THE FULFILLMENT OF THE UNITED STATES CONSTITUTIONAL DIRECTIVE
TO PROMOTE THE GENERAL WELFARE:
IN SEARCH OF A NATIONAL HEALTH CARE PURPOSE

By
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The members of the Committee appointed to examine the project of Kelly M. Bell find it satisfactory and recommend that it be accepted.

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The Fulfillment of the United States Constitutional Directive
To Promote the General Welfare:
In Search of a Health Care Purpose
Abstract
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The U.S. constitution’s preamble specifically addresses having a “common defense,” and as such the current military fulfills that directive. The words “health care” are not expressly worded in this document however, leaving it to interpretation whether or not health care should be provided by the government to all U.S. citizens. Because the constitution does state that one purpose of this country is to “promote the general Welfare” of “We the People,” it can be construed that the constitution would support a national health care plan that included in the entire populace. While Americans would never tolerate the military only protecting three quarters of the population, somehow, we tolerate this in health care. This paper explores the fundamental lack of purpose found in the United States health care policies that has led to greater disparities of health as well as leaving more than 16 percent of the populous of this country uninsured. Despite the great wealth of this country and health care expenditures of $1.1 trillion in 1998, more than 40 million people are without health care insurance, and consequently, without health care access. Despite the fact that the U.S. initiated Healthy People 2000 and 2010 with two national goals of increased quality and years of healthy life and to eliminate health disparities among different segments of the population; there is no mechanism to assure that private markets share these goals or will implement policies to attain them. The current system that provides health care in this country does not execute the U.S. constitutional directive of “promoting the General Welfare” of the entire population, but the continuance of the status quo that continues to benefit physicians, insurers, the pharmaceutical industry and well-insured Americans.

Current health care spending and programs such as Medicare, Medicaid, employer-based insurance, and tax subsidies as well as proposed programs such as a Medicare drug benefit and national
health care insurance are evaluated and costed. Legislative attempts to stem the tide of uninsured Americans are assessed as less than adequate as the cost of maintaining insurance was never addressed. Trends in population demographics and health care usage are confronted along with looking at governmental macroeconomic projections for future health care usage and cost as the population continues to age. Market based health care financing is seen in violation of supply and demand law of economics. Current as well as future rationing and the ethics that drive health care are challenged as unbalanced towards autonomy, neglecting social justice. By keeping health care insurance tied to employment means that all Americans, except the very wealthy, are one job away from not being able to access health care in time of need. It is past time for Americans to embrace their collective national inheritance to “promote the general Welfare” for all of “We the People,” and to insure that legacy to “our Posterity” by insisting that health care access be provided for everyone equally.
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Why U.S. Health Care Needs to Have a Purpose

The word ‘purpose’ is a simple double syllable word with a straightforward definition of *intent to do something* (Webster’s, 1988). The word can be aligned with such other words as end, objective, or mission. Perhaps it’s not the definition that is so difficult to grasp but the defining or narrowing of goals that is so difficult to contend with. Any entity having a profound effect on the citizenry of this country should have a clear, relevant statement of purpose that is politically arrived at and fiscally sound, since the U.S. is a democracy and it is unwise for people or countries to live beyond their means. Because private and public monies fund U.S. health care, it does not have one or even two overall, well-articulated purposes that encompass the entire populace. At a glance, it is a kaleidoscope pattern of patchwork programs, goals and fiscal management schemes designed to maintain the status quo. The Amish quilt is admired and coveted throughout this country for its blending of differing fabrics into a warm, practical mosaic of warmth and beauty. But unlike the Amish quilt, the U.S. health care system is a patchwork of programs and financing schemes, each pulling away from the whole, leaving up to one fourth of the population uncovered in the coldness of night with its inequitable access to health care.

The Legislative, Executive, and Judicial branches of the U.S. government are set up and run under the auspices of the United States Constitution and the interpretation of this unique document. Perhaps the most quoted and famous part of this manuscript is the preamble,

> 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, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America (Constitution, 1787).

Each of the three branches of the government is to carry out this mandate to the best of their ability with each sphere of influence being balanced and responsible to the other branches with ultimate accountability to the American people.

The U.S. government has maintained a “common defense” using the Army, Navy, Airforce, and Marines and as such, has fulfilled the constitutional directive. Their objective or purpose is to protect American lives and land from assault from outside forces. The Department of Defense articulates a very clear mission statement,
To support and defend the Constitution of the United States; to provide for the common defense of the nation, its citizens, and its allies; and to protect and advance U.S. interests around the world.

To accomplish this mission, the Department maintains trained forces ready to respond to threats to U.S. security arising anywhere on the globe (Defense Strategy, 2000, p. 1+).

While the Department of Defense addresses other activities of the military in its documents, such as humanitarian and peacekeeping efforts, natural disaster relief, drug interdiction, and security at international sporting events; these are not considered part of the military’s purpose or priorities in planning and budgeting. Indeed, any activity outside of the military’s budget and afore mentioned mission statement must obtain an emergency appropriation from congress; as the military does not have approval to move money from one budget year to another or from one program to another (Defense Strategy, 2000; Defense Budget, 1995).

In order to procure funds from congress with presidential support for the last 4 fiscal years of the Clinton administration, the military performed a Bottom-Up Review, which was completed in September of 1993. Each branch of the military, in preparation of this new budget, “carried out a year-long assessment of defense strategy, force structure, priorities, and programs” (Defense Budget, 1995). In this budget was a clearly articulated mission statement with short and long-term goals to fulfill that purpose. The military organization asked for and received $250-$260 billion per year through 2001, representing approximately 3.4 percent of the Gross Domestic Product (Defense Budget, 1995).

That there are national contracts awarded and money to be made by nonmilitary business for new and improved tanks, weaponry, and planes is an offshoot of the military’s purpose, but not the purpose itself. That there are civilian businesses that prosper in close proximity to U.S. bases that bolsters the local economy is a welcome outcome, but not the purpose of the base. The purpose or intent of a ready military machine is for national defense and to fulfill the constitutional directive. The fulfillment of that purpose is what the military will be measured against in time of conflict and war, not that they made a few businesses rich or incurred cost overruns. If the U.S. military wins a war, it will be considered a success. If the U.S. losses a war and American soil is subject to a foreign government, regardless of the money spent and the talent infused, the military will be considered an abject failure. It will have fulfilled its constitutional mandate by existing; however, it will have failed its stated mission, purpose, and goal. While failing to
perform a purpose can have catastrophic consequences, perhaps more tragic is the lack of purpose at all. Without purpose there are no goals or objectives to meet or to be measured against. Without purpose there is no vision or clearly articulated plan for the future or built-in accountability for its success or failure. Without purpose there is only the throwing of more good money after bad.

While a "common defense" is specifically addressed in the constitution, "health care" is not expressly worded nor mentioned in this famous document. This makes interpretation of the text necessary and controversial, regardless of where various parties stand on the debate that health care is a right of all U.S. citizens. The argument can be forwarded that health care for all Americans is constitutionally supported, making it subject to governmental control and policy setting similar to the U.S. military. Constitutional authors penned the words "general Welfare" and few would argue the statement that primary health care does promote general well being to those who receive it (Churchill, 1994). While the writers of the constitution could not have possibly envisioned the health care possibilities of the twenty-first century, it would be safe to say they also could not have envisioned the 'smart bomb' or stealth fliers used by the military, either. The creators of this document envisioned a country that "promote[d] the general Welfare" of "We the People" looking to the future by including "our Posterity." Because the framers would have every American protected by the military, not just three-fourths of the population; it would not be a stretch of the imagination to include health care in their goal of promoting the general welfare of the entire population. This would support the argument that a single governmental entity should control health care in this country. Government control/oversight would be supported by the constitution; it would, by its political nature, have to have purpose and goal setting with built-in accountability and clear budget constraints very much like the U.S. military.

Military preparedness falls under the U.S. government’s purview for comprehensive goal setting, planning, and budgeting. It would be inconceivable for the military to be privatized in order for it to somehow be made more efficient, profitable, or better than it already is. It would also be incomprehensible for the military to charge or collect money from individual U.S. citizens for its services over and above what is already collected by taxation in order to benefit from its protection. This paper argues that health care for all U.S. citizens would benefit from the same governmental oversight, planning, and budgeting that is currently seen with the military. All citizens would be protected versus only three quarters of the
population; there would be a national purpose for health care, and as such, accountability for health care outcomes not currently seen with the current mix of private and governmental plans.

