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The Health Care Crisis in America: Is Universal Health Care the Solution to Our Problems

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Despite the United States’ commanding economy, leading technology, and superior medical programs, it ranks 32nd in life expectancy, 37th in adult mortality, and fifth in infant mortality among World Health Organization (WHO) member states. In 2005, the United States’ total health care expenditures were $2 trillion, representing 16 percent of its Gross Domestic Product (GDP) compared to 10.9 percent of the GDP in Switzerland, 10.7 percent in Germany, 9.7 percent in Canada, and 9.5 percent in France. Yet, our country’s poor health status is largely due to its inequitable distribution of medical resources. For the wealthy minority, access to health care is virtually unlimited. But the majority of Americans face economic, social, and political barriers to the quality health care services and cutting edge technologies available in the United States.

Studies show that enrollment in a health insurance program promotes positive health outcomes by encouraging healthy behavior. Insured individuals tend to seek medical attention early when conditions are easier and less costly to treat. Individuals without insurance are more likely to postpone or forego care, thereby increasing their risk of developing preventable health problems, disability, and premature death. In a recent study, 28 percent of uninsured participants reported that they did not seek necessary medical services within the last year because they could not afford them. This figure was three times higher than the percentage of persons with health insurance who chose to forego treatment. Additionally, mortality during hospitalization is higher among uninsured patients. The Institute of Medicine (IOM) estimates that lack of insurance is associated with 18,000 unnecessary deaths every year among adults between the ages of 25-64.

Presently, the United States is the only industrialized nation that lacks a universal health care system guaranteeing all citizens access to quality medical care. Recent attempts at health care reform in the United States have been ineffective at reducing the number of uninsured individuals. The U.S. Census Bureau reported that 46.6 million Americans, of which 8.3 million were children, did not have health insurance in 2005 – an increase from 45.3 million in 2004. Even when individuals have insurance, their coverage may be insufficient. In 2003, 16 million Americans were underinsured, meaning that they had health insurance, but their plans were inadequate. This status could result from employers not providing health care. Individuals may also have limited insurance plans that do not cover family members, or plans with unreasonably high deductibles or co-insurance.

In the United States, the financial burden on uninsured families is inversely proportional to family income. Most people are uninsured because they cannot afford coverage. More than half of the uninsured are in low-income families and about half are ethnic or racial minorities. Seventy percent of insured individuals are in families with one or more full-time workers who do not receive employer-provided coverage, or are unable to afford corresponding insurance premiums. The majority of uninsured Americans are between the ages of 19-64 years, of whom twenty percent are children. Thirty-six percent of the American population falls below the federal poverty level, but only 25 percent of the population receives public assistance through Medicare or Medicaid. While almost half of non-citizens are uninsured, American citizens still comprise 79 percent of the uninsured population.

According to the Kaiser Family Foundation and the Health Research and Educational Trust, employer health insurance premiums increased by 9.2 percent in 2005, nearly three times the rate of inflation and five times the average increase in workers’ salaries. The annual premium for an employer health plan for a single person is $4,000 and for a family of four, premiums average $11,000. Based on current trends, premiums are expected to rise. Experts predict that prices will reach $2.9 trillion in 2010 and $4 trillion in 2015 (20 percent of the GDP in the United States).

Currently, a combination of federal and state taxes, property taxes, and tax subsidies finance 64 percent of the cost of the American health care system. Individual out-of-pocket payments, such as co-pays, deductibles, and fee-for-service payments collected when service is rendered, account for approximately 17 percent of total health care costs. Employers only pay 19 percent of health care costs.

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Access to health care is not just a problem for the uninsured – it is a problem for the entire nation. The increasing uninsured population has wide-reaching effects across communities, such as a higher morbidity rate and decreased workplace productivity. Higher rates of sick days reduce productivity and incoming revenue within an organization, forcing employers to terminate jobs, lay off employees, or decrease salaries to compensate for this loss. In addition, uninsured individuals are less likely to be immunized, which increases the possibility of outbreaks of communicable diseases creating risks for greater morbidity and premature mortality.

