.C. §§1395-1395cc.

<sup>24</sup> Social Security Act, Volume I, Title 19, codified at 42 U.S.C. §§1396-1396v.

<sup>25</sup> Anna Biemat, "Healthcare costs unsustainable in advanced economies without reform," Organization for Economic Co-operation and Development (Sept. 24, 2015) <http://www.oecd.org/health/healthcarecostsunsustainableinadvancedeconomieswithoutreform.htm>, David Grasso, "Cost of Care: Healthcare Costs Rising To Unsustainable Levels," The Issues published by GenFKD a project of YoungAmerica.Org (Apr. 7, 2017)

<sup>26</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (42 U.S.C. § 18001 (2010)).

<sup>27</sup> Dan Karr, "Why Obamacare Will Fail," The Huffington Post – The Blog (Updated Nov. 18, 2016) [https://www.huffingtonpost.com/dan-karr/why-obamacare-will-fail\\_b\\_8586192.html](https://www.huffingtonpost.com/dan-karr/why-obamacare-will-fail_b_8586192.html)

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> Susan Adler Channick, "Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market and Culture," 28 Law & Inequality 1 (2010). West Law

<sup>31</sup> "Fundamentals of Insurance: Implications for Health Coverage," Issue Brief American Academy of Actuaries, July 2008 [http://www.actuary.org/pdf/health/coverage\\_ib\\_08.pdf](http://www.actuary.org/pdf/health/coverage_ib_08.pdf)

<sup>32</sup> Gerald Friedman, "Funding HR 676: The Expanded and Improved Medicare for All Act, How we can afford a national single-payer health plan," Physicians for a National Health Program (July 31, 2013) [http://www.pnhp.org/sites/default/files/Funding%20HR%20676\\_Friedman\\_7.31.13.pdf](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13.pdf), Greg Olear, "Five Arguments for Universal Healthcare the Democrats Should be Making," The Weeklings (May 29, 2012) <https://theweeklings.com/golear/2012/05/29/five-arguments-for-universal-health-care-democrats-should-be-making/>.

<sup>33</sup> "Healthcare Reform: Creating a Sustainable Healthcare Market Place," A Report to Business Roundtable by Hewitt Associates (Nov. 2009).

## II. Purposes and Functions of Government

This section will analyze the ultimate source of all governmental power and how that power shapes the basic functions and roles of government. I will demonstrate how the nation's historical founding documents express the purposes of government, in particular healthcare and how governmental functions and roles are subject to change as the needs of the governed change. I will conclude with a historical view of healthcare as a public function.

A. Source of Power and Roles of Government. All modern forms of government share certain fundamental tasks, including preservation of the state's authority, supervision, and resolution of citizen conflicts, regulation of the economy, protection of political, and social rights, as well as the provision of certain goods and services.<sup>34</sup> In performing these vital roles, modern governments including Russia, China and the United States all derive their power from those governed.<sup>35</sup> Unlike ancient and preindustrial autocratic<sup>36</sup> governments that depended on unskilled peasant labor, today's developed and developing nations are dependent on the consent of their skilled and informed citizens.<sup>37</sup> However, the manner of attaining such consent may be by "force, chicane or lack of genuine choice...rather than a desirable...connection" to democracy and freedom.<sup>38</sup>

B. Consent of the Governed Relative to the Duty to Provide. In countries where governmental power is derived through the voluntary consent of the governed, such consent is essential to determine what goods and services will be provided or performed by the government. In the United States the connection between consent of the governed and the governmental duty to provide for the governed has an extensive lineage beginning with the Mayflower Compact<sup>39</sup> that states in part "*We...covenant and combine ourselves together into a civill body politick, and by virtue hereof to enact, constitute, and frame such just and equall laws, ordinances, acts, constitutions and offices, from time to time, as shall be thought most meete and convenient for the general good of the Colonie unto which we promise all due submission and obedience.*"<sup>40</sup>

The same theme carries on in The Declaration of Independence, which declares: "*Governments are instituted among Men, deriving their just powers from the consent of the governed ... it is the Right of the People to ...institute new Government, laying its foundation on such principles and organizing its powers in such form, as to them shall seem most likely to affect*

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<sup>34</sup> D. Alan Heslop, "Political System," Encyclopaedia Britannica, Inc., (March 17, 2017) (accessed July 31, 2018). <https://www.britannica.com/topic/political-system/The-functions-of-government>; Thomas B. Hartmann, "Government." *Grolier Multimedia Encyclopedia*. Grolier Online <http://gme.grolier.com/article?assetid=0123980-0> (July 1, 2014) (accessed July 31, 2018); "Functions of Government," Dallas Learning Solutions – Dallas Community College District (accessed July 31, 2018). <https://dlc.dcccd.edu/usgov1-1/functions-of-government>.

<sup>35</sup> Bernard Crick, "The Elementary Types of Government," *Government and Opposition*, 3 No. 1, 3-20 (Winter 1968).

<sup>36</sup> " 'Autocratic' I take as either the government of an autocrat ('tyrant', 'despot', 'chieftain', 'king' or 'emperor' all being associated words of local and varying shades of meaning) or of an autocracy ('aristocracy', 'oligarchy', 'theocracy', 'bureaucracy', 'military caste', etc.). There is, at this level of generality, no significant difference of behaviour between regimes ruled by a few or by one." *Id.* Pgs. 6-7.

<sup>37</sup> Crick, *supra note 35*, at 7.

<sup>38</sup> Crick, *supra note 35*, at 7.

<sup>39</sup> Mayflower Compact, Nov. 11, 1620. <http://www.ushistory.org/documents/mayflower.htm>

<sup>40</sup> *Id.* emphasis added

*their Safety and Happiness.*"<sup>41</sup> Again in the Articles of Confederation recognition is given that the delegates are acting "by virtue of the power and authority" given to them did ratify and confirm the Articles of Confederation "in the name and in *behalf of our respective constituents.*"<sup>42</sup>

Ultimately, the Preamble to The Constitution of the United States provides that "*We the people* of the United States, *in order to* form a more perfect union, establish justice, insure domestic tranquility, provide for the common defense, *promote the general welfare*<sup>43</sup>, and secure the blessings of liberty *to ourselves and our posterity*, do ordain and establish this Constitution for the United States of America."<sup>44</sup>

Each of the above documents contains a nexus between the grant of power by the people and the government's duty to provide for the needs of the people. In performing these duties the government may rely on the Preamble for shaping its purposes (as discussed below) and the specific powers as granted by the Constitution.<sup>45</sup>

C. Purposes of Government as Ordained by the Preamble. The legal status of the Preamble has been addressed directly only once by the Supreme Court,<sup>46</sup> holding that "the *Preamble indicates the general purpose* for which the people ordained and established the Constitution" and that "[the Preamble] has *never been regarded as the source of any substantive power* conferred on the Government." Consistent with the Preamble not granting substantive powers is *U.S. v. Boyer*<sup>47</sup> quoting from former Supreme Court Associate Justice Joseph Story's "Commentaries on the Constitution of the United States" that the Preamble can *never be used to enlarge the express powers* granted under the Constitution.<sup>48</sup> Although not referred to in the Boyer case, Justice Story also comments "that the preamble of a statute is a key to open the mind of the makers, as to ...the objects, which are to be accomplished..."<sup>49</sup>

Supporting Justice Story's position on the usefulness of the Preamble is the Supreme Court case, *Richfield Oil v. State Board*,<sup>50</sup> citing *Holmes v. Jennison*<sup>51</sup> that "...every word (of the Constitution) must have its due force, and appropriate meaning; for it is evident from the whole all words in the Constitution are meaningful. Every word appears to have been weighed with the

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<sup>41</sup> The Declaration of Independence, July 4, 1776 <http://www.ushistory.org/documents/declaration.htm>

<sup>42</sup> The Articles of Confederation and Perpetual Union – 1777, July 9, 1778  
<http://www.ushistory.org/documents/confederation.htm>

<sup>43</sup> Joseph Story, "Commentaries on the Constitution of the United States," 3 chapter 6 § 457-505 (1833) for a discourse on the advantages of a national government with jurisdiction to promote the general welfare.  
<https://lonang.com/library/reference/story-commentaries-us-constitution/>

<sup>44</sup> The Constitution of the United States, Sept. 17, 1787 <http://www.ushistory.org/documents/constitution.htm>

<sup>45</sup> Amendments to the Constitution of the United States, Dec. 15, 1791. Amendment X

<sup>46</sup> *Jacobson v. Mass.*, 197 U.S. 11 (1905) <https://www.law.cornell.edu/supremecourt/text/197/11>

<sup>47</sup> *United States v. Boyer*, 85 F. 425, 430–31 (W.D. Mo. 1898).

<sup>48</sup> Story, *supra* note 43, § 462 ("The preamble never can be resorted to, to enlarge the powers confided to the general government, or any of its departments. It cannot confer any power *per se*. It can never amount, by implication, to an enlargement of any power expressly given. It can never be the legitimate source of any implied power, when otherwise withdrawn from the constitution. Its true office is to expound the nature and extent and application of the powers actually conferred by the constitution, and not substantively to create them.").

<sup>49</sup> Story, *supra* 43, §459.

<sup>50</sup> *Richfield Oil v. State Board*, 329 U.S. 69 (1946) 77-78. <https://www.law.cornell.edu/supremecourt/text/329/69>

<sup>51</sup> *Holmes v. Jennison*, 39 U.S. 14 Pet. 540, (1840) 570-571. <https://caselaw.findlaw.com/us-supreme-court/39/540.html>



utmost deliberation, and its force and effect to have been fully understood. No word in the instrument therefore can be rejected as superfluous or unmeaning..."

To this writer, the express substantive powers found in the Constitution, Article 1, § 8,<sup>52</sup> including for example, the power to tax<sup>53</sup> for certain purposes<sup>54</sup>, to borrow money, regulate commerce, coin money, establish post offices and post roads, protection of intellectual properties, establish courts, wage war, etc. exhibit a common theme that the government shall provide those goods and services that individual citizens cannot or should not perform individually or in smaller units than the national government.<sup>55</sup> Such reasoning being consistent with and in furtherance of the purposes stated in the Preamble.

D. Provisions for Change Based on the Will of the Governed. The writers and those that ratified the Constitution and its Amendments recognized the need for future substantive change by crafting a process<sup>56</sup> for amending the Constitution upon approval by three fourths of the states. The Constitution also provides for more temporal changes that are subject to periodic modification through laws passed by the Congress. For example, Article 1, § 8, Clause 1 provides "[t]he Congress shall have power to ...provide for ...the general welfare of the United States..." which is supplemented by Clause 8 providing that the Congress shall have power "[t]o make all laws which shall be necessary and proper for carrying into execution the foregoing powers...".<sup>57</sup> These provisions firmly establish means by which the changing will of the governed can be realized, either by Amendment requiring a widely held need for change or to a lesser degree by legislative change. According to Oliver Wendell Holmes, Jr. change will happen "whenever the interest of society, that is, of the predominant power in the community, is thought to demand it."<sup>58</sup> "For Holmes, law and society are always in flux, and courts adjudicate with an eye to law's practical effects."<sup>59</sup>

With change being inevitable,<sup>60</sup> powers that were once thought to be vitally necessary may later be found less significant. For example, the power to establish post offices and post roads was of great importance in 1787 "[t]he benefits of which [could] scarcely be too strongly stated in respect to the public interests, or to private convenience."<sup>61</sup> A national government providing this service enabled the prompt notice of approaching dangers, transmittal of orders, dissemination of its laws, and transfer of money and negotiable paper throughout the Union.<sup>62</sup> As compared to using private post that "moved on with tardy indifference and delay, which made it almost

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<sup>52</sup> The Constitution of the United States, Sept. 17, 1787 <http://www.ushistory.org/documents/constitution.htm>

<sup>53</sup> *United States v. Boyer*, 85 F. 425, 430–31 (W.D. Mo. 1898).

<sup>54</sup> Joseph Story, "Commentaries on the Constitution of the United States," 3 chapter 6 § 905. "In this sense, congress has not an unlimited power of taxation; but it is limited to specific objects, – the payment of the public debts, and providing for the common defense and general welfare."

<sup>55</sup> Story, *supra* 43, §§496-505. §505 stating "Thus we see, that the national government, suitably organized, has more efficient means, and more extensive jurisdiction to promote the general welfare, than can belong to any single state of the confederacy."

<sup>56</sup> U.S. Const. art. V.

<sup>57</sup> U.S. Const. amend IX.

<sup>58</sup> Oliver Wendell Holmes, Jr., "Natural Law," *Harv. L. Rev.*, Vol. 32 (1918).

<sup>59</sup> Bradley C. S. Watson, "Oliver Wendell Holmes, Jr. and the Natural Law," Witherspoon Institute (2011) <http://nlprac.org/critics/oliver-wendell-holmes>

<sup>60</sup> Ecclesiastes 3:1-8, American Standard Version.

<sup>61</sup> Story, *supra* 43, §502.