What is the purpose of health care in the United States currently? Some would say that it is to provide the best health care that money and research can buy. Considering the underserved and uninsured rates found in the U.S. one has to wonder...for whom? Others would say that it’s to make doctors wealthy since health care expenditures are how they make a living (Iglehart, 1999). Still others would argue that it is just another commodity to be bought and sold on the New York Stock Exchange at a profit. Callahan (1995) argues that the goal of medicine seems to be the complete eradication of all known causes of death and mortality in the attempt to defy the surety of death. Others would argue its goal is to protect insurers against risk (Churchill, 1994). Some would say it bolsters the economy since the U.S. health care industry is a trillion dollar industry employing some nine million people (Iglehart, 1992). But again, while these are consequences of health care, none qualify as a purpose. Healthy People 2000 and its more current version 2010 envision the fulfillment of two goals; increase quality and years of healthy life and eliminate health disparities among different segments of the population (Healthy People 2010, 2000). While these are admirable national goals, there is no mechanism in place currently to assure that the private markets share these goals or will implement policies to attain them. With health care expenditures doubling the national inflation rate year after year, consuming more of the gross domestic product, it would behoove this country to seriously look at this question and answer it; “What is the U.S. health care purpose and how best to implement it” (Churchill, 1994; Kuttner, 1999)?

Because of health care’s escalating cost, many health care and economic experts are warning that Americans simply cannot afford the open-ended health care system as it is currently set up and have proposed various rationing scenarios. If one considers rationing involving a commodity that is not actually scarce, but done economically by price, health care rationing is a current phenomenon versus a distant threat in this country, at least to the underinsured and uninsured (Churchill, 1987). While most of these same health care and economic experts acknowledge current rationing by ability to pay is unjust, they are stymied about how to deliver health care to such a culturally diverse populous. Health care costs cannot be contained regarding choice, cost of treatment or accessibility without having limitations placed on everyone. Some have put forth arguments, for and against, limiting health care to the elderly, especially
high-tech-end-of-life care that is so costly with little apparent benefit (Arcangelo, 1994), (Baltz & Wilson, 1995; Bodenheimer & Grumbach, 1998; Callahan, 1993, 1994, 1995, 1998; Churchill, 1987, 1994; Clark, 1985; Fisher & Gill, 1996; Hunt, 1993; Jecker & Pearlman, 1992; Lantos, Mokalla, & Meadow, 1997; Levinsky, 1998; Pawlson, Glover & Murphy, 1992; Shaw, 1994; Williams, 1997). Before rationing health care in a different way from the present, and proposing changes to the system with its attendant ethical issues can be seriously entertained on a national scale, Americans need to first look closely at what we want our national health care purpose to be (Churchill, 1994).

Only when overall goals are clearly articulated can the aims and actions of the particular players be assessed. So in the real sense, any ethical analysis of the U.S. health care system can go no further until it is determined what is worth doing, what purposes should command our allegiance. Short of that determination of values, there is no benchmark against which to measure the actions of insurers, physicians, patients, or any of the other participants (Churchill, 1994, p.14).

While the United States is known to be the ‘melting pot’ of the entire world and made of up diverse political, ethnic, and racial groups, it is also well known for its populous stance for low taxes and generalized distrust of government (Iglehart, 1992). While diversity enriches this nation, it is this very lack of cohesiveness that has failed to bring the American people together to force legislators to enact a national health care policy that would include everyone. Without purpose there are no goals or objectives to meet or to be measured against. Without purpose there is no vision or clearly articulated plan for the future built-in accountability for its success or failure (Churchill, 1994). Without purpose there is only the throwing of more good money after bad. Without purpose there is only more of a patchwork quilt of health care goals and management to endure with an ever-increasing fragment of the population without coverage. Without purpose the only people to benefit from our current health care system are physicians, insurers, the pharmaceutical industry, and well-insured Americans, leaving the rest of Americans to fend for themselves. Without a national health care purpose there will be no “promote the general Welfare” for “We the People” and “our Posterity.” There will be only the promotion of the welfare of those with money; there will not be an inclusive policy designed with everyone in mind that looks to future generations of Americans.

Americans were offended when the military could not extrapolate American hostages in Iran for 444 days beginning November 4, 1979. “For the United States, as a superpower, the hostage crisis marked
a turning point in its climate of opinion—from aversion to war and foreign entanglements born out of the Korean and Vietnam experiences to one of support for assertiveness and military preparedness” (Tehranian, 1997, p.1+). If such an event involving less than 20 persons could generate significantly increased military spending and doom President Carter’s reelection campaign; it would be safe to say that Americans would never tolerate any elected official that proposed the military only defend three quarters of the U.S. citizens and their property from foreign assault. If Americans are so clear about our military’s objectives, why do they remain so ambiguous regarding health care for every citizen? Do Americans look at military benefits as having more value than health care? Monetary expenditures say otherwise. If the amount of money in a budget suggests priority of interests, it is safe to conclude that Americans prize health care over any other benefit offered a U.S. citizen that comes with a price tag, including the military.

**U.S. Health Care Spending Now**

The World Health Organization (WHO) analyzed and evaluated the healthcare delivery system of each of its 191 members, the report being released in June of 2000. WHO did not rate the countries by infant mortality and morbidity statistics, as one might expect; but it evaluated each country’s resources to provide for its entire population and how well it did that. Prior assessments of health by the WHO looked only at how healthy people were, while this assessment looked at resources and the distribution of those resources. Perhaps the most striking aspects of the report are the evident imbalances of healthcare costs and number of years of life one can expect to live in a particular country. France, while rated at the top spent only $2,125 per citizen per year in contrast to the U.S., being rated 37th, spent $3,724 per person on health care per year. A French citizen, while spending less, could also expect to live three years longer than an American citizen. The differences in costs and longevity are succinctly summed up, “Americans—while good at expensive, heroic care—are very poor at the low-cost preventive care that keeps Europeans healthy” (Ross, p.2). According to Churchill (1994) the blame for the U.S. high cost and lack of access can be summarized as a lack of purpose; a lack of a national healthcare policy.

While the WHO study sighted the United States as spending $3,724 per person on health care, the Health Care Financing Administration (HCFA, 2000) reports that in 1998 spending was 13.5 percent of the Gross Domestic Product (GDP). Translated into dollars that is $4094 per person on healthcare. These
figures are further skewed by the fact that the current 40 million noninsured population while being factored into the $4094 per person equation, are not a part of the population with access to that healthcare. Consider three other countries with national health care policies controlled by their respective governments: Germany, United Kingdom, and Canada. While the television commercials (usually sponsored by pharmaceutical and insurance companies) attempt to sway the American public with “a governmental controlled…” fear tactics, these other three countries have a higher satisfaction rate with health care delivery and outcomes than the U.S. “In a 1990 survey of 10 nations, Canada ranked first in public satisfaction with the health care system. West Germany ranked third, the UK ranked eighth, and the United States came in last” (Bodenheimer & Grumbach, 1998, p.256). The other three countries have lower infant mortality rates, higher life expectancy rates for men and women, as well as spending significantly less of their GDP for that health care. In 1995 while the U.S. spent 14.2 percent of its GDP covering most of its citizens, Germany spent 10.4 percent, United Kingdom spent 6.9 percent, and Canada spent 9.6 percent covering all of their citizens (Bodenheimer & Grumbach, 1998).

The U.S. government is the single largest purchaser of healthcare services and products in the country. In 1998 it spent $217 billion in Medicare payments for the elderly, disabled, and transplant care, and $176 billion in public assistance payments for the poor. National expenditures for healthcare totaled more than $1.1 trillion in 1998 (U.S. Census Bureau, 2000, May 5). Health Care Financing Administration (1998) published an actuary report predicting future spending through the year 2008. Before recording its predictions, the report had a caveat stating, “it is important to recognize the uncertainty inherent in the projection process. These estimates must be regarded as an indication of possible trends, conditional on our assumptions regarding future macroeconomic conditions, as well as assumptions regarding the nature and impact of future institutional change in the health sector” (p. 2). The report predicts, National health expenditures are projected to total $2.2 trillion and reach 16.2 percent of GDP by 2008…these developments are expected to increase growth in health spending through 2001, after which growth is projected to decelerate through 2008 [emphasis author’s]. Factors acting to restrain growth over the next decade include the implementation of the 1997 Balanced Budget Act (BBA), a projected increase in the uninsured fraction of the population, the continued (although
smaller) impact of managed care, and the effect of projected excess capacity among health
providers" (1998, p.2).