This article describes various strategies to increase access to health care, and examines single and multi-payer health insurance systems, including universal health care in other countries and states. Both the advantages and disadvantages of each system are discussed.

II. Discussion: Strategies to Increase Access to Health Care

A. Single Payer Health Insurance Systems

Advocates of universal health care have proposed replacing our current system, which has multiple payers, plans, and options, with a single payer system in which either the federal government or a subcontracting entity will cover the cost of health care for the entire population. Proposed legislation “would prohibit private insurance companies from duplicating coverage for services already covered by the public insurance program.”23 Opponents of a single payer health system criticize its effectiveness by categorizing it as a form of “socialized medicine” in which the government owns and operates all health care facilities. Contrary to socialized medicine schemes, however, a single payer system is a financing, not a governing, mechanism. The government collects and allocates money for health care but has little involvement in the actual delivery of services. Although public funds pay the costs, care is provided privately at not-for-profit hospitals and clinics where individuals can choose their own providers. Physicians are compensated either on a fee-for-service basis or paid salaries by hospitals or nonprofit health maintenance organizations.24

Contrary to the current system in the United States, services in the single payer system would be delivered based on need rather than on an ability to pay; co-payment and deductibles would be eliminated. Single payer universal health care systems closely resemble the United States’ government-funded Medicare and Medicaid programs.25 Overall, these changes would result in decreased consumer costs.26

i. Examples of Single Payer Universal Health Care Systems in Other Countries

a) Canada

Canada has operated under a single payer universal health care framework since 1947.27 Canada’s estimated annual total health expenditure is only 9.9 percent of its GDP, approximately $2,669 per person. Its infant mortality rate is just five per 1,000 live births, while life expectancy is 78 years for men and 83 years for women.28

The federal government in Canada administers the national health insurance plan (Medicare). The Canadian Medicare program receives funds from general tax revenues that account for 72 percent of health expenditures.29 In addition, most Canadians have private insurance plans that extend their access to supplemental services, such as dental care, rehabilitation, prescription drugs, and private nursing care. This private sector component, along with out-of-pocket payments, accounts for 28 percent of health expenditures.30 Most physicians in Canada are in private practice and accept fee-for-service Medicare payments as set by the government. Hospitals are mainly not-for-profit and operate under regional or institution-specific budgets.31

While every Canadian citizen has health insurance, and health care expenditures represent a reasonable percent of the nation’s economy (compared to United States), the Canadian health care system has been described as a system of rationing where “everything is free but nothing is readily available.”32 Cost-control problems are evident by long waiting lists, dilapidated equipment, and outdated technology. A study conducted by the Fraser Institute found that median waiting times were “consistently and significantly longer than physicians feel is clinically reasonable.”33 For example, in 2005, the total average waiting time for surgery was 17.7 weeks from 12.3 weeks for an MRI scan, 5.5 weeks for a CT-scan, and 3.4 weeks for an ultrasound.34

b) Australia

Australia’s estimated annual total health expenditure is only 9.6 percent of its GDP, which is approximately $3,123 per person. Its infant mortality rate is six deaths per 1,000 live births and life expectancy is 71 years for men and 74 years for women.35

In Australia, national health insurance is funded by a mixture of general tax revenue, a 1.5 percent levy on taxable income, state revenue, and patient fees. The government funds 68 percent of health expenditures (45 percent federal and 23 percent state) and governs
hospital benefits, pharmaceuticals, and medical services. States are responsible for operating public hospitals, regulating nursing homes, and community-based general service clinics. Australians also have access to several not-for-profit private insurers that offer plans to cover gaps between Medicare benefits and fees assessed for inpatient services. These private insurance plans cover a third of the population and account for 11 percent of health expenditures.