<sup>62</sup> Story, *supra* 43, §502.

useless."<sup>63</sup> To consider a postal service provided by each state with separate regulations and disparate fees would amount "to a positive prohibition upon any extensive internal intercourse by the mail."<sup>64</sup> Conversely, modern private post services such as Federal Express (FedEx) and United Parcel Service (UPS) compete and partner with the United States Postal Service (USPS).<sup>65</sup> Each service using the same post roads, but catering to different customer needs. Other substantive areas of change from public function to private function include the privatization of roads<sup>66</sup> and use of military contractors to provide defense services,<sup>67</sup> and space exploration.

Space exploration began as a government function under the National Aeronautics and Space Administration (NASA) on October 1, 1958.<sup>68</sup> Today it is has morphed into a public and private partnership as demonstrated by NASA providing astronauts to fly commercial spacecraft made independently by Boeing and SpaceX on International Space Station missions. In other areas, private industry has taken the lead as "[b]oth Boeing and SpaceX are working with Bigelow Aerospace, a Las Vegas company that proposes to launch private space stations into orbit."<sup>69</sup>

As noted in the Introduction to this paper, another example of responsibilities changing between the public and private sectors is the steady migration of healthcare from a private responsibility to a public responsibility. It has long been recognized that providing or paying for healthcare was a public responsibility with regard to certain populations that garner sufficient political consensus (the incarcerated<sup>70</sup>, aged<sup>71</sup>, children<sup>72</sup> and disabled<sup>73</sup>). The successes and failures of prior healthcare reform efforts give indications of the voting consensus needed to make healthcare a public function

E. Historical View of Healthcare as a Public Function. The history of publicly funded healthcare and the forces at play deserve special attention for any reform movement to be successful. This is highlighted by the failure of President Bill Clinton's Health Security Act<sup>74</sup> proposal in 1993 and Mrs. Hillary Clinton's later comments. As the chairperson of the White House Task Force on Health Reform,<sup>75</sup> Mrs. Clinton "acknowledged in 1994 that 'I did not appreciate how sophisticated the opposition would be in conveying messages that were effectively

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<sup>63</sup> Story, *supra* 43, §502.

<sup>64</sup> Story, *supra* 43, §502.

<sup>65</sup> "Frenemies - The Complex Relationship between the Postal Service, FedEx and UPS," The Postal Record, 14-17 (June, 2015). [https://www.nalc.org/news/the-postal-record/2015/june-2015/document/06-2015\\_frenemies.pdf](https://www.nalc.org/news/the-postal-record/2015/june-2015/document/06-2015_frenemies.pdf)

<sup>66</sup> Michael Cooper, "States Consider Privatizing Roads," New York Times (Apr. 1, 2009) <https://thelede.blogs.nytimes.com/2009/04/01/going-down-the-private-road-route/>

<sup>67</sup> List of more than 40 private military contractors. [http://www.privatemilitary.org/security\\_contractors.html](http://www.privatemilitary.org/security_contractors.html)

<sup>68</sup> Steve Garber and Roger Launius, "A Brief History of NASA," NASA Fact Sheet. <https://history.nasa.gov/factsheet.htm>

<sup>69</sup> Karen Zraick, "NASA Names Astronauts' for Boeing and SpaceX Flights to International Space Station," The New York Times, (Aug. 3, 2018). <https://www.nytimes.com/2018/08/03/science/nasa-astronauts-boeing-spacex.html>

<sup>70</sup> *Estelle v. Gamble*, 429 U.S. 97 (1976).

<sup>71</sup> Social Security Act, Volume II, Title 18, codified at 42 U.S.C. §§1395-1395cc.

<sup>72</sup> Title XXI of the Social Security Act, CHIPS (USC §§1397aa-1397mm, subchapter XXI, chapter 7, Title 42).

<sup>73</sup> Social Security Act, Volume II, Title 18, codified at 42 U.S.C. §§1395-1395cc and Social Security Act, Volume I, Title 19, codified at 42 U.S.C. §§1396-1396v.

<sup>74</sup> Health Security Act, S. 1757, 103 Cong. (1993).

<sup>75</sup> "Timeline: History of Health Reform in the U.S.," Kaiser Family Foundation (last viewed Sept. 30, 2018). <https://www.kff.org/health-reform/timeline/history-of-health-reform-efforts-in-the-united-states/>



political even though substantively wrong'. Maybe Hillary should have had this history lesson first."<sup>76</sup>

1. *Early Reform Movements.* Healthcare as a public function has been an agenda item for both major political parties beginning as early as 1854 with the "Land-Grant Bill for the Benefit of the Indigent Insane"<sup>77</sup> proposed by Dorothea Dix the former Union Army Superintendent of Women Nurses during the Civil War and early activist for the indigent mentally ill.<sup>78</sup> The bill was passed by both houses of Congress but vetoed by President Franklin Pierce (Democrat) based on his interpretation of the Constitution. President Pierce deemed that the Bill presented fundamental questions regarding those powers granted by the Constitution to the Federal Government stating:

"It cannot be questioned that if Congress has power to make provision for the indigent insane without the limits of this District it has the power to provide for the indigent who are not insane, and thus to transfer to the Federal Government the charge of all the poor in all the States. It has the same power to provide hospitals and other local establishments for the care and cure of every species of human infirmity, and thus to assume all that duty of either public philanthropy, or public necessity to the dependent, the orphan, the sick, or the needy which is now discharged by the States themselves or by corporate institutions or private endowments existing under the legislation of the States...Whatever considerations dictate sympathy for this particular object apply in like manner, if not the same degree, to idiocy, to physical disease, to extreme destitution. If Congress may and ought to provide for any one of these objects, it may and ought to provide for them all...the question of means and expediency will alone be left for consideration."<sup>79</sup>

President Pierce concluded that "the Federal Union is the creature of the States" and "(t)he powers conferred upon the United States have reference to *federal* relations," which he defined as maintaining harmony between the States, "protecting their common interests and defending their common sovereignty against aggression from abroad or insurrection at home." However, President Pierce's analysis found it necessary to assume unwritten language to Article I, Clause 8 (Congressional power to provide for the general welfare) in order to rebut the inference that such power exists under Article 1 Clause 8 and as further justification for his veto stated that the States would be more efficient administering the healthcare services needed. In conclusion, President Pierce tendered a distinction between prior acts of Congress granting federal lands to Connecticut and Kentucky for the establishment of mental health facilities as being "national objects" as was the current bill granting public lands to all the States for the benefit of indigent insane persons, but "national objects" were not necessarily "Federal" in nature.<sup>80</sup> Right or wrong President Pierce's

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<sup>76</sup> "A Brief History: Universal Healthcare Efforts in the US," Physicians for a National Health Program, Source URL (retrieved on Friday, Sept. 18, 2018): <http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us>

<sup>77</sup> Land-Grant Bill for Indigent Insane Persons, S. 44, 33rd Cong. (1854).

<sup>78</sup> Elizabeth Hanink, "Dorothea Dix (1802-1887), Champion of the Mentally Ill," WorkingNurses.Com, (last viewed Oct. 19, 2018), <https://www.workingnurse.com/articles/Dorothea-Dix-1802-1887-Champion-of-the-Mentally-Ill>

<sup>79</sup> Veto Message (May 3, 1854), <http://www.presidency.ucsb.edu/ws/?pid=67850>

<sup>80</sup> Veto, *supra* note 79, 5.

decision and analysis are significant for two reasons, in this writer's opinion, first his arguments characterize the boundaries of constitutional debate for the next 165 years regarding government provided healthcare, and second his veto emphasizes how vital it is to have the support of the governed. Even with sufficient popular support to pass Congress, there was not enough support to sway the President and certainly not enough for a Constitutional amendment.

Although the use of public land grant funds was deemed inappropriate for mental health in 1854, the same methodology was approved eight years later by President Abraham Lincoln (the first Republican president) who signed the Morrill Act,<sup>81</sup> which created land-grant universities providing "each state the income from 30,000 acres of land for each member of Congress, with the provision that the funds should be used for mechanical and agricultural colleges, with provision for military training."<sup>82</sup> Despite the public sentiment to use public funds as expressed by the Morrill Act and the fact Theodore Roosevelt (Republican) endorsed health insurance as part of his 1912 campaign,<sup>83</sup> the "narrow construction of federal authority in the welfare field as set forth in the Pierce veto remained unchallenged...until the ravages of the Great Depression, producing bankrupt local governments and overburdened voluntary agencies, forced significant modifications of old traditions."<sup>84</sup>

2. *Great Depression Era.* President Franklin D. Roosevelt (Democrat) responding to the Great Depression and its impact on access to healthcare, requested the help<sup>85</sup> of Isidore Falk and Edgar Sydenstricker as members of the Council on Economic Security working on the Social Security Act to also address healthcare. Falk and Sydenstricker included a federal health insurance provision in the Social Security Act but later omitted the provision from the committee's final report to the President, bowing to pressure from the American Medical Association that labeled it "socialized medicine."<sup>86</sup> However in 1933, Roosevelt's Federal Emergency Relief Administration (FERA) formally recognized medical care as a basic human right stating that "conservation and maintenance of the public health is a primary function of our Government."<sup>87</sup> By means of the Federal Emergency Relief Administration and a mandate to fund medical services to indigent patients through existing state and local agencies President Franklin Roosevelt was able to plant a seed that eventually grew into many of America's current publicly funded healthcare programs.<sup>88</sup> Roosevelt's modest successes to provide publicly funded healthcare were not easy as organized

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<sup>81</sup> Land-Grant College Act of 1862, 7 U.S.C 13, §301 et seq.

<sup>82</sup> Seaton W. Manning, "The Tragedy of the Ten-Million-Acre Bill," *Social Service Review*, Vol. 36, No. 1 (Mar., 1962), pp. 44-50. <https://www-jstor-org.flagship.luc.edu/stable/pdf/30016764.pdf?refreqid=excelsior%3A5e280f2578a053d2631a497f150c2791>

<sup>83</sup> "Timeline: History of Health Reform in the U.S." *supra* note 75.

<sup>84</sup> Manning, *supra* note 82.

<sup>85</sup> "History of Healthcare - Americans need Healthcare Coverage," National Center for Biotechnology Institute, (Last viewed 9/30/2018). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3036678/pdf/438.pdf>

<sup>86</sup> Forrest A. Walker, "Americanism versus Sovietism: A Study of the Reaction to the Committee on the Costs of Medical Care," *Bulletin of the History of Medicine*, Vol. 53, No. 4 (Winter 1979), pp. 489-504. <https://www.jstor.org/stable/44450946>

<sup>87</sup> "Federal Emergency Relief Administration Rules and Regulations No. 7," (Washington, D.C.: Government Printing Office, 1933), 1.

<sup>88</sup> Jan Coombs, "The Rise and Fall of HMOs: an American healthcare revolution," Madison: University Press. pp 5-6, (Last viewed Sept. 30, 2018). <https://books.google.com/books?id=tK71nX5LxSEC&pg=PA5#v=onepage&q&f=false>

medicine continued "to oppose nearly every healthcare reform proposal during the next six decades"<sup>89</sup>.

3. *Post-Depression Activities.* While Roosevelt was unable to secure federal health insurance as part of the Social Security legislation in 1935, multiple legislative efforts continued to surface including the 1943 Democratic Wagner-Murray-Dingell bill that provided for compulsory national health insurance to be funded by payroll taxes.<sup>90</sup> This bill engendered serious on-going national debate as it was reintroduced every session of Congress for fourteen years.<sup>91</sup> Others expressed agreement with a national health insurance program as "the Social Security Board called for compulsory national health insurance as part of the Social Security system."<sup>92</sup> However, support rose and fell over the next 20 years being influenced by "ideological differences, anti-communism, anti-socialism, fragmentation of public policy, the (emerging) entrepreneurial character of American medicine, a tradition of American voluntarism, removing the middle class from the coalition of advocates (due to) ... alternative(s) (such as) ... Blue Cross private insurance plans, and the association of public programs with charity, dependence, personal failure and the almshouses of years gone by."<sup>93</sup>

4. *The Great Society.* As employer-based health coverage grew and the health insurance industry matured, health insurance companies began excluding retired and disabled individuals by utilizing experience rating techniques to set premiums, thereby raising the costs for those most needing coverage.<sup>94</sup> This sudden lack of access to healthcare generated a major grass roots movement from seniors that forced the issue of national healthcare, albeit for only a limited segment of the population. With sufficient political capital shared by both parties, negotiations and compromises resulted in President Lyndon Johnson's (Democrat) Great Society Legislation adding Medicare and Medicaid to the Social Security Act in 1965.<sup>95</sup> Passage of this most significant healthcare legislation of the 20<sup>th</sup> century would not have been possible without a strong president pushing for reform, a Congress with a predominate party willing to negotiate, a minority party conceding to the expressed will of the people, support from the insurance industry and major economic concessions being given to hospitals and physicians.<sup>96</sup>

5. *Expansion Efforts and Rising Costs.* Although the Medicare and Medicaid programs were significant steps toward publicly funded healthcare, their fragmented approach with limited coverage reflected a nation still divided on the issue. This is further evidenced during the 1970's by both political parties continuing to make proposals for national health insurance programs driven by inflation and unchecked healthcare costs that raised individual insurance premiums as well as the costs being borne by the Medicare and Medicaid programs. Senator Ted Kennedy (Democrat) proposed a national health insurance program with President Nixon (Republican)

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<sup>89</sup> *Id.*

<sup>90</sup> "Wagner-Murray-Dingell Bill of 1943" (S. 1161, H.R. 2861), 78<sup>th</sup> Congress (1943-1944). <https://www.healthcare-now.org/legislation/wagner-murray-dingell-bill-of-1943/>

<sup>91</sup> "A Brief History: Universal Healthcare Efforts in the US," Physicians for a National Health Program, Source URL (retrieved on Friday, Sept. 18, 2018): <http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us>

<sup>92</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75, p. 5.