The report goes on to predict slower spending for pharmaceuticals as fewer drugs are introduced into the
market and a trend away from hospital inpatient stays and home healthcare as the BBA further reduces
reimbursements for these services. The report also predicts a slower growth in the elderly population over
the age of 85, which will reduce the demand for these services. Analyzing this report and comparing it
with others published by other U.S. governmental agencies makes for interesting reading at best. Other
reports contradict many of these suppositions which will be addressed in the section discussing health care
of the 65 years of age and older section further in this paper.

Under 65 Years of Age and Insured, Underinsured, or Not Insured at All

It is now estimated that there are currently 43.4 million Americans that have no health care access
because they lack insurance; this represents 16.3 percent of the population (Kilborn, 1999; U.S. Census
Bureau, 2000, January 24). Despite the unprecedented strong economy of the 1990s, more Americans than
ever are uninsured. Part of this phenomenon is related to the fact that the fastest growing groups of
employers are small business owners who cannot afford rising health care insurance premiums (Kuttner,
1999). “About half of businesses with fewer than 200 workers did not offer health insurance in 1998, while
nearly all companies with more than 200 employees did”(Alliance of Health Reform, 2000, p.2).

To assist people in maintaining their health care insurance, congress enacted the Health Insurance
Portability and Accountability Act (HIPAA) in 1996. This act was to enable people with health conditions
not to lose their protection with a job change and gives self-employed persons tax breaks when they buy
insurance (Alliance for Health Reform, 2000). HIPAA provides no subsidy for health insurance in the event
of job loss and does not regulate health care insurance prices. So while HIPAA “prohibits outright denial of
insurance because of previous medical conditions, it allows insurers to charge people with previous
conditions substantially higher premiums, thus sharply limiting effective coverage” (Kuttner, 1999, p. 165).

While HIPAA could theoretically protect 25 million Americans, by its non-regulation of prices, it affects
only a few thousand people (Kuttner, 1999). Another legislative act assisting Americans to keep current
health insurance benefits was the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA).
COBRA allows people to privately pay their insurance premiums when leaving a job. Like HIPAA, COBRA does not address the economics of keeping that insurance affordable (Kuttner, 1999). Just under one million people joined the uninsured ranks last year alone; and it is estimated that by 2008 there will be 55 million Americans without health insurance unless the government does something about it. (Alliance for Health Reform, 2000). “Because of its link to employment, health insurance may be a fleeting benefit” (Bodenheimer & Grumbach, 1998, p.24). Unlike the United States, Canada and United Kingdom do not tie their national insurance plans to employment, making job transition less stressful and inconsequential in regards to maintaining access to medical care (Bodenheimer & Grumbach, 1998).

Most Americans, who have insurance, obtain it through their employer. This system of private health insurance has been linked to employment since WWII, when worker shortages and wage freezes made it imperative that an incentive be offered to tantalize potential employees. In 1987 67.2 percent of non-elderly employees had employer-based health insurance. While that percentage dropped in the early nineties because of escalating insurance premiums, it is estimated that 64.2 percent of employees had employer-based insurance in 1997 (Kuttner, 1999). Despite low unemployment in the 1990s, unions are weak and employees have far less bargaining power now than in the past. With the merger and acquisition frenzy of the 90s there is less employment stability and less employee connection with firms further eroding this once meaningful benefit (Kuttner, 1999).

An advantage of employer based insurance is that group buying through a large employer allows for better pricing as risk is shared by many. A large and/or wealthy business providing health care insurance is a win-win for both the employer and the employed. Insurance benefits are not taxable income to the employee because this benefit is exempted from state and federal income tax. The benefit is a deductible business expense for the employer who provides this benefit. While this method of insurance acquisition is traditional over the last 50 years, it is seen as inequitable on several points. With the current tax code, this benefit is regressive, worth more to those with higher incomes. People with the higher incomes have better insurance benefits and therefore, the most nontaxable ‘income.’ “The exclusion from income taxes and Social Security payroll deductions creates a substantial tax subsidy for employment-based insurance” (Iglehart, 1999, p.71). The cost of this benefit to the U.S. government is estimated at $76.2 billion in 1999 and projected to cost the treasury more than $430 billion in tax revenue between 1999
and 2003 (Alliance for Health Reform, 2000). If this subsidy represented a single insurance program it would be the most expensive one after Medicare and Medicaid (Iglehart, 1999).

Not everyone benefits from this current tax code. While slightly more employers are offering health insurance benefits, fewer workers are taking them because of “shifted costs to employees by capping the employer’s contribution, choosing plans with higher out-of-pocket payments, or both” (Kuttner, 1999, p.163). Workers who tend to be lower on the socioeconomic scale, those working part-time or minimum wage jobs, and who work for small businesses often have no access to health care insurance, or the insurance is too cost prohibitive to obtain, especially for a family. When these businesses do offer insurance many employees do not participate because,

Employees often have to pay a large share of the total premium, and family incomes for many are too low for them to afford the monthly premium... It costs workers an average of just $84 a month to buy the cheapest family policy in a company where the typical wage surpasses $15 an hour. In contrast a company where hourly wages are about half that, the cost to the worker is $130 a month (Alliance for Health Reform, 2000, p.2).

The paradox of the push to clear welfare rolls and employ these Americans, is what it has done to their health care benefit. Eighty-four percent of Americans without health care insurance are working full-time jobs or are the dependent of a full-time worker. About half of these workers are living at or below the federal poverty level. It is ironic that a full-time worker is more likely to be without health care insurance than one who does not work. An unfortunate fallout of the federal Welfare to Work Program was that 49 percent of women who had left the welfare roll, within one year had effectively lost their health care insurance. This same program saw 29 percent of children lose their access to health care insurance at the same time (Alliance for Health Reform, 2000). These facts counter the myth that uninsured persons are lazy or seek to manipulate ‘the system.’ Most uninsured people do work and work full time; they just do not have health insurance benefits that are affordable.

The consequences of being without health care insurance are many. The uninsured person is 70 percent more likely to go without needed treatment necessitating an expensive emergency room visit or hospital stay. Twenty-five percent of uninsured adults rely on emergency medical room care for routine care compared to 6 percent of insured individuals. An uninsured adult is 35 percent more likely to die than
the same aged adult with insurance is (Alliance for Health Reform, 2000). “Children in low-income communities get sick more often from preventable acute and infectious illnesses such as measles, conjunctivitis, and ear infections; and are more likely to suffer from chronic medical conditions such as asthma and diabetes” (Children’s Defense Fund, 2000, p.2). Black infants under the age of one are twice as likely to die than a white infant is. A black infant is four times more likely to die from low birth weight consequences than a white child is. This data suggests inequities in access to prenatal care (Children’s Defense Fund, 2000). The uninsured cannot depend on charity of hospitals and physicians as in the past. The pressure of the Balanced Budget Act and managed care competition has driven down profit margins, making cost shifting once enjoyed by hospitals (charging patients with insurance more), and philanthropy harder to come by (American Hospital Association, 2000).

The current private health care insurance business is clearly set up for their economic and profit taking interests to be protected. The goal of every insurance company is to make a profit like any other business entity in the U.S. Just because health insurance companies deal with the health or sicknesses of individuals, they are not exempt from stockholder wrath should profit margins erode. The health insurance business in the U.S. is ‘for profit’ and will remain so unless the government itself takes on the mantle of providing health care to every citizen, thus freeing up the ‘profit’ for health care delivery. Woolhandler and Himmelstein (1991) reported that Canada spent 11 percent of its total health care dollars on administrative expenses, while the U.S. spent 25 percent on administrative expenses in the same year. Canada, having a tax-financed health insurance program, eliminated the need for private insurance marketing and profit taking while at the same time simplifying enrollment. Claims processing is streamlined under a global budget process and eliminates the need of expensive case-by-case utilization review process that is inherent in the U.S. system (Bodenheimer & Grumbach, 1998).