<sup>93</sup> "A Brief History: Universal Healthcare Efforts in the US," *supra* note 91, p. 5.

<sup>94</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>95</sup> "A Brief History: Universal Healthcare Efforts in the US," *supra* note 91, p. 6.

<sup>96</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

proposing his own "Comprehensive Health Insurance Plan."<sup>97</sup> Other less sweeping benefit plans were proposed and passed throughout the 1970s extending benefits to specific segments of the population that were deemed to need assistance, such as extending Medicare benefits to persons under age 65 with long-term disabilities,<sup>98</sup> benefits for end-stage renal disease,<sup>99</sup> and providing Supplemental Security Income (SSI)<sup>100</sup> cash assistance to certain elderly and disabled. Ultimately, no comprehensive health plans were passed, instead the government was faced with offsetting rapidly rising healthcare costs by implementing containment initiatives.

With costs continuing to rise<sup>101</sup> through the 1980s, healthcare legislation continued to be limited to (1) expanding coverage under existing programs,<sup>102</sup> (2) recognizing that some hospitals serve a disproportionate share of the Medicaid population and require additional funding,<sup>103</sup> (3) cost containment efforts including the use of Diagnostic Related Groups (DRGs) as a prospective payment system for hospitals<sup>104</sup> and (4) legislation affecting the general public including the Emergency Medical Treatment and Active Labor Act (EMTALA)<sup>105</sup> and the Consolidated Omnibus Budget Reconciliation Act (COBRA)<sup>106</sup>. As costs were rising, access to care was declining. The Census Bureau estimated that 31 million persons were uninsured which was 13% of the population in 1987.<sup>107</sup>

6. *1990s Federalism.* With the 1990s came a new resurgence for a national health system. President Clinton (Democrat) proposed the Health Security Act, a "managed competition" approach that would provide "universal coverage, employer and individual mandates, competition between insurers, (and) ... government regulation to control costs."<sup>108</sup> As President Clinton and others were unable to garner enough support for the sweeping reform efforts,<sup>109</sup> other less lofty but significant Federal legislation was approved. In particular, the Health Insurance Portability and Accountability Act of 1996 (HIPAA)<sup>110</sup> restricted health insurance companies from using pre-existing conditions as a basis for denying coverage and set privacy and security standards for medical records. Continuing during the 1990s Congress sought through bipartisan efforts to expand available healthcare coverage for previously identified and approved groups. Such

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<sup>97</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>98</sup> 42 U.S.C. §1381.

<sup>99</sup> 42 U.S.C. §1395rr.

<sup>100</sup> 42 U.S.C. §1381.

<sup>101</sup> Amadeo, *supra* note 4.

<sup>102</sup> Omnibus Budget Reconciliation Act of 1981 (OBRA 81, P.L. 97-35) – mandates managed care enrollment for certain groups and to cover home and community-based long-term care for those at risk of being institutionalized, Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) – mandates coverage for pregnant women and children under 6.

<sup>103</sup> Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) §9105 amended §1886(d) (5) of the Social Security Act to provide DSH adjustment payments for discharges on or after May 1, 1986.

<sup>104</sup> Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248, enacted Sept. 3, 1982), Social Security Amendments of 1983 (Pub. L. 98-21, enacted April 20, 1983).

<sup>105</sup> 42 U.S.C. §1395dd

<sup>106</sup> 29 U.S.C. §1162

<sup>107</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>108</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>109</sup> The American Health Security Act of 1993 (Wellstone-McDermott-Conyers single-payer bill), S. 491, H.R. 1200 103<sup>rd</sup> Cong. (1993).

<sup>110</sup> 42 U.S.C. §1320d-6, Pub. L. 104-191.

legislation included the Mental Health Parity Act,<sup>111</sup> the State Children's Health Insurance Program (S-CHIP) and the expansion of Medicaid coverage for working disabled with incomes up to 250% of the poverty limit.<sup>112</sup> Even with these focused efforts to expand coverage, the U.S. Census Bureau estimated that the number of uninsured in 1997 had grown to 15.7% of the population or 42.4 million people,<sup>113</sup> an increase of 11 million people in ten years.

As Congress was expanding coverage to those with the most need, it was also faced with the continuous spiraling rise of healthcare costs. In the 1990's healthcare prices rose on an average of 6.4 per cent per year<sup>114</sup> and were consuming 13.3 per cent of the Gross Domestic Product by the year 2000.<sup>115</sup> Congress responded with the Balanced Budget Act of 1997<sup>116</sup> containing provisions designed to curb Medicare and Medicaid spending by freezing Medicare payments for inpatient hospital stays, establishing a prospective payment system for skilled nursing facilities and generally reducing payment increases for all providers. In addition, fraud and abuse were of growing concern particularly in the home health segment which resulted in a moratorium on certifying new home health agencies.<sup>117</sup> The payment reductions of the 1997 Balanced Budget Act along with private insurers narrowing their Health Maintenance Organization (HMOs) provider networks forced many healthcare providers out the business<sup>118</sup> only to exacerbate supply and demand issues. Congress eventually relented on the provider payment restrictions in 1999<sup>119</sup> and 2000.<sup>120</sup> Not only did Congress feel the backlash from trying to contain costs, so did private insurance companies offering HMOs. Being dissatisfied with the new HMOs, people began leaving the narrow networks offer by HMOs in favor of Preferred Provider Organizations (PPOs) allowing more provider choices.<sup>121</sup> Because of mergers and decisions to discontinue HMO products, by the late 1990s the number of major national insurance companies offering HMO plan options dropped from about two dozen to six.<sup>122</sup>

7. *New Century – Same Issues.* The early 2000s saw no major healthcare reform and changes were again limited to expansion of care for those already under a federal healthcare program.<sup>123</sup> However, as part of the Medicare Prescription Drug Improvement and Modernization

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<sup>111</sup> Mental Health Parity Act, (Pub. L. 104-204), H.R. 3666, 104<sup>th</sup> Cong. (1996).

<sup>112</sup> Balanced Budget Act of 1997 (Pub. L. 105-33), H.R. 2015, 105<sup>th</sup> Cong. (1997-1998).

<sup>113</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>114</sup> Amadeo, *supra* note 4, p. 3.

<sup>115</sup> The National Health Expenditure Accounts (NHEA), Table 1 National Health Expenditures; Aggregate and Per Capita Amounts 1960-2015. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

<sup>116</sup> Balanced Budget Act of 1997, Pub. L. 105-33, H.R. 2015, 105<sup>th</sup> Cong. (1997-1998).

<sup>117</sup> Aaron C. Catlin and Cathy A. Cowan, "History of Health Spending in the United States, 1960-2013," Centers for Medicare and Medicaid website: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf>

<sup>118</sup> Amadeo, *supra* note 4, p. 3.

<sup>119</sup> Balanced Budget Refinement Act of 1999, Pub. L. 106-113, H.R. 3426, 106<sup>th</sup> Cong. (1999-2000).

<sup>120</sup> Benefits Improvement and Protection Act of 2000, Pub. L. 106-554, H.R. 5661, 106<sup>th</sup> Cong. (1999-2000).

<sup>121</sup> Amadeo, *supra* note 4, p. 3.

<sup>122</sup> Coombs, *supra* note 88, p. 224.

<sup>123</sup> For example, The Breast and Cervical Cancer Treatment and Prevention Act of 2000 extending Medicaid coverage to uninsured women for treatment of breast or cervical cancer and President George W. Bush's 2002 Health Center Growth Initiative, expanding the number of community health centers.



Act of 2003,<sup>124</sup> signed by President George W. Bush (Republican) there were enhancements to features available through commercial insurance alternatives to traditional Medicare known as Medicare Advantage Plans and the establishment of Health Savings Accounts (HSAs) as a response to the new high deductible plans. As individual health insurance premiums rose, the market sought lower premiums but with higher deductibles, thereby shifting the payment responsibility back to the individual in exchange for more affordable high deductible plans.<sup>125</sup> With high deductible health insurance, the insured is responsible for the first dollars of healthcare costs which may, depending on the amount of deductible, result in the insurance portion only applying to a catastrophic situation.<sup>126</sup> As mentioned above, to help offset a portion of the individual's high deductible costs, Congress provided a tax subsidize for contributions to HSAs.<sup>127</sup>

By 2006 some state and local governments began reacting to the healthcare needs of their citizens. Massachusetts passed legislation providing healthcare coverage to nearly all its residents.<sup>128</sup> One month after Massachusetts, Vermont passed similar comprehensive healthcare reform attempting to provide near-universal coverage as did the City of San Francisco.<sup>129</sup>

With 45.6 million or 15.3% of the population<sup>130</sup> being uninsured and costs continuing to rise,<sup>131</sup> both political parties began to push for national healthcare reform. In 2007 the Healthy Americans Act,<sup>132</sup> a self-financing universal healthcare system, was first introduced as a bipartisan bill co-sponsored by Senators Ron Wyden (Democrat) and Robert Bennett (Republican). The Healthy Americans Act would have eliminated the deduction for employer-provided insurance and shifted those funds to subsidize state health insurance programs from which individuals would be required to purchase private coverage insurance.<sup>133</sup> While the bill did not pass, it was unsuccessfully reintroduced in 2009.<sup>134</sup> In addition to the unsuccessful legislative attempts, President George W. Bush's 2008 budget proposed re-characterizing employer-sponsored insurance contributions from being nontaxable benefits to taxable income with a corresponding deduction of \$7,500.<sup>135</sup> This Executive Branch attempt to address healthcare concerns was also unsuccessful and omitted from the final budget.<sup>136</sup>

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<sup>124</sup> Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. 108-173, H.R. 1, 108<sup>th</sup> Cong. (2003-2004)

<sup>125</sup> "PNHP Fact Sheet: Health Savings Accounts – No Savings," Available website:

<http://www.pnhp.org/facts/hsa.pdf>

<sup>126</sup> Lauren Pollini, "5 Things to Know About High Deductible Health Plans," One Medical, January 29, 2015 blog,

<https://www.onemedical.com/blog/live-well/high-deductible-health-insurance-plans/>

<sup>127</sup> Richard Cauchi, "Health Savings Accounts and the States," National Conference of State Legislatures,

10/10/2017. <http://www.ncsl.org/research/health/hsas-health-savings-accounts.aspx>

<sup>128</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>129</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>130</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>131</sup> The National Health Expenditure Accounts (NHEA), Table 1 National Health Expenditures; Aggregate and Per Capita Amounts 1960-2015. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

<sup>132</sup> Healthy Americans Act, S. 334, 110<sup>th</sup> Congress (2007-2008). <https://www.govtrack.us/congress/bills/110/s334>

<sup>133</sup> William A. Galston, "The Healthy Americans Act is No Laughing Matter," Brookings Institute, Op-Ed April 14, 2009. <https://www.brookings.edu/opinions/the-healthy-americans-act-is-no-laughing-matter/>

<sup>134</sup> Healthy Americans Act, S. 391, 111<sup>th</sup> Congress (2009-2010). <https://www.govtrack.us/congress/bills/111/s391>

<sup>135</sup> Johnathan Gruber, "The Tax Exclusion for Employer-Sponsored Health Insurance," National Tax Journal, 64 (2, Part2), 511-530 (June 2011). <https://economics.mit.edu/files/11418>

<sup>136</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.



The Presidential election of 2008 brought promises from both parties of comprehensive healthcare reforms and with his election, President Barack Obama (Democrat) established the Office of Health Reform to "coordinate administrative efforts on national health reform."<sup>137</sup> With sufficient political capital being held by a Democratic Congress and a Democratic President, the first major healthcare reform since 1965 was passed on March 23, 2010 in the form of the Patient Protection and Affordable Care Act (ACA).<sup>138</sup> And more recently, Senator Bernie Sanders (Independent/Democrat) released a new bill that would require drug companies to lower prices to match prices from foreign countries or lose market exclusivity, very similar to the recently released plan by President Trump (Republican).<sup>139</sup>

Although the ACA extended healthcare coverage for many citizens previously not covered, and retarded the growth rate of healthcare spending,<sup>140</sup> it did not address the underlying national issue of providing a sustainable quality healthcare system for all.<sup>141</sup> Based on this writer's research and observations, our history of addressing national healthcare as a governmental function clearly demonstrates that:

1. Both major political parties recognize healthcare as a national issue.
2. The right to healthcare only exists if the governed wish it so.
3. The levels of public interest and political will increase as healthcare access is restricted, thus demonstrated by previous governmental interventions.
4. The nation's political will is in direct proportion to the number of voters adversely affected.
  - a. Adversely affecting a single class equals a single voting block which will result in temporal changes such as Medicare, Medicaid and the Affordable Care Act.
  - b. Adversely affecting multiple classes will result in sufficient political capital to make more permanent changes by Constitutional amendment, which may well be the next point of history.

F. Social Movement Necessary for Change. As history has shown many may "disagree about what a reformed healthcare system should be they are nearly unanimous in their dissatisfaction with both access to and cost of healthcare."<sup>142</sup> Prior legislation, including the ACA, has made significant steps toward substantive healthcare reform, but a social reform may be necessary to strengthen the political will necessary to produce a comprehensive reform.<sup>143</sup> "Such

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<sup>137</sup> "Timeline: History of Health Reform in the U.S.," *supra* note 75.

<sup>138</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (42 U.S.C. § 18001 (2010)).

<sup>139</sup> Paul Lee, Weekly Report of Strategic Healthcare (November 26, 2018). <https://strategichealthcare.net/resources/>

<sup>140</sup> Amadeo, *supra* note 4.

<sup>141</sup> Robert Scheer and Dr. Paul Song, "Why the Affordable Care Act Hasn't Gone Far Enough," Huffington Post (Apr. 17, 2017). [https://www.huffingtonpost.com/entry/why-the-affordable-care-act-hasnt-gone-far-enough\\_us\\_58f490c3e4b04cae050dc8d0](https://www.huffingtonpost.com/entry/why-the-affordable-care-act-hasnt-gone-far-enough_us_58f490c3e4b04cae050dc8d0)

<sup>142</sup> Carolyn Ann Conti, Duquesne University, McAnulty College and Graduate School of Liberal Arts, American Healthcare: Justice, Policy, Reform (Dec. 2010). <https://search-proquest-com.flagship.luc.edu/dissertations/docview/816337693/fulltextPDF/55B002C5C0E24F6BPQ/1?accountid=12163>

<sup>143</sup> *Id.* 142, Pg. 3.

social reform movement would not replace political effort but would instead both complement and supplement the work of the political legislative process."<sup>144</sup>

Successful social reform movements are bottom-up approaches driven by ordinary people without resources or power in order to address a perceived injustice.<sup>145</sup> "As these movements spread wide, they also percolate up the social ladder to reach the elites, the influential and the authorities" while always demanding action.<sup>146</sup> Each social movement consists of three common elements: (1) a campaign, (2) an assortment of political actions, and (3) a continuing public display of worthiness, unity, numbers and commitment.<sup>147</sup>

### III. Delivery of Healthcare

This portion of the paper focuses on how healthcare services have been delivered in the past and how they have evolved into today's complex healthcare industry, with multiple profit takers along the continuum of care. I will analyze how the complexities of a multi-payer, multi-provider, and fragmented delivery system impedes access to care.

#### A. History of Healthcare Delivery.

1. *Early Medicine.* "Between the years 1750 and 2000, healthcare in the United States evolved from a simple system of home remedies and itinerant doctors with little training to a complex scientific, technological, and bureaucratic system often called the 'medical industrial complex.'"<sup>148</sup> Before 1800 the women of a family were expected to provide all necessary medical care with a doctor being called only in life threatening situations. The care rendered was crude, using home remedies without scientific support and delivered by unlicensed providers charging a negotiated fee for their services.<sup>149</sup> Life expectancies were less than half those of today and the cures were often more deadly than the diseases.<sup>150</sup> Prior to 1846, surgeries were performed quickly and brutally without anesthesia, often ending in death of the patient.<sup>151</sup>

Scientific discoveries pertaining to germs and living conditions as potential causes of communicable diseases resulted in townships establishing publicly supported healthcare facilities that dispensed medicines to the poor and provided free physician services. As public health began to develop, private fee-for-service healthcare also began to emerge.<sup>152</sup> By the "mid-1800s, hospitals, first built by city governments to treat the poor, began treating the not-so-poor"<sup>153</sup> and

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<sup>144</sup> *Id.* 142, Pg. 6.

<sup>145</sup> *Id.* 142, Pg. 225.

<sup>146</sup> *Id.* 142, Pg. 225.

<sup>147</sup> *Id.* 142, Pg. 225, citing Tilly, *Social Movements*, Chapter 1; Sidney Tarrow, *Power in Movement: Social Movements and Contentious Politics*, 1993, Second Edition (Cambridge, MA: Cambridge University Press, 1998), Introduction and Chapter 1.

<sup>148</sup> Fillmore Randolph, "The Evolution of the U.S. Healthcare System," Cengage Learning, Last viewed 10/28/2018, [http://www.sciencescribe.net/articles/The\\_Evolution\\_of\\_the\\_U.S.\\_Healthcare\\_System.pdf/](http://www.sciencescribe.net/articles/The_Evolution_of_the_U.S._Healthcare_System.pdf/) 336-338

<sup>149</sup> *Id.* Pg. 1.

<sup>150</sup> The History and Evolution of Healthcare in America: The Untold Backstory of Where We've Been, Where We Are, and Why Healthcare Needs Reform, By Thomas W. Loker (2012), <https://www.iuniverse.com/>

<sup>151</sup> *Id.* Pg. xxii.

<sup>152</sup> Randolph, *supra* note 148, p. 2.

<sup>153</sup> Randolph, *supra* note 148, p. 2.

providing some patients with private rooms instead of wards.<sup>154</sup> "Following the Civil War (1865), hospitals became either publicly funded facilities or privately financed institutions."<sup>155</sup>

2. *Professionalization.* Individual healthcare providers began to professionalize their services with the founding of the American Medical Association (AMA) in 1846 and with Johns Hopkins University medical school raising their admission standards in 1893 to require all entering medical students to have a four-year undergraduate degree.<sup>156</sup> Nursing also professionalized following the Civil War with the establishment of three nursing schools which later led to advanced nursing degrees that allowed greater freedom in treating patients.<sup>157</sup>

3. *Specialization.* Just as healthcare providers professionalized, they also specialized. By the end of the 1800s medical training and research unified the two disciplines of medicine and surgery, thereby producing a volume of medical science so that mastering all was impossible for any given individual.<sup>158</sup> Further driving medical specialization were the "increasing economic complexities of capitalist societies ... (which) generated the concept of 'division of labor'" that made "specialization appear natural and advantageous."<sup>159</sup> Medical specialization reinforced itself by accelerating the expansion of medical knowledge through first-hand observations of many similar cases within the same specialty and comparing the results from traditional treatments with new potential cures.<sup>160</sup> For all its benefits, specialization also increased costs as was noted in 1841 that "a specialty is a necessary condition for everybody who wants to become rich and famous rapidly. Each organ has its priest, and for some, special clinics exist."<sup>161</sup> Currently, specialization in the United States has been further entrenched in the practice of medicine by the medical bureaucracy controlling specialization:

- a. Universities control medical degrees,
- b. States control physician licensing,
- c. The American Medical Association controls entrance to medical specialization training through the Council of Medical Education and the Residency Review Committees, and
- d. The American Boards control certification of specialists.<sup>162</sup>

4. *Scientific Growth and Practice Changes.* In addition to specialization, the science and practice of medicine has changed rapidly since the 1950s due in part to technological

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<sup>154</sup> Randolph, *supra* note 148, p. 2.

<sup>155</sup> Randolph, *supra* note 148, p. 2.

<sup>156</sup> Randolph, *supra* note 148, p. 2.

<sup>157</sup> Randolph, *supra* note 148, p. 2.

<sup>158</sup> George Weisz, "The Emergence of Medical Specialization in the Nineteenth Century," *Bulletin of the History of Medicine*, 2003, 77:536-575. Project MUSE, <https://muse.jhu.edu/> (accessed Sept. 10, 2018)

<sup>159</sup> *Id.* p. 539.

<sup>160</sup> *Id.* pp. 546,547.

<sup>161</sup> *Id.* p. 542, an 1841 quote from Carl Wunderlich, *Wien und Paris: Ein Beitrag zur Geschichte und Beurteilung den gegenwärtigen Heilkunde in Deutschland und Frankreich* (Stuttgart, 1841; new ed., Bern: H. Huber, 1974), p. 35. The translation of this quote is taken from Ackerknecht, *Medicine at the Paris Hospital* (n. 13) p. 163.

<sup>162</sup> The History of Family Medicine and Its Impact on U.S. Healthcare Delivery, a symposium paper presented by Cecilia Gutierrez, MD and Peter Scheid, MD  
<https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-are/cfhm/FMImpactGutierrezScheid.pdf>

advancements and developments.<sup>163</sup> Scientific medical advancements have included the invention of wonder drugs and antibiotics, world-wide eradication of smallpox, introduction of hepatitis A and B vaccines, development of artificial heart implants, transplantation of human organs, the Human Genome Project to map DNA, and use of robotics in surgery.<sup>164</sup> As the science of medicine was rapidly changing so were the methods of practice "from (the 1960s fictional solo family practitioner) Marcus Welby, M.D. to (a variety of cost saving structures encouraged by) managed care."<sup>165</sup> These new practice structures "included horizontal integration of physicians into group practices (multispecialty and single specialty), vertical integration of physicians into hospitals (and) health plans,"<sup>166</sup> such as UnitedHealth Group's 47,000 currently employed physicians.<sup>167</sup> With the consolidation and employment of physicians along with managed care assuming increasing authority over physicians' behavior, the Marcus Welby M.D. type of practice is at risk of disappearing.<sup>168</sup>

B. Rise of the Medical Industrial Complex. As the science and practice of medicine changed so did the payment methodologies, stakeholders and motives.

1. *Before the Medical-Industrial Complex.* For most of the twentieth century delivery of healthcare was shaped by the following characteristics with each playing a part in the rise of the "New Medical-Industrial Complex"<sup>169</sup>:

- a. Patients relied on independent physicians to act as their agents for the patient's best interests,
- b. Complex healthcare was provided by independent non-profit hospitals before the emergence of corporate for-profit hospital systems,
- c. Insurers left medical decisions to the providers and reimbursed physicians and hospitals on a fee-for-service basis,<sup>170</sup> and
- d. Insurance premiums were based on the healthcare needs and experiences of the entire subscriber community rather than being based on the more profitable and predictable homogenous groups of subscribers.<sup>171</sup>

*Payer Evolution.* As the healthcare continuum became more sophisticated and complex, it also became more expensive, creating unacceptable financial burdens for all involved: patients,

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<sup>163</sup> Thomas W. Loker, *supra* note 150, p. xxii.

<sup>164</sup> Thomas W. Loker, *supra* note 150, pp. 273-274.

<sup>165</sup> Thomas P. Conklin, "Healthcare in the United States: An Evolving System," Michigan Family Review, Vol. 7 Issue 1, Fall 2002, 5-17. <https://quod.lib.umich.edu/m/mfr/4919087.0007.102?view=text;rgn=main>, quoting David Dranove, "The Evolution of American Healthcare," Princeton, NJ: Princeton University Press (2000).

<sup>166</sup> Lawton Robert Burns, Jeff C. Goldsmith and Aditi Sen, "Horizontal and Vertical Integration of Physicians: A Tale of Two Tails," Advances in Healthcare Management, Vol. 15, 39-117, Emerald Group Publishing Limited, (2003). ISSN: 1474-8231/doi:10.1108/S1474-8231(2013)0000015009, [https://faculty.wharton.upenn.edu/wp-content/uploads/2014/04/HORIZONTAL-AND-VERTICAL-integration-of-physicians\\_2.pdf](https://faculty.wharton.upenn.edu/wp-content/uploads/2014/04/HORIZONTAL-AND-VERTICAL-integration-of-physicians_2.pdf)

<sup>167</sup> Morgan Haefner, "Becker's Hospital Review," June 1, 2018, <https://www.beckershospitalreview.com/payer-issues/unitedhealth-ceo-150m-members-will-be-in-value-based-care-arrangements-by-2025.html?tmpl=component&print=1&layout=default>

<sup>168</sup> Conklin, *supra* note 165, p. 3.

<sup>169</sup> Arnold S. Relman, "The New Medical-Industrial Complex," The New England Journal of Medicine, Vol. 303, No. 17 963-970 (Oct. 23, 1980). <https://www.nejm.org/doi/full/10.1056/NEJM198010233031703>

<sup>170</sup> Conklin, *supra* note 165, Pg. 3.