The Oregonian Newspaper published in Portland, Oregon recently featured a story about Jackson County, population 175,000. As of December 31, 2000 Providence and Regence HMO Oregon, the two largest providers of HMO (Health Maintenance Organization) type insurance, are completely pulling out of the county. While HMOs have recently been vilified in the media, they have typically been more responsible in tracking patients’ health maintenance needs like mammograms and immunization status, as well as having low co-pays for prescriptions and visits. With the HMO pullout, this leaves employers
scrambling to provide insurance coverage for their employees, including Providence Medford Medical Center. Because many employers cannot absorb the 20 to 30 percent rate hike of a managed care plan, employees will be going without health care insurance in many cases or contributing much more in the way of premiums and deductibles. Currently 20,000 people in Jackson County who are enrolled in the Oregon Health Plan (national and state funded insurance for low-income Oregonians), do not have a health plan responsible for insuring that these people have a physician or nurse practitioner to care for them. The consequences have already been felt in the two area hospital emergency rooms this year. One hospital reports a 10 percent increase, while the other reports a 37 percent increased utilization of emergency room visits for non-urgent care. The other outcome of the lack of primary care is that the county clinics previously set up to care for the underinsured (22,000+ people) and uninsured (22,000 people) are filling up with insured patients who have no primary care provider. The causes for this are complex; first the HMO plans underpriced themselves to get marketshare. Secondly, there has been unprecedented growth in the need for expensive treatments and prescription medications. While Preferred Provider Organizations (PPO) are gaining in popularity with physicians and employers, it remains to be seen how they will keep costs down without resorting to limits on services (Rojas-Burke, 2000). It is unlikely that Jackson County will remain an outlier in health care market insurance trends for long.

Interestingly enough, the American government has been drawn into the health care business by providing insurance for people that private markets have rejected, veterans, the elderly, the poor, Native Americans, people with end-stage renal disease and HIV infection. “The protection of insurers from ‘bad risks,’ underwritten by the belief that a private market for health care is workable if properly adjusted or regulated, is not just a part of the system, but one of its goals” (Churchill, 1994, p.13). Why should the U.S. government subsidize the high-risk and not have the advantages of the low-risk clientele that insurance companies have, in order to bring down costs for everyone? While administrative costs for the private sector insurance are high, Medicare’s administrative costs are two percent (Himmelstein & Woolhandler, 1996). So much for ‘governmental inefficiency.’ How much profit is morally acceptable given that the alternative to health care is the very real fear of disease, disability and death? Is being profitable a morally acceptable health care goal? Americans do not have to worry about whether or not the military will protect them in time of war, why should they worry that they will be rejected to have their basic health care needs
met because of the of the lack of money? These types of private insurance business practices should be held to the light of day with all Americans questioning: how does privatization of health care “promote the general Welfare” of “We the People” “and our posterity?”

65 Years of Age and Older Health Care

In 1965 President Johnson signed into legislation the Medicare Insurance Act. Its goal was simple, provide those people over 65 years of age with medical insurance. Before its enactment, the 65 years of age and older age cohort had an insurance rate of approximately 50 percent. This same age group is now insured at the rate of 97 percent. The goal of Medicare was to provide these people health care access that would not cost them their life savings, or that of their children’s (HCFA, 2000). The health care provided to seniors has done so well that a 65-year-old man that had a life expectancy of 77.9 years in 1965 now has one of 80.9 years. A women in 1965 had a 80.9 year life expectancy, now has a 84.2 year life expectancy post Medicare enactment. As he signed the Medicare program into law, President Johnson said,

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and to their aunts... No longer will this nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country (HCFA, 2000, p.2).

Medicare is the largest public insurance in the U.S. financing 19 percent of healthcare with taxpayer monies from four different sources. Medicare requires all employers and employees to make payments into the trust fund. General tax revenues, premiums paid by beneficiaries, copayments and deductibles make up the other three revenue sources. It guarantees every citizen aged 65 and above, citizens disabled more than two years, and transplant recipients healthcare coverage. Every employee and employer pays into the trust fund with the understanding they will one day draw from the fund themselves. What most people do not understand is the fact that current contributions are being spent now, monies are not set aside for future use, but are used for the current beneficiaries health care needs (Iglehart, 1999). It is
important to note that, “most beneficiaries who require medical care receive far more from the program than they contributed in payroll taxes, and far more than members of the baby-boom generation, the first of whom will turn 65 in 2010, are likely to receive” (Iglehart, 1999, p.328). Despite problems, Medicare enjoys strong intergenerational support. Any politician seen jeopardizing or threatening this program puts themselves in peril at election time (Iglehart, 1999).

In 1998 there were 38.8 million enrollees, 35 million of those are 65 or above (HCFA 2000, January 10). The Administration on Aging (1999) predicts that in 2010 there will be over 40.1 million people above age 65, in 2020 there will be 53.3 million, and by 2030 there will be 70.1 million over age 65. This isn’t counting the disabled and transplant recipients. In the next 30 years the population of one age cohort is effectively doubling.

The fastest growing age group in the over 65 years category are those 85 years and older. In 1900 there were 122,000 people 85 and older, while in 2000 there are 4.3 million. This same report by the Administration on Aging predicts that by 2030 there will be 8.8 million people 85 years and older. The National Institute of Aging (1996), reports that while the U.S. population is aging dramatically, “…it is currently projected that there will be as many people age 85 and older as there are people age 65 to 69” by the middle of the 21st century (p.2). The ramifications of having such a large elderly population is obvious, “increasing age heightens the probability of functional limitations.” (p. 2). The report further states, “In one survey, 9 percent of people age 65 through 69 required day-to-day assistance, including help with bathing, dressing, and eating, compared with 50 percent for those aged 85 and older” (p.2). The elderly currently fill 40 percent of the hospital beds at any given time (Arcangelo, 1994). National hospital inpatient and ambulatory centers in 1996 performed 13.6 million procedures on people over the age of 65. “This is 401.0 visits per 1,000 population, which was approximately three and a half times the rate of 114.4 for persons under 65” (Hall, 1999). Keep in mind HCFA’s own actuary report, projecting future national health care expenditures, stated that this age cohort growth was slowing, thereby reducing the need for inpatient and homecare services. This is highly unlikely considering this age group’s current utilization and future growth projections, which will necessitate more inpatient and homecare services, not less.
Here Come the Baby Boomers

One would have to live in an information vacuum in this country not to be aware that Medicare is in trouble financially. While Medicare recipients represent 12.7 percent of the population in 1998 they are expected to represent 20 percent of all Americans in 2030. In 1970 it took 3.7 younger employees to finance 1 senior citizen, in 2000 it takes 3.4. It is projected to take 2.2 younger workers to maintain solvency of social security and Medicare by 2030 when the last of the baby boomers enroll in Medicare. That means that payroll taxes will have to be raised substantially for younger workers to subsidize older Americans health care expenses at current levels. Expenditures for Medicare recipients in 1998 exceeded $216 billion, which computes to $5410/beneficiary (HCFA, 2000, January).

To slow the growth of Medicare many financial restraints have been put into place in the attempt to assure its viability when the largest age cohort, the baby boomers, enter their 60s. Hospital and medical providers were primary targets of the Balanced Budget Act as well as attempting to lure seniors into managed care programs. The Balanced Budget Act (BBA) was signed into law in 1997 with the goal of extending the life of the Medicare Trust Fund. The BBA expanded preventative health maintenance for seniors, covering such things as mammograms and vaccinations. It also has significant bite in fines and penalties for those committing Medicare fraud as well as rewards for those who report those frauds. But the main thrust of the BBA was to reduce Medicare and Medicaid growth (HCFA-BBA, 1997).

Congress directed HCFA to replace Medicare’s cost-based reimbursement method with more restrictive prospective payment approaches that would apply to postdischarge services, the fastest-growing component of Medicare in the 1990s. These services include skilled-nursing facilities, hospital outpatient services, inpatient rehabilitation services, and home health care. The growth of home health services, one of two major Medicare benefits for which there is no cost sharing by the beneficiary…has been particularly explosive; total expenditures increased from $2 billion in 1988 to more than $17 billion in 1997, largely because of increased rates of use…In 1997 1 in 10 beneficiaries received home care, and the average number of visits exceeded 80 (Iglehart, 1999, p.329).