<sup>171</sup> "History of Health Insurance in the United States," an ACHE Morrisey Publication, Chapter 1 [https://www.ache.org/pubs/Morrisey2253\\_Chapter\\_1.pdf](https://www.ache.org/pubs/Morrisey2253_Chapter_1.pdf)

healthcare providers and hospitals<sup>172</sup>. In 1918, an Ohio study determined that 7.6 per cent of the average medical costs went to hospital care. The main cost of illness was not medical care but lost wages due to sickness.<sup>173</sup> A similar study in Illinois a year later determined that lost wages were four times the cost of medical care.<sup>174</sup> As doctors, through the AMA, and hospitals through the American Hospital Association (AHA) opposed any proposal for government funded national health insurance as being associated with socialism<sup>175</sup> and with rising costs and poor economic conditions affecting patients and providers alike, the economic doors were opening for an alternative system of payment.<sup>176</sup> Enter collective risk sharing in the form of private health insurance as an expansion of sickness (disability) insurance and a means to reduce the overall financial burden of illness.<sup>177</sup> In 1929 a group of teachers in Dallas, Texas organized to provide prepaid hospital services provided by Baylor University Hospital. The fixed prepaid amounts covered the unexpected and unpredictable costs of hospital care. These local cooperatives worked to provide compensation for services that may have otherwise gone unpaid if the individual patient was unable to pay<sup>178</sup>. At the expense of losing the business relationship between patient and provider, the shared risk pools provided economic certainty for both the individual patient and the healthcare provider.<sup>179</sup>

As the shared hospital risk pools matured into for-profit insurance business ventures that became known as Blue Cross, the network of healthcare providers created similar physician services insurance companies known as Blue Shield.<sup>180</sup> As more people became covered by health insurance, those that were uninsured did not have the economic clout to negotiate either the means or amount of payment for healthcare services.<sup>181</sup> Therefore, higher demand for health services by those with insurance combined with a limited number of healthcare providers resulted in lower access to healthcare for those without insurance.<sup>182</sup>

A rival to Blue Cross's fee-for-service payment method appeared during World War II when Henry J. Kaiser offered healthcare services to his employees by pre-paying the medical providers a fixed predetermined daily amount for each patient assigned to that provider.<sup>183</sup> Kaiser's capitated prepaid program paved the way for what would become, forty years later, an industry upsetting model of payment known as managed care, that included new organizational structures referred to as Health Maintenance Organizations (HMOs).<sup>184</sup> Private health insurance grew rapidly during World War II, primarily as a tool to circumvent the wage and price controls set by

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<sup>172</sup> Kenneth Shueter, *Because of History, Philosophy, The Constitution, Fairness & Need: Why Americans Have a Right to National Healthcare*, 10 Ind. Health L. Rev. 75, 2 (2013)

<sup>173</sup> State of Ohio, Health and Old Age Insurance Commission. Health, Health Insurance, Old Age Pension. Columbus, Ohio (1919). *Id.* 6

<sup>174</sup> State of Illinois. Report of Insurance Commission, (1919). *Id.* 6

<sup>175</sup> Randolph, *supra* note 148, p. 3.

<sup>176</sup> Randolph, *supra* note 148, p. 3.

<sup>177</sup> Thomasson, *supra* note 5.

<sup>178</sup> Thomasson, *supra* note 5 p. 3.

<sup>179</sup> "History of Health Insurance in the United States," *supra* note 171.

<sup>180</sup> Thomasson, *supra* note 5 p. 5.

<sup>181</sup> Conti, *supra* note 142.

<sup>182</sup> Thomasson, *supra* note 5 p. 3, footnote 2.

<sup>183</sup> "History," Kaiser Permanente, Home Page, (Oct. 28, 2018), <https://share.kaiserpermanente.org/about-us/history> .

<sup>184</sup> Randolph, *supra* note 148, p. 3.

the National War Labor Board.<sup>185</sup> Following World War II private employer funded insurance continued to grow due in part to (1) the 1947 Taft-Harley Act that made health insurance a condition of employment subject to collective bargaining and (2) the Internal Revenue Code of 1954 exempting employer-sponsored health insurance from federal income tax, granting a deduction to the employer and not taxing the benefit to the employee.<sup>186</sup> Whether intended or not, the federal tax subsidy is still significant, estimated to be \$248 billion in 2013 which was slightly less than all Medicare spending for inpatient and outpatient hospital services in 2012.<sup>187</sup>

2. *Early Warnings.* Similar to President Eisenhower's 1961 warning regarding "the military-industrial complex" exercising great self-serving political and economic power,<sup>188</sup> there was also a warning in 1980 about the growing medical-industrial complex comprised of organized physicians,<sup>189</sup> pharmaceutical companies, medical equipment suppliers and investor owned hospitals with great potential to influence public policy for their own private gain.<sup>190</sup> To this writer, the common emerging theme across all types of healthcare providers has been and still is investor ownership seeking to maximize profitability. This is borne out by the December 27, 1979 Wall Street Journal report that "net earnings of healthcare corporations with public stock shares rose by 30 to 35 per cent in 1979 and...expected to increase another 20 to 25 per cent in 1980."<sup>191</sup> And further evidenced by a Merrill Lynch vice-president's contemporaneous description of the lure of investing in healthcare stocks:

"Healthcare is now the basis of a huge private industry, which is growing rapidly, has a bright future, and is relatively invulnerable to recession. He predicted that the health business would soon capture a large share of the health-care market and said that the only major risk to investors was the threat of greater government control through the enactment of comprehensive health insurance or through other forms of federal regulation."<sup>192</sup>

3. *Capital, Cost Control, and Marketing.* It was inevitable that equity investors would be attracted to this very profitable market with its ever increasing needs for investor capital to fund modern healthcare technology, as not-for-profit institutions were limited to traditional bond financing.<sup>193</sup> Conventional wisdom also postulated that competition spawns better management of costs and services, therefore "the free market should operate to improve the efficiency and quality of healthcare."<sup>194</sup> These same forces have continued since 1980 when healthcare expenditures were approaching 9 per cent of the Gross National Product (GDP) which was viewed as being "clear that costs cannot continue to rise at anything near their present rate unless other

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<sup>185</sup> "History of Health Insurance in the United States," *supra* note 171, p. 11.

<sup>186</sup> "History of Health Insurance in the United States," *supra* note 171, p. 12.

<sup>187</sup> "History of Health Insurance in the United States," *supra* note 171, p. 12.

<sup>188</sup> Relman, *supra* note 169, Pg. 963.

<sup>189</sup> The American Medical Association is one such organization that has on multiple occasions, discussed herein, demonstrated the will and ability to sway public opinion and legislative agendas.

<sup>190</sup> Relman, *supra* note 169, p. 963.

<sup>191</sup> Relman, *supra* note 169, p. 965.

<sup>192</sup> Relman, *supra* note 169, pp. 965-966.

<sup>193</sup> Relman, *supra* note 169, p. 966.

<sup>194</sup> Relman, *supra* note 169, p. 966.



important social goals are sacrificed."<sup>195</sup> However, some thirty-six years later, healthcare spending is approaching 18 per cent of GDP with expectations of continued growth<sup>196</sup> and the free market approach has only produced more marketing to "sell as many units (of healthcare) as the market will bear."<sup>197</sup>

4. *Future Expectations regarding the Medical-Industrial Complex.* As private enterprise continues to invite the gross commercial exploitation of healthcare, one can expect governmental regulatory intervention.<sup>198</sup> However, any legislation will have "to be palatable both to the voters, who have the power to oust unsatisfactory legislators, and to the legislators themselves, who are often beholden to the special interest groups formed by healthcare's key players,"<sup>199</sup> the medical-industrial complex.

### C. Access to Care as Affected by Cost and Complexity.

1. *Cost Issues affecting Access.* Although the rise in healthcare costs can be attributed to many factors, as discussed below, including an aging population, accelerated technological advancements, and increased consumer demand, none stands out like the investor-owned corporate profiteering that has taken place in the financially unregulated healthcare market place.<sup>200</sup> "The medical-industrial complex, with all its disturbing elements, has become fully entrenched at the core of the U.S. healthcare system. The costs of this revolution, in terms of dollars, inefficiency, and decreased value, are only now starting to become clear. For investor-owned healthcare corporations, money is the mission, not the public interest."<sup>201</sup> Under these conditions healthcare has become unaffordable, not just for low-income, but for a growing part of the middle class as well.<sup>202</sup> As costs rise so do insurance premiums and "insurance coverage, whether public or private, has been found to be the single most important factor for adequate access to care."<sup>203</sup>

2. *Health Literacy and Health Insurance Literacy affecting Access.* As healthcare and health insurance both become consumer driven, health literacy and health insurance literacy play more significant roles in the access to care.<sup>204</sup> Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."<sup>205</sup> Health insurance literacy is defined as

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<sup>195</sup> Relman, *supra* note 169, p. 967.

<sup>196</sup> The National Health Expenditures 2016 Highlights, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

<sup>197</sup> Relman, *supra* note 169, p. 967.

<sup>198</sup> Relman, *supra* note 169, p. 967.

<sup>199</sup> Channick, *supra* note 30, p. 2.

<sup>200</sup> John P. Geyman, "The Corporate Transformation of Medicine and Its Impact on Costs and Access to Care," *J. Am. Board Fam. Med.*, Vol. 16, No. 5 443-454 (Sept. 1, 2003).  
<http://www.jabfm.org/content/16/5/443.full.pdf+html>

<sup>201</sup> *Id.* p. 449.

<sup>202</sup> *Id.* p. 449.

<sup>203</sup> *Id.* p. 449.

<sup>204</sup> Zsofia A. Parrgh and Deanna Okrent, "Health Literacy and Health Insurance Literacy: Do Consumers Know What they are buying?" Alliance for Health Reform, Robert Wood Johnson Foundation (January 6, 2015).  
[http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit\\_163.pdf](http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf)

<sup>205</sup> "Fact Sheet - Quick Guide to Health Literacy," U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, last viewed 11/4/2018,  
<https://health.gov/communication/literacy/quickguide/factsbasic.htm>

"the capacity to find and evaluate information about health plans, select the best plan given financial and health circumstances, and use the plan once enrolled."<sup>206</sup> According to the organization America's Health Insurance Plans (AHIP), nearly 90 per cent of adults have difficulty using health information to make informed decisions about their health<sup>207</sup> and "only 12 per cent of English-speaking American adults had proficient health literacy skills."<sup>208</sup> Approximately one-half "(51 per cent) of Americans do not understand the basic health insurance terms premium, deductible and copay"<sup>209</sup> and when math skills are required only 16 per cent could calculate the insured's cost for an out-of-network lab test.<sup>210</sup> Lack of health insurance literacy can lead to confusion regarding which health insurance plan is best and how to effectively use the chosen plan.<sup>211</sup> For example, "those who don't know what a provider network is and that cost-sharing differs substantially between in-network and out-of-network clinicians and medical institutions might unwittingly run up (unnecessary) charges."<sup>212</sup>

3. *Number of Choices affecting Access.* Compounding the issues of rising premiums and low health insurance literacy are the sheer abundance and complexity of insurance choices that can overwhelm consumers and impact their understanding of plan features.<sup>213</sup> Studies have shown that enrollment in Medicare's Part D prescription drug program wanes when consumers are faced with too many choices,<sup>214</sup> a counterintuitive result known as the "paradox of choice."<sup>215</sup> Consumer enrollment was lower when there were (1) too few choices because they had trouble finding what they wanted and (2) when there were too many choices making it difficult for consumers to compare features of plans.<sup>216</sup>

4. *Managed Costs affecting Access.* Assuming selection and use of a chosen insurance plan are not issues, access to care may still be difficult due to the essential nature of managed care plans. Managed care is "typically driven by the (free) market with a strong focus on managing costs rather than care."<sup>217</sup> The inherent business strategy of managed care is to utilize a mixture of cost-control

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<sup>206</sup> Parrgh and Okrent, *supra* note 204, Pg. 2, quoting Measuring Health Insurance Literacy: A Call to Action, A Report from the Health Insurance Literacy Expert Roundtable. Consumers Union, University of Maryland College Park, American Institutes for Research, February 2012. <http://goo.gl/FywWmL>

<sup>207</sup> Parrgh and Okrent, *supra* note 204, p. 1, citing New Report Highlights Health Plans' Commitment to Health Literacy, AHIP Coverage (Dec. 10, 2013). <http://goo.gl/lehMIg>

<sup>208</sup> Parrgh and Okrent, *supra* note 204, p. 1, citing Kutner, M. et.al. "The Health Literacy of America's Adults Results From the 2003 National Assessment of Adult Literacy," U.S. Department of Education, Washington, DC: National Center for Education Statistics & American Institutes for Research, Sept. 2006. <http://goo.gl/bUufeA>

<sup>209</sup> Parrgh and Okrent, *supra* note 204, Pg. 1, citing Half of U.S. Adults Fail 'Health Insurance 101,' Misidentify Common Financial Terms in Plans. American Institute of CPAs, Aug. 27, 2013. <http://goo.gl/aCGRN8>

<sup>210</sup> Parrgh and Okrent, *supra* note 204, Pg. 1, citing Norton, M. et.al. "Assessing Americans' Familiarity with Health Insurance Terms and Concepts." The Henry J. Kaiser Family Foundation, Nov. 11, 2014. <http://goo.gl/z79tuW>

<sup>211</sup> Larry Levitt, "JAMA Forum: Why Health Insurance Literacy Matters," JAMA Newsletter (Nov. 26, 2014). <https://newsatjama.jama.com/2014/11/26/jama-forum-why-health-insurance-literacy-matters/>

<sup>212</sup> *Id.* p. 1.

<sup>213</sup> Parrgh and Okrent, *supra* note 204, p. 3.

<sup>214</sup> Parrgh and Okrent, *supra* note 204, p. 3.

<sup>215</sup> "Is the Famous 'Paradox of Choice' a Myth?" PBS News Hour, Paul Solman interview with Barry Schwartz, (Jan. 29, 2014). <https://www.pbs.org/newshour/economy/is-the-famous-paradox-of-choic>

<sup>216</sup> Parrgh and Okrent, *supra* note 204, p. 3.

<sup>217</sup> Geyman, *supra* note 201, p. 444.

mechanisms<sup>218</sup> including access barriers to specialist referrals, costly diagnostic tests, and hospitalization<sup>219</sup> thereby managing financial "budgets (with)...the numbers of physicians, hospital beds and high-cost equipment"<sup>220</sup> available for providing care.

#### IV. Rising Cost of Healthcare

As demonstrated in the preceding sections, the cost of healthcare is affected in varying degrees by the role of government, the impact on service delivery by the medical-industrial complex and who shoulders the responsibility for payment. This section will focus on the factors affecting healthcare costs and how these costs impact the sustainability of a healthcare system and are the ultimate catalyst for healthcare reform.

A. Factors Affecting Healthcare Economics. The primary factors affecting healthcare policy have been referred to as the "Iron Triangle" based on a concept developed by William Kissick.<sup>221</sup> Dr. Kissick identifies three factors, cost, quality and access that operate in a dynamic and complex relationship.



The Triangle is Iron because change to any leg of the triangle will inherently affect the others, creating a system of trade-offs.<sup>222</sup> For example, to make healthcare cheaper, either access or quality must be reduced. If access is increased creating more demand, it will either cost more or the quality of care will suffer while providing more services.<sup>223</sup> Aaron Carroll has written that "anyone who tells you that he or she can make the healthcare system more universal, improve quality, and also reduce costs is in denial or misleading you."<sup>224</sup>

1. *Access Drivers.* While affordability and the supply of providers<sup>225</sup> are central elements of access, many patients may also face nonfinancial barriers. A 2012 study used the following dimensions to categorize the primary reasons why U.S. adults had unmet or delayed healthcare:

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<sup>218</sup> Thomas Bodenheimer and Kevin Grumbach, "Understanding Health Policy A Clinical Approach," McGraw-Hill Education (2016) 114. ISBN 978-1-259-25119-1; MHID 1-259-25119-5.

<sup>219</sup> Geyman, *supra* note 201, p. 444.

<sup>220</sup> Bodenheimer and Grumbach, *supra* note 218, p. 114.

<sup>221</sup> William L. Kissick, "Medicine's Dilemmas: Infinite Needs versus Finite Resources," New Haven: Yale University Press, 1994. ISBN 0-300-05964.

<sup>222</sup> Aaron E. Carroll, "The 'Iron Triangle' of Healthcare: Access, Cost, and Quality," The JAMA Forum, October 3, 2012. <https://newsatjamajama.com/2012/10/03/Jama-forum-the-iron-triangle-of-health-care-access-cost-and-quality/>

<sup>223</sup> *Id.*

<sup>224</sup> *Id.*

<sup>225</sup> Jeffrey S. Flier, "How can we remedy the shortage of health providers?" STAT News, First Opinion (Feb. 21, 2018) <https://www.statnews.com/2018/02/21/health-providers-shortage/>

- a. Affordability of Services - determined by the patients' capacity to pay and any existing healthcare insurance;
- b. Accommodations to Receive Services – measured by the patient's inability to meet with the healthcare provider for reasons relating to the patient's work, the provider's hours, or the patient caring for others;
- c. Provider Availability – considering the timeliness of appointments, the patient's knowledge of where to find a provider, and patient's access to the provider of choice;
- d. Provider Accessibility – relative to suitable patient transportation; and
- e. Provider Acceptability – patient's third party payment method is acceptable, provider's attitude is appropriate, and patient's experience with care is acceptable.<sup>226</sup>

2. *Quality Drivers.* Quality healthcare has been defined by the Institute of Medicine as "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."<sup>227</sup> Variables that may affect the perceived quality of care include:

- a. The effectiveness of care as measured by the care provided relative to the expected outcomes as supported by scientific evidence;
- b. The efficiency of care delivered relative to the healthcare resources used;
- c. The equity of care based on delivering equal quality to all with like clinical conditions;
- d. Patient centeredness care meeting the patients' needs and preferences while providing education and support;
- e. Patient safety based on actual or potential bodily harm; and
- f. The timeliness of care delivered.<sup>228</sup>

3. *Cost Drivers.* Increasing access to care by reducing cost is always the goal.<sup>229</sup> As described above, the drivers of access and quality also drive cost, with each also affecting the other. There is no single cause affecting healthcare costs, however the following are major factors:

- a. *Risk Shifting.* One means of lowering costs is by spreading the risks of healthcare over a larger population through insurance, thereby lowering the cost for any single subscriber.<sup>230</sup> The degree of cost control by insurance is generally determined by the structure of the insurance program, ranging from relatively few controls with indemnity insurance to shifting all the risks of care to providers.<sup>231</sup> However,

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<sup>226</sup> Jeffery T. Kullgren, Catherine G. McLaughlin, Nandita Mitra, and Katrina Armstrong, "Nonfinancial Barriers and Access to Care for U.S. Adults," *Health Services Research*, 2012; 47 (1 Pt 2):462-485.

<sup>227</sup> "Understanding Quality Measurement." Content last reviewed Oct. 2018. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/chttoolbx/understand/index.html>

<sup>228</sup> *Id.*

<sup>229</sup> William Lewis, "What is the Iron Triangle of Healthcare?" *MORE Health* (May 18, 2017). <https://medium.com/more-health/what-is-the-iron-triangle-of-health-care-9ce6f5276077>

<sup>230</sup> *Id.* Pg. 2.

<sup>231</sup> *Id.* Pg. 3.

removing the patient from financial choices and responsibilities has also been found to be a major cause in the rise of over-all healthcare costs.<sup>232</sup> Along with inefficient cost controls of third party payers, the patient's perception that healthcare services are free or almost free advances overuse of finite healthcare resources thus squeezing access and inflating prices.<sup>233</sup>

- b. *Aging Population.* Americans are living longer with greater health needs.<sup>234</sup> The 2012 per-person healthcare spending for a person 65 and older was \$18,988 as compared to \$6,632 for a person of working-age.<sup>235</sup> Patients in their last six months of life go to the doctor's office 29 times on average and in the last month of life one-half go to the emergency room, one-third receive intensive care services and one-fifth undergo surgery.<sup>236</sup> "Medicare spending for patients in the last year of life is six times greater than the average. Care for these patients cost one-fourth of the Medicare budget."<sup>237</sup>
- c. *Pharmaceutical Cost.* The cost of pharmaceutical products also contributes to the overall cost of healthcare, representing 10 per cent of the total national health expenditures.<sup>238</sup> Factors driving the increase cost of pharmaceuticals include higher utilization of prescription drugs, higher priced new drugs replacing older versions, consolidation of drug companies resulting in fewer competitors, and general price increases for existing drugs.<sup>239</sup> Although expensive to create and develop, the use of new biotechnology synthetic drugs and biosimilar drugs have proved to be clinically effective.<sup>240</sup>
- d. *New Technologies.* The net cost of new technologies is subject to debate. Some sources indicate the cost to develop and diffuse new medical technology significantly contributes to the cost of healthcare.<sup>241</sup> In addition, testimony from the Congressional Budget Office (CBO) indicates that advances in medical technologies are a primary driver of rising healthcare costs.<sup>242</sup> And, the Robert

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<sup>232</sup> Stan Liebowitz, "Cato Institute Policy Analysis No. 211: Why Healthcare Costs Too Much," Cato Institute (June 23, 1994). <https://www.cato.org/publications/policy-analysis/why-health-care-costs-too-much>

<sup>233</sup> *Id.*

<sup>234</sup> "Healthcare Cost Drivers Write Paper," National Association of Health Underwriters (June 2015).

<https://nahu.org/media/1147/healthcarecost-driverswhitepaper.pdf>

<sup>235</sup> National Health Expenditure Fact Sheet, Centers for Medicare & Medicaid Services, Last viewed Nov. 9, 2018.

<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

<sup>236</sup> Amadeo, *supra* note 4.

<sup>237</sup> Amadeo, *supra* note 4.

<sup>238</sup> The National Health Expenditures 2016 Highlights, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

<sup>239</sup> "Healthcare Cost Drivers Write Paper," *supra* note 234, p. 2.

<sup>240</sup> "Healthcare Cost Drivers Write Paper," *supra* note 234, p. 2.

<sup>241</sup> "Snapshots: How Changes in Medical Technology Affect Healthcare Costs," The Henry J. Kaiser Family Foundation (Mar. 02, 2007). <https://www.kff.org/health-costs/issue-brief/snapshots-how-changes-in-medical-technology-affect/>

<sup>242</sup> Mark Mack, "What Drives Rising Health-Care Costs?" Government Finance Review (August 2016) 26-32. <https://www.gfoa.org/sites/default/files/GFR081626.pdf>, referring to Peter R. Orszag, Congressional Budget Office, January 2008.



Wood Johnson Foundation concluded in 2011 that "spending on medical technology implementation accounts for between 38 and 65 percent of healthcare spending increases."<sup>243</sup> However, analysis of 86 various studies having to do with healthcare technology suggest that the relationship between advances in technology and healthcare spending is complex and often conflicting.<sup>244</sup> Concluding that healthcare policy should extend beyond just cost and consider also the value of better health and socioeconomic benefits. This conclusion was quantified in an earlier study comparing "the value of a year of life (anywhere from \$50,000 to \$200,000) to the study's finding that each year of increased life expectancy cost about \$19,900 in health spending."<sup>245</sup>

- e. *Administrative Cost.* Administrative costs include all payments by health insurers and healthcare providers that are not for healthcare services.<sup>246</sup> These costs are so significant that a recent bill proposing the Medicare for All Program provides "the program must give employment transition...to individuals whose jobs are eliminated due to reduced clerical and administrative work under this bill."<sup>247</sup> One study found that 31 per cent of healthcare expenditures were related to administrative costs<sup>248</sup> and another determined that administrative costs make up 25.3 per cent of total hospital spending in the U.S.<sup>249</sup> As discussed in Section I - Introduction, the ACA made important strides in containing insurance company administrative costs and profits by mandating that minimum amounts be paid for healthcare expenses known as Medical Loss Ratios.<sup>250</sup> Although the ACA recognized the issue of runaway administrative costs, comparative studies with other countries indicate that "reduction of administrative costs in the U.S. would best be accomplished through a simple and less market-oriented payment scheme"<sup>251</sup> such as a single-payer government funded system.<sup>252</sup>

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<sup>243</sup> "Healthcare Cost Drivers Write Paper," *supra* note 234, p. 2. Citing

[https://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf71331](https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71331)

<sup>244</sup> Corinna Sorenson, Michael Drummond, and Beena Bhuiyan Khan, "Medical technology as a key driver of rising health expenditure: disentangling the relationship" *Clinico Economics and outcomes research: CEOR* vol. 5 223-34. 30 May. 2013, doi:10.2147/CEOR.S39634. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3686328/>

<sup>245</sup> "Snapshots: How Changes in Medical Technology Affect Healthcare Costs," *supra* note 241, p. 5. Referring to David M. Cutler, Allison B. Rosen and Sandeep Vijan, "The Value of Medical Spending in the United States, 1960-2000," *The New England Journal of Medicine*, 355;9 (Aug. 31, 2006) 920-927.

<sup>246</sup> Mack, *supra* note 242, pp. 30-31.

<sup>247</sup> H.R. 676, 115<sup>th</sup> Cong. (2017-2018), Sec. 303 (e).

<sup>248</sup> Steffie Woolhandler, Terry Campbell and David U. Himmelstein, "Costs of Healthcare Administration in the United States and Canada," *The New England Journal of Medicine*, 349:768-775 (2003). <https://www.nejm.org/doi/full/10.1056/NEJMsa022033>

<sup>249</sup> "Why U.S. hospital administrative costs are among the highest in the world: 7 things to know," *Becker's Hospital Review* (Sept. 08, 2014). <https://www.beckershospitalreview.com/finance/why-u-s-hospital-administrative-costs-are-among-the-highest-in-the-world-7-things-to-know.html>

<sup>250</sup> Karr, *supra* note 27.