HCIA-Sachs and Ernst & Young (2000) recently published a study on behalf of the Federation of American Health Systems detailing the erosion of profit margins post BBA 1997 enactment. The purpose
of the report was "to present a comprehensive picture of the current and anticipated state of the hospital industry's financial health in light of the Balanced Budget Act and the Balanced Budget Refinement Act" (p.2). They cite incomplete information of the Medicare Payment Advisory Commission (MedPAC), a nonpartisan body that advises Congress each year on Medicare policy, as leading to mistaken conclusions that hospital finances are robust. While the study agrees that Medicare inpatient margins of 16.9 percent in 1997 were consistent with MedPAC projections, they represent only a segment of the overall economic representation for hospitals. Inpatient Medicare margins have declined from 15.8 percent in 1998 to 13.1 percent in 1999. Total hospital margins which measures the margin on all hospital services to patients of all payer classes has been significantly reduced from pre-BBA levels. Margins have declined from 5.5 percent to 2.6 percent in 2000 since BBA enactment. Many hospitals with less than 100 beds (often in rural areas) have reported margins at less than one percent. The reason many hospitals are in trouble is that they have diversified into other service lines such as outpatient care, skilled nursing and home health to meet the needs of their patient population (or to remain competitive). The BBA has significantly reduced outpatient payment, "payments that were already inadequate" (HCIA-Sachs, 2000, p. 1). Hospital outpatient margins, a negative 17 percent in 1998, were previously sheltered by over-inflated inpatient margins. Hospital outpatient margins are expected to drop to negative 27.8 percent by 2002 unless there is significant relief. "As outpatient revenues continue to increase as a portion of total hospital revenues, the impact of these negative margins will be even more injurious to hospitals" (HCIA-Sachs, 2000, p.1-2). Lower margins and higher costs related to pharmaceutical and technology advances led MedPAC to recommend a 3.5-4.0 percent payment inflation adjustment for fiscal year 2001 (HCIA-Sachs, 2000).

The unexpected fallout of the BBA, managed care, capitation, and increased competition has been the reduction of many hospitals credit rating in the bond market. Because of a weakened financial outlook, many hospitals are less attractive to potential lenders and may have to forgo needed upgrades in infrastructure and technology (HCIA-Sachs, 2000). The BBA was enacted by the legislature to reduce Medicare and Medicaid spending. That was the stated purpose and as such, can be considered successful. The unintended consequences of the BBA may be the ultimate closure of outlying hospitals leading to the rationing of health care to rural communities because it simply will not be there. This will further erode access not only for those without health insurance, but for those with health insurance. Another
consequence is the rationing of primary health care to Medicare and Medicaid recipients by implicit or explicit means, as providers attempt to remain financially viable for those with other insurances that pay a higher dividend.

Another disturbing trend is the rise of luxury hospitals in the U.S. catering to the baby-boomer generation. In a national weekly paper Japenga (2000) reports these 60 plus heart boutiques and orthopedic centers resemble a hotel room more than a hospital room or intensive care suit. These centers limit their practice to a single high-revenue procedure, thereby making it possible to offer amenities such as gourmet meals cooked by a chef and a nightly massage. “The trend is driven by anticipated demand from aging baby-boomer patients who are drawn to luxurious touches—such as herb gardens and stress-reducing aquariums—absent in traditional hospitals” (p.10). On the surface this would seem to be the ‘American way,’ giving full service hospitals competition and the paying public what it wants; however these luxury hospitals further erode general hospitals operating margins. Luxury hospitals only select high revenue capturing procedures and can be selective on who accesses them, unlike a general hospital. General hospitals argue they need the high revenue stream procedures to cover the other lower revenue, but vital services, like trauma and burn units. It would be unfortunate if a general full service hospital had to close its doors to an entire community because of a luxury boutique center siphoned off money to cater to one particular age group receiving one specific procedure. This trend will further erode health care access to everyone; even to the baby-boomer generation that wants his or her heart done at a luxury hospital will more than likely need a less cost-efficient or revenue generating medical procedure some other time in their life. Where will they go for that procedure or care if the general hospital is closed because of insistence of having one particular want met at one specific time of life? Is this a worthy health care purpose or goal?

While Americans applaud tax savings, efficiency, and even competition, it is doubtful that they would sanction rationing health care to those with insurance. After all, what’s the point of having health care insurance if you can’t access health care when you need it? Without a meaningful national health care purpose, stated policy and goals, the legislative branch has no choice but to do what they think best for the financial security of the Medicare trust fund, even if what they do has unintended consequences with far-reaching effects, as discussed above. Without overall governmental oversight of health care policy and
control these luxury boutique hospitals may very likely continue to expand and jeopardize essential care for numerous population groups needing other types of care that are not high revenue generating.

The lack of governmental management and planning of health care throughout the U.S. along with a closed-ended budget will continue to inspire various medical providers and hospitals to continue to duplicate services or restructure to a single high-revenue service stream. All of these will eventually erode health care for larger and larger populations, thus further endangering the constitutional mandate of “promoting the general Welfare,” of “We the People” “and our Posterity.”

Hail to the New Chief

The year 2000 is another presidential election year, and once again health care is on the tongues of politicians and the United States citizenry. This time Medicare prescription benefit packages are being hotly debated between the Republicans and Democrats of both houses as well as the presidential candidates. Prescription medications are being produced and then marketed to the public at an accelerated rate. While healthcare expenses are growing at seven to ten percent per year, prescription drug expenditures have grown to 17-20 percent (Day, 2000; Iglehart, 1999). Day further reports that half of the growth of prescription spending, over $100 billion in 1999, was for drugs that came into the market since 1994. Iglehart credits several reasons for this phenomenon,

- Broader insurance coverage of prescription drugs,
- Growth in the number of drugs approved by the Food and Drug Administration,
- And direct advertising of pharmaceutical products to consumers.

The use of some new drugs reduces hospital costs, but not enough to offset the increase in expenditures for drugs (p.75).

The recent push by President Clinton for congress to initiate Medicare prescription benefits highlights the costs to seniors for medications. Toppo (2000) reported that people aged 65 and over pay an average of $1,205 per year for prescription medication. This is double what it was in 1992. It is predicted that unless there are prescription benefits to older Americans, in the next 10 years those costs will exceed $2810 per year; the average cost of a prescription now being $42.30 is projected to be $72.94 in 2010 (Toppo, 2000). Older Americans consume twice the number of medications than all other age groups combined (Arcangelo, 1994). While there is much ‘finger pointing’ at the pharmaceutical industry for
excess profit taking; one has to acknowledge that there are more people living longer, taking more pills, often for the rest of their life, and there are better and more expensive drugs to take. This prescription benefit for Medicare beneficiaries, depending upon how generous it is, could cost $250 billion or more between now and 2010 (Rosenbaum, 2000).

In light of these facts begs the question, do senior citizens have the right to demand yet more healthcare expenditures on their age cohort when there are so many children and young adults without any access to health care? Considering the fact that the elderly will soon represent 20 percent of the voting population and Medicare’s vast popular support, it behooves Americans to look at this benefit from a rational and ethical perspective versus an emotional one. This issue highlights like no other current event that health care must have clear cut goals before approving yet another expenditure everyone will pay into, yet not have access to.

Health Care Financing in the U.S. Based on Free-Market Economy...or is it?

Health care in America is a trillion-dollar business and as such, is larger than most other nations entire budget. “It serves as a perpetual job-creating enterprise, providing employment to some 9 million people” (Iglehart, 1999, p.75). Financing of health care in the U.S. is free-market based which presupposes the following of the economic laws of supply and demand. Free market based health care is considered the least restrictive and promoting of individuals rights. Sade (1971), a physician who claims that there is no right to health care, equates physicians as bakers owning the bread. Since a physician owns his/her professional skills, they are obligated to serve only themselves. Sade argues that forcing a physician into a fee schedule or national health care plan is to rob them of liberty. Many physicians see the free-market based health care payment system as equitable. While a physician may donate part of their time to charitable care, they are not obligated to provide such. Like any other commodity on the market, health care can be purchased if one can afford it. While arguably, physicians have educated themselves, half of medical graduate education expenses are paid for with taxpayer money. Medicare in its 35-year report highlighting its goals and history, prominently states that it spends over $8 billion dollars per year on graduate medical education (HCFA, 2000). So while the baker may own the bread as Sade contends, it
would seem reasonable that the U.S. government could stipulate where the bakery would be placed in order to serve both the baker and the clientele.