<sup>251</sup> David U. Himmelstein, Miraya Jun, Reinhard Busse, Karine Chevreur, Alexander Geissler, Patrick Jeurissen, Sarah Thomson, Marie-Amelie Vinet, and Steffie Woolhandler, "A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others By Far," *Health Affairs*, 33, No. 9 (2014): 1586-1594. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1327>

<sup>252</sup> Arnold Relman, "In Dire Health," *The American Prospect* (Jan. 13, 2012). <http://prospect.org/article/dire-health>



- f. *Individual Behavioral and Lifestyle Choices.* "Research shows that behavior is the most significant determinant of health status, with as much as 70 percent of healthcare costs attributable to individual behaviors such as smoking, alcohol abuse, and obesity."<sup>253</sup> Over the past 30 years the number of adolescents being overweight or obese has quadrupled and doubled for children, resulting in one out of every six children under the age 20 being overweight or obese.<sup>254</sup> Smoking is responsible for roughly 8.7 percent of total healthcare costs with each smoker costing an employer \$5,128 per year in healthcare costs and lost productivity.<sup>255</sup> These and other lifestyle behaviors have led to consumers seeking costly medical solutions for the resulting chronic conditions such as cancer, diabetes, health and cardiovascular disease, rather than modifying their behaviors.<sup>256</sup> The sickest 5 percent of the population consume 50 percent of total healthcare costs as compared to the healthiest 50 percent who only consume 3 percent.<sup>257</sup>
- g. *Consolidation of Investor-owned Healthcare Enterprises.* The larger the market share controlled by either providers or payers, the more negotiating power to drive cost.<sup>258</sup> The pendulum of power swings from providers to payers and back to providers as the medical-industrial complex changes. Currently, in order to maximize profits, there is significant vertical integration activity leveraging payer and provider relationships,<sup>259</sup> including CVS's \$69 billion purchase of Aetna<sup>260</sup> and potential reciprocal equity investments of Humana and Walgreens<sup>261</sup> with rumors of Walmart putting clinics in their parking lots<sup>262</sup> and of buying Humana.<sup>263</sup> In addition, there are new comers to the investor owned medical-industrial complex such as Amazon-Berkshire-JPMorgan healthcare system.<sup>264</sup>

<sup>253</sup> "Healthcare Cost Drivers Write Paper," *supra* note 234, p. 2.

<sup>254</sup> "Healthcare Cost Drivers Write Paper," *supra* note 234, p. 3.

<sup>255</sup> "Healthcare Cost Drivers Write Paper," *supra* note 234, p. 3.

<sup>256</sup> "Healthcare Cost Drivers Write Paper," *supra* note 234, p. 3.

<sup>257</sup> Amadeo, *supra* note 4.

<sup>258</sup> Mack, *supra* note 242, p. 31.

<sup>259</sup> Jeff Byers, "Optum a step ahead in vertical integration frenzy," Healthcare Dive (Apr. 12, 2018)

<https://www.healthcaredive.com/news/optum-unitedhealth-vertical-integration-walmart/520410/>

<sup>260</sup> Morgan Haefner and Alia Paavola, "CVS Health posts \$1.4B profit, expects Aetna deal to close by Thanksgiving," Becker's Hospital Review (Nov. 06, 2018).

[https://www.beckershospitalreview.com/pharmacy/cvs-health-posts-1-4b-profit-expects-aetna-deal-to-close-by-thanksgiving.html?origin=bhre&utm\\_source=bhre](https://www.beckershospitalreview.com/pharmacy/cvs-health-posts-1-4b-profit-expects-aetna-deal-to-close-by-thanksgiving.html?origin=bhre&utm_source=bhre)

<sup>261</sup> Ayla Ellison, "Walgreens, Humana looking to take equity stakes in each other," Becker's Hospital Review (Nov. 21, 2018). <https://www.beckershospitalreview.com/payer-issues/walgreens-humana-looking-to-take-equity-stakes-in-each-other.html>

<sup>262</sup> Ayla Ellison, "Walmart looks to add health clinics in its parking lots," Becker's Hospital Review (Oct. 29, 2018). <https://www.beckershospitalreview.com/finance/walmart-looks-to-add-health-clinics-in-its-parking-lots.html>

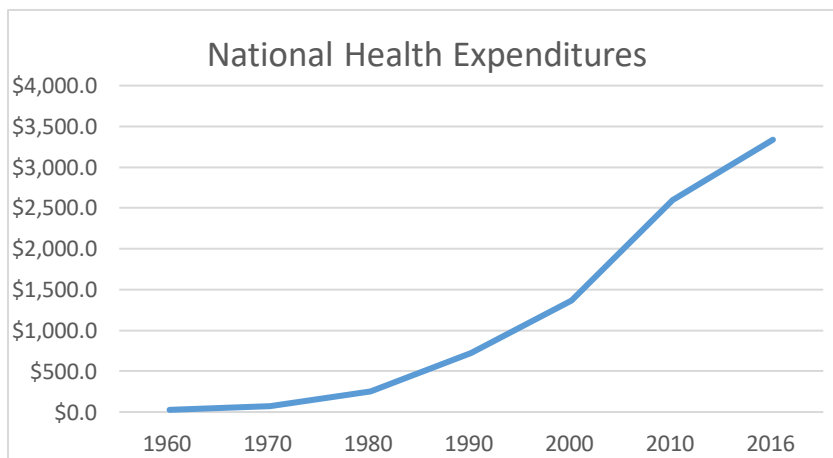
<sup>263</sup> Ayla Ellison, "10 of the most interesting healthcare transactions of 2017," Becker's Hospital Review (Jan. 08, 2018). <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/10-of-the-most-interesting-healthcare-transactions-of-2017.html>

<sup>264</sup> Zachary Tracer, "Amazon-Berkshire-JPMorgan Health Venture Takes Aim at Middlemen," Bloomberg (June 24, 2018). <https://www.bloomberg.com/news/articles/2018-06-24/amazon-berkshire-jpmorgan-health-venture-takes-aim-at-middlemen>

HEALTH PLAN	Aetna	Cigna	United	Humana
SITES OF CARE	MinuteClinic		MedExpress + SCA	Walmart Care Clinics
PBM	CVS/caremark	Express Scripts	OptumRx	Humana Pharmacy Solutions
PHARMACY	CVS/pharmacy			Walmart Pharmacy + PillPack
CLINICAL STAFF			DaVita	Kindred

*Credit: Revive Health*

B. Trajectory of Healthcare Costs. With national healthcare costs of \$3.3 trillion in 2016, healthcare is one of the largest industries in the U.S. consuming 17.9 per cent of Gross Domestic Product (GDP).<sup>265</sup> These cost are 121 times more than 1960 when it was \$27.2 billion and 5 per cent of GDP.<sup>266</sup> On a per-person basis, the cost has risen from \$146 per person in 1960 to \$10,348 per person in 2016 with healthcare costs rising faster than annual incomes.<sup>267</sup> Based on CMS data tables the trajectory of healthcare costs may be graphically represented as follows:<sup>268</sup>



Consistent with the increases in total national health expenses, Federal Medicare healthcare spending is also expected to grow by more than twice as much due primarily to increased enrollment, increased use of services, severity of care and generally rising healthcare prices.<sup>269</sup>

<sup>265</sup> Amadeo, *supra* note 4.

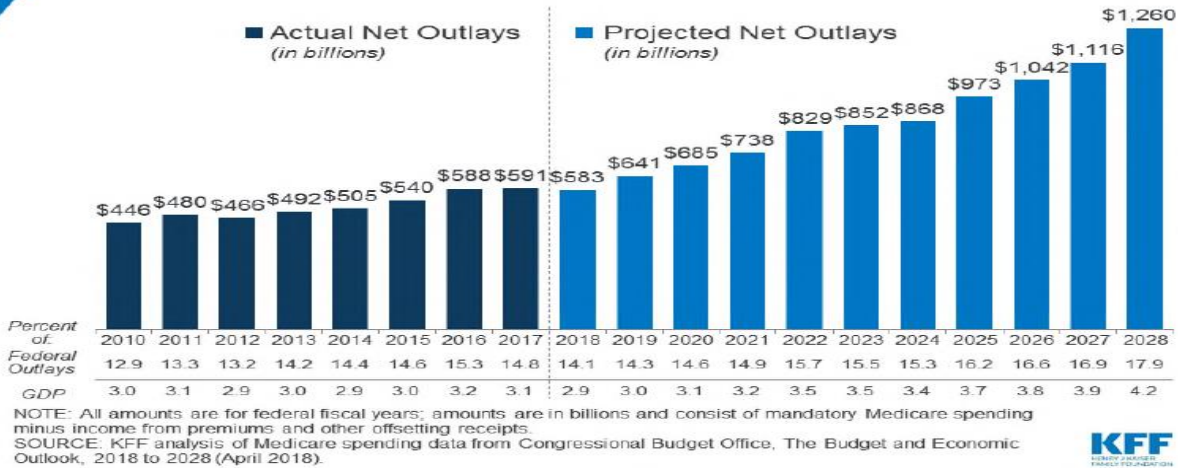
<sup>266</sup> Amadeo, *supra* note 4.

<sup>267</sup> Amadeo, *supra* note 4.

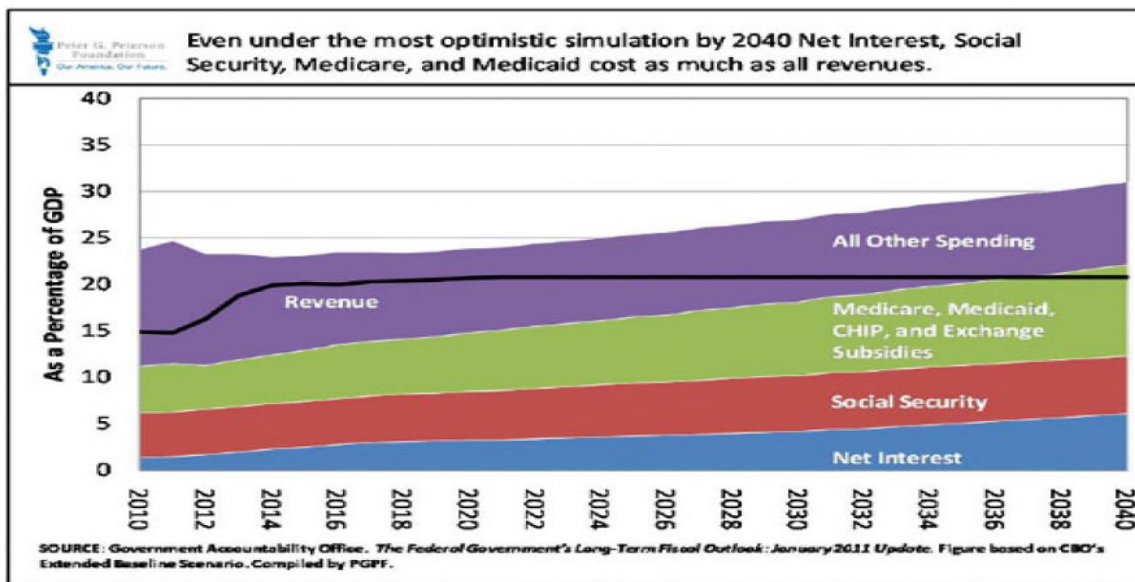
<sup>268</sup> National Health Expenditure Fact Sheet, Centers for Medicare & Medicaid Services, Last viewed Nov. 9, 2018. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

<sup>269</sup> Juliette Cubanski and Tricia Neuman, "The Facts on Medicare Spending and Financing," The Henry J. Kaiser Family Foundation, (Jun 22, 2018). <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>

Figure 6  
Actual and Projected Net Medicare Spending, 2010-2028



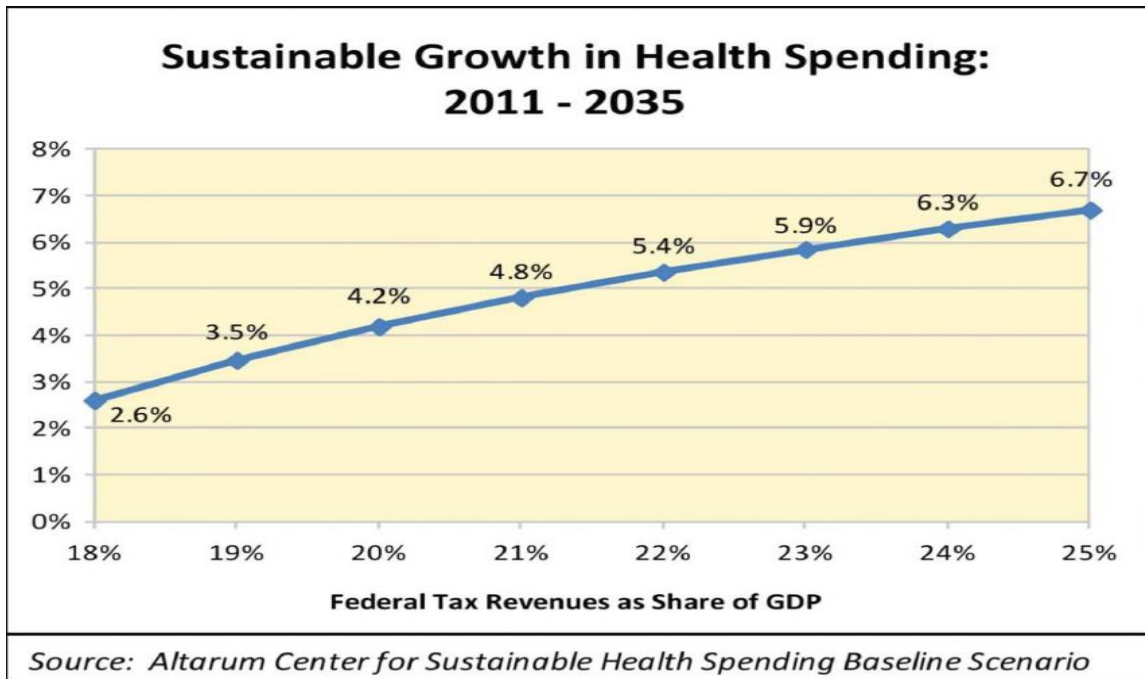
Projections by the Government Accountability Office (GAO) based on data from the Congressional Budget Office (CBO) estimate that under the most optimistic assumptions by 2040 the Federal government's expenditures for interest, Social Security, Medicare, and Medicaid will be equal to the total Federal revenues, leaving national security, infrastructure, education and all other programs to be paid with borrowed funds.<sup>270</sup>