While health care may be free-market based, it is not like purchasing a car. The problem is that people who are ill are physically, emotionally, and perhaps psychologically compromised. The very act of going to a health care provider for assistance is to admit that one has a “deficiency or a defect and to ask to have it alleviated. In effect, disease makes a petitioner out of an independent individual and threatens the person’s self-image” (Curtin, 1979, p.4). Churchill (1987) contends,

Seeking help when one is ill is not like shopping for a shirt or soliciting bids on a building project. The ‘sick role’ entails a somewhat compromised capacity to judge, and it includes a restriction on what is optimally only a theoretical range of choices about whom to see and how much to pay for services (p.77).

Because of this, Churchill asserts the concept of a patient as a ‘free agent’ a flawed concept.

Yet another argument against market based health care financing is that medicine does not follow the law of supply and demand as other retailers, and as such has been exempt/protected from the consequences of too much supply that generally lowers prices. Medicine is the only field in which the production of more physicians has resulted in more expense in health care because physicians generate their own business. Remember that HCFA’s (1998) report that projected excess capacity among health care providers would lower costs of health care. Medical providers are the ones who decide who needs what kind of care and how often and also receive the financial benefit of those decisions (Churchill, 1987; Enthoven & Kronick, 1989). This poses ethical issues with fee-for-service payment plans. The U.S. health system is also the most inflationary in the world because there is no closed-ended budget. Because of these variances with the laws of supply and demand, there is no real incentive to find and use best practices and to curtail marginal technologies (Enthoven & Kronick, 1989). Until capitation payment systems were instituted through the use of HMOs there was little to no incentives for cost control.

A third argument against the free-market based system is that it is entered into by the ability to pay for services. Churchill (1987) calls this “a tacit and unacceptable merit criterion for access to care” (p.77). While one would be hard-pressed to hear anyone say the poor are ‘unworthy’ of health care, the current system of financing supports this unethical stance. Market forces reward those with higher social standing
and better paying jobs with health care insurance, while disenfranchising those less fortunate. "Market justice says that disparities of wealth can legitimately translate into disparities of health care. It sees the financial barriers to health care as unfortunate, but not unfair" (Churchill, 1987, p.78).

Americans need to question the premises that medical providers should be exempt from governmental control regarding practice type (general or specialized practitioner), monetary compensation, and standards of care. To maintain the current status quo is to encourage the continuing practice of more physicians becoming specialists, serving the few with higher compensation patterns, than generalists, serving the many with lower compensation patterns (Bodenheimer & Grumbach, 1998). The public also needs to ask themselves, "How much wealth is acceptable for a physician or a system to gain being that it comes from vulnerable people?" Perhaps it would be in Americans' best interest to completely underwrite graduate medical education with tax payer money in order to oblige what specialty a physician practiced and where, to better meet the needs of the entire population. It is conceivable that until physicians are employees of the U.S. government (i.e., the American tax paying public), that they will continue to pick and choose among individuals whom they will and will not treat based solely on whether or not that individual can pay for that health care.

Rationing Health Care in the United States: History and Implications

According to Churchill (1994), a definition of rationing would be the fair sharing of limited goods according to a centralized plan. An economic view of rationing is much broader entailing the withholding of any beneficial service whether or not it is necessary. "Economists view rationing as being omnipresent. It is simply any method used to distribute scarce resources. To economists, all resources are scarce because desires are always greater than the ability to fulfill them" (Ubel & Door Goold, 1998, 209+). Levinsky (1998) views rationing as, "withholding effective medical care for financial benefit of any other than the patient. The beneficiaries may be physicians, health insurance companies, managed-care plans, or local, state, or national government" (913). Rationing is perhaps most equated with World War II in the U.S. with gasoline and aluminum foil allotted by family so there would be enough to support U.S. troops overseas. Rationing was not popular; however, it was centralized and fair with everyone knowing the methodology. Rationing was perceived as being for a good cause, and when the war ended so would the rationing. With
health care taking a larger bite out of personal family and governmental budgets, there is more and more speculation about when and how health care rationing will occur in the United States. Even supposing no actual shortage of medical personnel, hospitals, and technology, there will eventually be a shortage of money. An upper limit on the Gross Domestic Product will eventually be realized with the result being rationing (Jecker & Pearlman, 1989). Part of the reason is that despite the efficiencies that have been brought to bear in the health care market with managed care, capitation, and the BBA of 1997, health care needs are essentially open-ended and never ending (Churchill, 1994). While Churchill’s rationing definition is purest, rationing occurs in the U.S. based on the ability to afford (via cash or insurance), the various therapies or remedies for health problems of Americans. Currently, there is no centralized plan for an equitable distribution of health care resources and technologies.

The advent of renal dialysis technology in the 1960s highlighted like no other event, Americans distaste for the rationing of health care. It was a time of limited dialysis machines and selection committees. These committees decided which individuals with end-stage-renal-disease had access to the new technology. The consequence of not being selected for this life-saving technology was death. Rationing of dialysis was based on age, marital status and number of dependents, past performance, occupation, and future potential. When the public became aware of these selection committees, there was outrage and an intense lobbying effort in Congress. A revision to Medicare legislation was made in 1972 to pay for this technology for anyone who needed it. Medicare now pays for all renal and peritoneal dialysis and renal transplants. Americans effectively eliminated the problematic choice of rationing by preferring to legislate and pay for everyone to receive this particular care (Churchill, 1987; Fisher & Gill, 1996). What was to originally cost the American taxpayer $35 million at its inception, now costs more than $2 billion per year to dialyze 80,000 patients; one-third of which are over 65 years of age (Callahan, 1995; Churchill, 1987; Fisher & Gill, 1996). This further illustrates the flaw of trying to repair the U.S. health care system in a piecemeal fashion instead of having a systematic, population-based approach with overall governmental planning and closed-ended budget.

Health care costs have escalated to the point that it consumes 13.5 percent of the Gross Domestic Product (HCFA, 2000). This figure is with 25 percent of the population underinsured or uninsured. If the U.S. were to enact a universal health plan without changing aspects of the system, it would easily and
immediately consume 20 percent or more of the gross domestic product and continue to escalate (Churchill, 1994). While there is debate about the actual value of medical care, “few would disagree that at least a basic provision of care is essential to a decent life” (Churchill, 1994, p.89). If health care were not such a benefit or were only marginally effective, an argument could be made that it not be provided to people universally. But when medical care becomes effective enough that society recognizes its value and invests resources to it, it must be considered more than a good to be bought and sold on the free market.

While all Americans need access to health care, they also need access to adequate roads, schools, fire and police protection and a national defense. A universal insurance program cannot come about by legislating it into law as the dialysis program was without an eye to the future expense of this benefit and costs it might extract from other needed services. A ceiling to health care benefits for all Americans would have to be placed for it to be affordable. No country on earth can currently afford all the health care that technology has made available. A prioritization would have to be made (Callahan, 1995; Churchill, 1994). “Our current system takes a consumer-oriented approach to health care, one that encourages us to satisfy all our personal health needs regardless of the effect this has on the well-being of others. Not only is this approach disrespectful of others, it is ultimately self-defeating” (Churchill, 1994, p.84).

Sabin (1998) a physician, asserts that to be an excellent clinician is to love the individual patient and do as much as possible to enhance health, as well as keep in mind the population’s health with available resources. He maintains that the current managed care arrangement throughout the country is a direct outcome of physician reluctance to avoid the need for rationing and priority setting in the U. S. Physicians, in not doing anything, have essentially set in motion a social experiment; an “adversarial system of priority setting. We have asked our insurance companies...to set our priorities for us” (1002+). Physicians can advocate for any beneficial treatment plan for their patient, leaving it up to the insurer to approve or deny payment based on available funds. “Physicians hold to fidelity. Insurers take care of stewardship” (p.1002+). Sabin further asserts that such a system that splits fidelity from stewardship encourages patients to see clinicians as impotent and the system as unfair.

Churchill (1987) has long maintained that health care rationing is alive and well in the U.S. Whether physicians or politicians want to acknowledge it or not, we ration health care by the ability or inability to pay for it. He states,
The first and perhaps most important item to notice is that we are already rationing care as a society, and that physicians as a profession are already rationing care. As a group, physicians have lobbied intensively for the current structure of health care. It's not that physicians are bad...Rather the difficulty lies with honorable professionals doing good in a sphere artificially bounded by a social-political philosophy and undergirded by a moral tradition which systematically excludes reference to the larger society. Taking off these blinders will be disturbing, for the larger picture is one of inequities and neglected needs (p.108-109).

Health care rationing is a morally charged phrase with potentially tragic consequences to individuals or groups of individuals and this is why it is so repugnant to people. While Americans can arguably survive without aluminum foil, TVs and other commodities ‘rationed’ (economist definition) by the ability to pay, health care falls outside of these other commodities in a unique way. An example is the current method of solid-organ transplantation. It is centralized in the United States, with the sickest person matching the harvested organ receiving the gift. With the exception of kidney transplants because of dialysis, one individual receives the organ while others are left waiting for another organ to appear, or die waiting, whichever comes first. Disease, disability and death are the real consequence of solid-organ transplantation for the individuals that do not receive the transplant. These are also the real prospective penalties of any other health care rationing that we eventually accept. That cannot be said about any other commodity on the U.S. market being bought and sold today. People do not die because there are not enough automobiles available or they are too costly to purchase. The real issue about rationing health care in the U.S. is that it is a direct attack against our pervasive culture of plenty. To say something is rationed “would imply limits and finite resources. American culture is ideologically committed to expanded opportunity, progress, and abundance. These culture traits do not dispose us to contemplate shortages, limits, and hard decisions” (Churchill, 1994, p.7). Americans want to have unlimited choice on primary and specialist physicians, unlimited access to every option available for their need, everyone covered with health care insurance, and have that insurance be affordable. No country in the world has that now and many have resorted to national health care plans to provide the most comprehensive care for all their people, like Canada, United Kingdom, and Germany. Regardless of U.S. culture and mindset, eventually political and economic realities will be brought to bear upon this issue of limitations on health care.
spending. When that happens, our society will have to then decide which and whose needs will be met. The question remaining will be how to do it fairly (Callahan, 1994; Churchill, 1994). Perhaps at that time Americans will finally be receptive to looking at governmental oversight of health care to “promote the general Welfare” of “We the People “ and “our Posterity.”

**Ethical Principles in U.S. Health Care: Unbalanced Views**

For the last several decades the emphasis in health care ethics has focused on a number of ethical concepts or foundational stones (Bodenheimer & Grumbach, 1998; Fisher & Gill, 1996). Autonomy, while not considered an ethical principle per se but a right, is seemingly the most treasured value in U.S. culture (Churchill, 1989; Jonsen, Siegler, & Winslade, 1998). Autonomy in health care is the right to choose for oneself what course of treatment one wishes to follow; and it is probably fair to say, the cornerstone of ethical reasoning in U.S. philosophy regarding health care issues (Bodenheimer & Grumbach, 1998; Fisher & Gill, 1996). With the exception of life-threatening emergencies, permission must be obtained from the patient prior to performing any and all medical treatment, procedures, and tests. Even if presented with a curative treatment which the patient refuses, one is obligated to honor that decision. If the patient involves a child the courts have many times sided with providers against parental choice, and mandated medical treatment; as young children are considered too immature to make medical decisions and evaluate risk/benefit consequences (Churchill, 1987; Clark, 1985; Jonsen, Siegler, & Winslade, 1998). Even if a patient or family wishes to pursue what is considered futile care; i.e. care that has less than one percent of success (Callahan, 1995, definition), many physicians feel obligated to provide such care. While many physicians disagree with that stance, the courts have often sided with the family despite poor prognostic indicators (Jonsen, Siegler, & Winslade, 1998).

Beneficence is the commitment of the health care provider to help people in need (Fisher & Gill, 1996; Jonsen, Siegler, & Winslade, 1998). “The principle of beneficence in the healing professions is the obligation to help people in poor health” (Bodenheimer & Grumbach, 1998, p.215). While clinicians are human, and therefore not perfect, it is the motivation to care for and cure the patient to the best of ones ability, which best defines beneficence. While it is an honorable motivation producing positive caring and cure, nonmaleficence provides the balance lacking in beneficence. It does little good to care for people if
one does it in ignorance or neglect. Nonmaleficence is the duty of every health care provider to do no harm (Bodenheimer & Grumbach, 1998; Fisher & Gill, 1996; Jonsen, Siegler, & Winslade, 1998). Many, if not most health care interventions from a simple prescription to the most complicated surgical technique, have the potential to cause varying degrees of harm unto death for each patient.

Justice is the last of the four cornerstones of accepted health care ethics, and probably the most misunderstood of these concepts in the United States. Justice is to treat everyone the same (Bodenheimer & Grumbach, 1998). Fisher and Gill (1996) equate justice with fairness, giving people what they deserve. Justice would not be necessary if society were "composed of persons who were inherently fair. But individuals' interests conflict and they are naturally eager to meet their own needs" (p.114). Perhaps it is because Americans see justice as an abstract idea, involving the criminal judicial system, that they fail to apply it to other requirements of a good society. Bodenheimer and Grumbach (1998) see resistance by physicians and others towards the concept of health care justice being as important as the other constructs; because the other ethical constructs of autonomy, beneficence, and nonmaleficence support the solitary physician-patient relationship. To embrace the idea of equal power of the construct justice, requires a much broader, larger view of society and medical care: what is provided for one individual in cure or care may deprive another individual of society cure or care (Pawlson, Glover, & Murphy, 1992). Whatever the motivation in medical resistance to the concept of justice, the specter of health care rationing and cost controls are pushing this ethical construct to the forefront. Churchill (1987) explains our reluctance to embrace this concept as a cultural issue,

Justice is a difficult concept for most Americans, but not because we are uninterested in it. Rather the difficulty is because questions of justice speak to us as members of a collective and appeal to our moral likenesses, our commonness, our basic sense of ourselves as creatures with shared vulnerabilities and shared needs (p.1). Justice demands the move beyond the individual relationships we cherish to embrace our connectedness with the society we live it. Like a rock thrown into a quiet pond, our individual actions have a rippling effect for those around us.

The sharing of health care benefits and burdens in society is the idea of distributive justice. While justice is linked to fairness, distributive justice is linked to the evening out of benefits such as wealth,
education, taxes, and the like for living in a common society. The government from first through the twelfth grade finances education in the United States. It is considered beneficial to society in the long run to produce an educated, productive, tax paying electorate, than depending upon parents ability to fund early education (Clark, 1985). The federal government often subsidizes college for the poor since higher education is linked to better paying jobs and benefits (improved tax base), while the wealthy pay full tuition. Affirmative action was initially set up to even out benefits (higher education, job preference, and contracts), to particular groups that had earlier been denied these benefits based on race or gender. Like affirmative action, health care benefits are controversial. Should those who work harder receive more benefits? Should those who need health care get it? Should those who participate in high-risk behaviors be excluded? Should the youth subsidize the health care needs of the elderly without being able to participate in health care now? Who should be the ones who decide these issues?

Throughout the history of the developed world, the concept that health care is a privilege that should be allocated according to ability to pay has competed with the idea that health care is a right and should be distributed according to need.... In the United States, the failure of the 80-year battle to enact national health insurance attests to the ongoing debate between ability to pay and need as the doctrine of fairness in health care” (Bodenheimer & Grumbach, 1998, p.217).

The principle of distributive justice in health care affirms that health care is a right for all people in a society (Bodenheimer & Grumbach, 1998). Churchill (1987) expresses the same sentiment differently,

There is a right to health care, but not of the sort often claimed. It is a right grounded not in purchasing power, merit, or social worth, but in human need. The right to health care finds its rationale in a social concept of the self, in a sense of common humanity, and in a knowledge of common vulnerability to disease and death (p.91).