<sup>270</sup> "Analysis of GAO Update To Federal Government's Long-Term Fiscal Outlook," Peter G. Peterson Foundation (Mar. 23, 2011). <https://www.pgpf.org/analysis/analysis-of-gao-update-to-federal-government%E2%80%99s-long-term-fiscal-outlook>

C. Sustainability.

1. Healthcare. Sustainability has been defined as the "projected growth path of spending that is within what the nation is willing to pay."<sup>271</sup> As such, sustainable healthcare spending, like beauty, is in the eye of the beholder or in this case the taxpayer. In June 2011, CMS predicted the long term annual growth rate of healthcare spending would be 6.2 per cent, which would only be sustainable with Federal Tax Revenues of 24 per cent of GDP as opposed to a historical average of 18 per cent of GDP.<sup>272</sup>



The sustainability of any particular rate of healthcare spending growth largely rests with the federal government's ability to meet all its various health spending commitments, including expansion of access and cost controls under the ACA.<sup>273</sup> This, in turn, depends upon the willingness of the citizenry to allocate the necessary tax revenues to healthcare at the expense of other spending.<sup>274</sup>

2. *Public and Private Debt.* As noted above, Federal spending for healthcare, social security and net interest expense is expected to equal all Federal revenues by 2040, with all other government functions being paid through borrowed funds. This imbalance between spending and revenues leads to large sustained deficits.<sup>275</sup> It is clear that even if the cost control measures of the ACA are fully implemented and sustained over the long term, there is still a significant imbalance

<sup>271</sup> Charles Roehrig, "What is 'Sustainable' Health Spending?" Health Affairs Blog (Feb. 3, 2012) DOI 10.1377/hblog20120203.016697. <https://www.healthaffairs.org/doi/10.1377/hblog20120203.016697/full/>

<sup>272</sup> *Id.*

<sup>273</sup> *Id.*

<sup>274</sup> *Id.*

<sup>275</sup> "Analysis of GAO Update to Federal Government's Long-Term Fiscal Outlook," *supra* note 270.

between revenues and spending making the current fiscal situation unsustainable.<sup>276</sup> This imbalance, worsened by other economic forces such as a recession, potentially caused by the pending world-wide debt crisis,<sup>277</sup> "will force the nation's attention on the federal deficit, the debt to GDP ratio, and the urgency of reducing the health spending cost trend."<sup>278</sup>

## V. Potential Recovery Solutions

Assuming that "despite the passage of the Affordable Care Act, the U.S. medical system is near collapse"<sup>279</sup> this portion of the paper will address potential recovery solutions for a sustainable healthcare system. However, designing a health reform plan that guarantees access, quality, and cost control is the easy part.<sup>280</sup> Designing a plan with sufficient political strategy to survive the legislative process is the difficult task.<sup>281</sup> So far, no unified plan has passed the test.<sup>282</sup>

A. Status Quo. One writer has described "the chief problem with the current healthcare delivery system (status quo)...is ... it is neither integrated, nor practical, nor functional. It has mutated in its form over decades with hit-and-miss solutions that tend to put the interests of industry players ahead of the interests of their patients. Having grown weed-like in an unbounded field the system is a tangled mess that defies comprehension."<sup>283</sup> Maintaining the status quo does not address any of the issues previously raised in this paper. "Moreover, incremental reform may not be sustainable in the long run, for the same reasons that makes it politically popular now: It does not change the status quo in the health system."<sup>284</sup> And, the status quo is politically easier to maintain than to overcome the following obstacles to fundamental reform:

1. *Institutional fragmentation*. Debate over healthcare reform produces numerous bills with diverse sponsorship.<sup>285</sup> Such fragmentation does not mean a majority supports any particular bill, although all may support healthcare reform.<sup>286</sup> In addition, there is an institutional bias favoring the status quo by requiring reformers to successfully clear multiple legislative hurdles while opponents only have to be successful at a single stage.<sup>287</sup>

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<sup>276</sup> "Analysis of GAO Update to Federal Government's Long-Term Fiscal Outlook," *supra* note 270.

<sup>277</sup> John Mauldin, "Debt Alarm Ringing," Thoughts from the Frontline, (Oct. 26, 2018).

<https://www.mauldineconomics.com/frontlinethoughts/debt-alarm-ringing>. The writer postulates a pending world-wide debt "train wreck" and eventual liquidation as debt is losing its ability to stimulate growth and growing at ten times the GDP it produces. A global economy breakdown could be triggered by any number of events including (1) corporate credit crisis, (2) trade wars and (3) European economic slowdown.

<sup>278</sup> Charles Roehrig, "'Moderate' Health Spending Growth Projections Exceed What We Can Afford," Health Affairs Blog, (Aug. 10, 2016) DOI 10.1377/hblog20160810.056124.

<https://www.healthaffairs.org/doi/10.1377/hblog20160810.056124/full/>

<sup>279</sup> Relman, *supra* note 252.

<sup>280</sup> Jonathan Oberlander, "The Politics of Health Reform: Why Do Bad Things Happen To Good Plans?" Health Affairs (Aug. 27, 2003).

[https://pdfs.semanticscholar.org/9557/8bb06a569ea44b95e91807322e360fb52554.pdf?\\_ga=2.159639549.1505227016.1543181514-525293917.1543181514](https://pdfs.semanticscholar.org/9557/8bb06a569ea44b95e91807322e360fb52554.pdf?_ga=2.159639549.1505227016.1543181514-525293917.1543181514)

<sup>281</sup> *Id.*

<sup>282</sup> *Id.*

<sup>283</sup> Loker, *supra* note 150, Pg. xx.

<sup>284</sup> Oberlander, *supra* note 280.

<sup>285</sup> Oberlander, *supra* note 280.

<sup>286</sup> Oberlander, *supra* note 280.

<sup>287</sup> Oberlander, *supra* note 280.

2. *Unbalanced political arena.* Any threat to national health spending for any member of the medical-industrial complex represents a threat to that member's income.<sup>288</sup> As demonstrated before, these groups are organized, financed, and willing to block any legislation perceived hostile to their financial interests.<sup>289</sup> On the other side are millions of uninsured individuals without resources and organization to complete.<sup>290</sup> The well-insured are unlikely to support healthcare reform that may alter their existing medical care arrangements, thereby reproducing the "politics of indifference."<sup>291</sup>

3. *Political culture.* Since the American Revolution, there "has been a strong antigovernment streak in U.S. politics that is suspicious of centralized authority and confident of the virtues of individual responsibility and free markets. This has made national health insurance an attractive target for ideological opponents to any expansion of federal authority."<sup>292</sup> Nonetheless, opinion polls indicate there is a general ambivalence about government supported healthcare for certain segments of the population and for much of the past fifty years a volatile and suspect majority have favored adoption of a national health insurance program for all.<sup>293</sup>

As stated above the status quo is easier to maintain than any adoption of any well planned healthcare reform measure. However, "a plan that is politically out of the question today may be feasible in a decade, so the only reliable judgements about political feasibility are those made for the short term, and those judgements are not reliable guides to the future."<sup>294</sup> Health reform plan options fit into one of three categories based on (1) the existing mixture of employer-based insurance with Federal tax subsidies and public insurance for certain populations, (2) individual insurance with individual tax subsidies similar to the Affordable Care Act, and (3) a national health plan with price controls.<sup>295</sup> Only a national health plan can set the necessary spending limits.<sup>296</sup>

B. National Health Plan. "Historically, the United States has focused on transforming patients into consumers through demand-side cost containment tools, such as higher deductibles and copayments that attempt to reign in individuals' demand for medical services. Canada and other industrial democracies have, by contrast, embraced supply-side cost containment, with global budgets, fee schedules and limits on diffusion of technology. These nations have sought to shield patients from rising costs of medical care, generally imposing no or very low levels of cost sharing. The result: Americans have the highest cost sharing and the highest healthcare spending in the world."<sup>297</sup>

1. *Access First, then Cost Control.* Building access through incremental programs such as the Affordable Care Act may be politically expedient as the individual mandates are

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<sup>288</sup> Oberlander, supra note 280.

<sup>289</sup> Oberlander, supra note 280.

<sup>290</sup> Oberlander, supra note 280.

<sup>291</sup> Oberlander, supra note 280.

<sup>292</sup> Oberlander, supra note 280, citing J. Morone, "American Political Culture and the Search for Lessons from Abroad," *Journal of Health Policy, Politics and Law* (Spring 1990): 129-143.

<sup>293</sup> Oberlander, supra note 280, p. W3-395.

<sup>294</sup> Oberlander, supra note 280, p. W3-396.

<sup>295</sup> Oberlander, supra note 280, p. W3-397.

<sup>296</sup> Oberlander, supra note 280, p. W3-397.

<sup>297</sup> Oberlander, supra note 280, p. W3-398.



perceived as converting an entitlement into a responsibility.<sup>298</sup> However, expansion of coverage without cost controls will ultimately strain the public budgets and compromise is complicated by a polarized Congress.<sup>299</sup>

2. *Cost Control.* As the trajectory of healthcare costs rises, healthcare reform becomes a national agenda item, but the more likely a reform proposal is to control costs, the less likely it is to be politically viable as it either reduces access or the medical-industrial complex income.<sup>300</sup> "Politically, the problem with national health plans is not that they cost too much but rather that they would take money out of the system."<sup>301</sup>

3. *Models.* There are different models of national health plans ranging from centralized, largely government operated systems like Britain's to employer-funded, multi-payer systems like Germany and other variations thereof.<sup>302</sup> Without discussing the prime elements of cost control, access and quality, most U.S. debate is focused on the two extremes of either maintaining the status quo or a single-payer system with the most centralized government operated system, like the Canadian plan.<sup>303</sup> Although geographically and culturally close to the U.S., the Canadian plan has features, which are particularly difficult to adapt in the United States.<sup>304</sup> In particular, Canada's system is a one-tier health system that prohibits the purchase of private health insurance for "covered" services and uses a centralized model of health insurance operating in each province as a public monopoly.<sup>305</sup> Whereas, a "Medicare for All" system would be culturally familiar and politically friendlier to the established U.S. medical-industrial complex, allowing the current players to continue to participate, but with modifications.<sup>306</sup> "The failure of U.S. health policy is not attributable to the absence of good reform plans; rather the lack of political will..."<sup>307</sup>

## VI. Conclusion

Although the need for comprehensive healthcare reform is compelling, the debate continues with no foreseeable solution leaving the status quo with healthcare being provided through employer funded insurance and fragmented governmental programs with access to care being expanded by mandate.<sup>308</sup> In order for significant healthcare reform to succeed in America certain fundamental conditions are required, including:

- A. There must be a constitutional right to provide healthcare funded by tax revenues.
- B. The people must provide the power and direct the government to exercise its right to provide healthcare.

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<sup>298</sup> Oberlander, supra note 280, p. W3-399.

<sup>299</sup> Oberlander, supra note 280, p. W3-400.

<sup>300</sup> Oberlander, supra note 280, p. W3-399.

<sup>301</sup> Oberlander, supra note 280, p. W3-400.

<sup>302</sup> Oberlander, supra note 280, p. W3-401.

<sup>303</sup> Oberlander, supra note 280, p. W3-401.

<sup>304</sup> Oberlander, supra note 280, p. W3-401.

<sup>305</sup> Oberlander, supra note 280, p. W3-401.

<sup>306</sup> Oberlander, supra note 280, p. W3-401.

<sup>307</sup> Oberlander, supra note 280, p. W3-402

<sup>308</sup> Oberlander, supra note 280, p. W3-401.

- C. Political ambivalence that preserves the status quo must be overcome by a sustained bottom-up social movement.
- D. In exchange for less individual financial responsibility, American tolerance for centralized authority must increase.
- E. Access to care being denied or restricted due to reasons outside the individual's control, such as cost, payment or program illiteracy, or service restrictions.
- F. Occurrence of a superordinate catalyst that makes change inescapable, such as uncontrolled health spending, world-wide debt crisis, or other worldly event that requires domestic cost controls.

all. With these criteria being met, the government will have the duty to provide healthcare for