While the ethic of beneficence is balanced by the ethic of nonmaleficence, the ethic of autonomy is balanced (or threatened), by the ethic of justice. The Oregon Health Plans decision not to provide certain organ transplants in order to provide insurance to more low-income Oregonians illustrates this concept. Brandy Stoeder an 18-year-old with cystic fibrosis needs to have a double transplant, lungs and liver, to have a chance to live longer (Hortsch, 2000). She sued the state of Oregon to force the Oregon Health Plan, her insurance carrier (a state and federally financed health care system that provides insurance to
lower income and disabled people), to pay for the double procedure. The insurance carrier denied the procedure and refused to pay for the double transplant. Her suing the state made her personal health problem a public dilemma, highlighting the conflict between technical expertise and financial constraints. There were many stories about her plight on Portland, Oregon local new stations and in the Oregonian newspaper. “In a story explaining financial decisions the state makes, the newspaper ran a chart showing how many heart transplants (three) or other procedures could be covered with the money if not spent on the double surgery for one person” (Hortsch, 2000, p.2). Hortsch goes on to comment that the newspaper reporter who had written the bulk of the stories for the Oregonian covering Stoeder’s fight with the state, told him that he had received more than 100 phone calls and 50 to 75 e-mails from readers. “Ninety percent, he said, were visceral reactions to Stoeder’s situation and said she should receive the transplants. The remainder discussed the practical realities of the Oregon Health Plan and why the state should stick to a difficult decision” (p.2). Stoeder’s autonomy (her right to choose her own health care path), in wanting this particular medical treatment collided directly with the state of Oregon’s commitment to distributive justice for the population it insures.

Brandy Stoeder’s plight demonstrates several reasons why the United States electorate has not mobilized congress to enact a national health care insurance plan. If health care were distributed equally, I might not get what I need when I need it. Jecker and Pearlman (1992) explains,

Allowing or even applauding high levels of consumption keeps alive for us the idea of some day having access to high levels of consumption ourselves. If correct, this explanation bolsters the equality argument which calls for placing a ceiling on health care consumption. It reveals that our tolerance of inequalities is based more on the prospect of personal advantage than ethical considerations of justice and fairness” (p.90).

According to Churchill (1987), another reason for our indifference resides in ability to keep our ‘moral distance.’ As long as we can turn our eyes away from the problems of the uninsured, we will lack the ability to identify with these people and will continue to easily put their plight out of our mind. No one in the United States deliberately decided to exclude poor or lower middle class Americans from insurance coverage. Because it is their lack of money which excludes them and not our action, no one is responsible, therefore, no one is to blame (Churchill, 1987). While we will sympathize and mobilize for the vibrant and
attractive Brandy Stoeder who appeals to us through the television and newspaper articles, we don’t see and therefore do not care about children who are not immunized and lack basic health care in this country.

Moral distance keeps us from looking at the inconsistencies and contradictions in our health care system.... Distance seems to blunt the moral imagination, and the lack of identified lives to whom to relate the rescue impulse seems to paralyze social ethics altogether" (Churchill, 1987, p.40).

Two ethicists, Callahan (1995) and Churchill (1987) have both proposed it is our inability to accept our own inevitable death, that provides the incentive towards our unwillingness to look at the greater society at large in regards to health care. In providing a basic level of health care for all Americans, there will have to be a decrease or ceiling of benefits for currently insured people, for it to be affordable. Society at large, for instance, may not allow us or our loved ones to have that high-priced-high-tech surgery, transplant, or drug that would allow us to live a little longer. Why? The consequences might mean that the clinic serving poor children and adults in our town might have to shorten its hours, ultimately endangering many people. This is the friction between autonomy and distributive justice. It is doubtful that either Callahan or Churchill would support Brandy Stoeder’s claim to more health care dollars for herself at the expense of other people. Even though each individual is priceless, and no dollar value should ever be assigned to a human being; one individual is not more valuable than another individual or another group of individuals. If the state of Oregon had agreed to pay for the dual transplant and stopped prenatal care for one hundred women, that would have assigned a higher value to one life at the expense of others. While Brandy is being denied a procedure she thinks will insure her continued survival, the state is not killing her for refusing to pay for the transplant. The state of Oregon will continue to give her basic acute and long-term care at the same time not denying the value of women pregnant with the next generation.

Callahan (1993) has written extensively on the individual making demands to avoid death that can be potentially ruinous not only for families, but for society at large. He challenges individuals to grasp the concept that we are part of a whole and that in demanding more for ourselves, we make less available for others. In his book, The Troubled Dream of Life, he calls for a rational way of looking at health care expenditures as a part of the total societal expenditures made for mutual defense, education, safety, etc. Health care is one thing we all need, because of our shared vulnerability to illness, but it is not the only thing we need. If the government spends more on health care, there will be less money to finance other
national needs, like defense and education. Are we as a society willing to advocate for less money on education for our young children so we can consume more and more health care dollars, especially as we grow older? Callahan also questions the motivation by which individuals make requests and medical providers give medical care. He believes that even though death is always present, it is 'the enemy' to be fought by individuals and the medical establishment at all and any cost in this country.

The trouble with an open-ended system, of the kind existing in the United States, is not only that it admits of no natural boundaries to health expenditures, but also that it in effect refuses to accept death. Treating each and every death as an equal threat to the human good, equally to be resisted, creates two harms. One of them is the expenditure of a disproportionate amount of money on comparatively few conditions, those that turn out to be amenable to expensive technological interventions. The other is the expenditure of a disproportionate amount of money at the fringes of life, working to save lives where the costs are high and the results, if good at all, marginal and short-term. In both cases—ironically, given the alleged dedication to life—money is diverted from health care for the many to serve the needs of the few. Only a society unduly fearful of death, and unduly captured by the notion that an unlimited amount of money should be spent on individual cases even at the neglect of public health, could end up with such a strange set of priorities” (p.143, 214).

Churchill (1987) also echoes this unwillingness to accept limitations of medicine and life by saying, "We are a society which is uneasy about death and, substituting longevity in this life for spiritual reassurance of the next, have imbued the priesthood of medicine with a maximalist ethic of preservation" (p.9).

Beneficence of doing good for an individual can be myopic toward the concept of beneficence for society when it places individual immediate need before the health care needs of an entire community (Callahan, 1995; Churchill, 1987; Fisher & Gill, 1996). As nonmaleficence balances beneficence, could it not be said that continuing to ignore the uninsured and society's health at large is to commit harm even if by the turning of a blind eye? To exalt the ethical principles of autonomy, beneficence and nonmaleficence at the expense of justice is to preserve unchallenged an unethical and unbalanced view. This view threatens
us all with national financial bankruptcy and moral impoverishment. Because our foundational ethical principles are unbalanced, our house, our health care system is crooked and in need of righting.

**Security for All of “We the People” and “Our Posterity”**

The election year 2000 sees health care reform lower on the electorate’s mind in regards to equal health care access for everyone. The Alliance for Health Reform (2000) sees the public pulse on the issue vacillating. In 1993, 35 percent of Americans listed the uninsured the single most important health care issue, while it fell to 31 percent in 1999. Amid the prosperity of the 90’s it’s hard to focus on the fact that underinsurance and uninsurance effects all of us. Unless very wealthy, most Americans are *one job away* from joining their ranks and *any* economic downturn is sure to swell the ever burgeoning group of the uninsured in our midst. Americans must come to terms with the fact that there is no health care security for *any of us* unless there is security for *all of us*.

Before rationing schemes, waiting times, drug formulary, and technology curtailments are looked at, *we first* must decide the purpose of having a health care system at all. If the military does not make it a top priority to protect *every American* on American soil, it is not worthy of our loyalty, our tax dollars, and has failed its stated purpose. Without purpose there are no goals or objectives to meet or to be measured against. Without purpose there is no vision or clearly articulated plan for future built-in accountability for its success or failure (Churchill, 1994). Without purpose there is only the throwing of more good money after bad. Without purpose the only people to benefit from our current health care system are health care providers, insurers, the pharmaceutical industry, and well-insured Americans, leaving an ever-growing group of Americans to fend for themselves. Without purpose there is only more of a patchwork quilt of health care goals and management to endure with an ever-increasing fragment of the population without coverage in the cold of night. It is past time for all Americans to embrace our collective national heritage and constitutional directive to “promote the general Welfare” *for all* of “We the People;” and insure our legacy to “our Posterity” by insisting our government fulfill this constitutional mandate in providing health care access for everyone.
Reference List


Japenga, A. (2000, October 27-29). Is a luxury hospital in your future?: A new wave of swanky specialized care is nice for patients, but the competition worries general hospitals. USA Weekend.


Rjas-Burke, J. (2000, October 29). Missing HMOs: With almost all the HMOs leaving Jackson County, patients, employers and providers learn the hard way that managed care has some advantages. The Sunday Oregonian B1.