Physicians in this system are generally reimbursed fee-for-service. The government sets the fee schedules, but physicians are free to charge above the scheduled fee or may directly bill the government when there is not a patient charge. Out-of-pocket payments account for 19 percent of health expenditures. Similar to Canada, patients are free to choose their general practitioner, an individual who serves as a managed care gatekeeper.

c) Denmark

Denmark’s estimated annual total health expenditure is only 8.6 percent of its GDP, approximately $2,780 per person. Its infant mortality rate is five deaths per 1,000 live births and life expectancy is 76 years for men and 80 years for women.

Progressive income taxes fund the publicly-administered Danish health care system. Each patient chooses a general practitioner who makes referrals to specialists. There are no co-payments for physician or hospital visits, but patients do pay co-payments for prescription drugs. Together, 14 counties and the city of Copenhagen run the country’s hospitals.

Physicians who work with hospitals receive salaries which are negotiated between the government and doctors’ unions. General practitioners are compensated 40 percent per capita and 60 percent fee-for-service, whereas specialists are mostly fee-for-service.

ii. First Step, First State: Single Payer Universal Health Care in the United States—Massachusetts Health Care Reform Act

The Massachusetts Health Reform Act (MHRA), enacted on April 12, 2006, is the first successful legislation creating a single payer health care system in the United States. Health benefits are administered by a newly created state agency, the Connector. The Connector serves as an intermediary between citizens and private insurance plans and funds all services. The Massachusetts program is designed to give consumers a choice of plans, ensure true coverage portability, and allow continuing federal tax-breaks for employer group health insurance.

Under the program, workers will be able to switch plans during an annual open season and retain the same coverage as they change jobs. The MHRA increases enrollment in Massachusetts’ current Medicaid program and includes all adults whose income is less than 100 percent of the Federal Poverty Level (FPL). Medicaid eligibility also extends to all children in households at 300 percent at or below the FPL. The MHRA then creates a single payer system based on both individual and employer responsibility.

The individual mandate of MHRA required all Massachusetts residents to obtain health insurance by July 1, 2007. Residents must show proof of this coverage on their annual tax returns. Failure to do so results in the loss of personal deductions. Continued failure to comply will subject individuals to financial penalties up to 50 percent of the cost of an insurance plan. People with incomes greater than 100 percent, but less than 300 percent of the FPL, will be eligible for government-funded sliding scale subsidies for the purchase of necessary coverage plans. To help make insurance affordable for the remaining population, the MHRA allows citizens to use pre-tax dollars to purchase plans.

MHRA’s “employer mandate” requires that all employers with more than ten employees provide “some degree” of health benefits. The government requires employers who do not offer such benefits to pay their “fair share” of health care expenditures for the uninsured up to $295 annually per full-time employee. In order not to burden small businesses, the Connector offers new specially-priced plans that were previously not available to small businesses because insurers could now pool the risk of the small businesses and insure themselves a profit previously unavailable. Each worker may choose the most suitable health plan from those offered.

Any Massachusetts resident may buy coverage directly through the Connector as an individual. The disadvantage of doing so is that the federal tax-breaks for individually purchased health insurance are not as large as those for employer-group coverage.

iii. Advantages of a Single Payer System

The single payer approach to a universal health care system effectively addresses the issue of cost containment for health care expenditures. The for-profit element of health care would dramatically decrease and the system would transition into a market of non-for-profit services. Using government agencies (or government subcontracting agencies) as liaisons between small businesses and individual health
consumers creates bargaining power for consumers to negotiate discounts with health care providers and suppliers. In addition, single payer systems naturally utilize centralized electronic medical record databases that facilitate patient care and help prevent medical errors. Physicians, pharmacists, and other health care providers can access information from different offices and across state lines, making medical records truly portable.

In a proposed single payer system for the United States, there would be no preferred providers (i.e., no distinction between in-network physicians and out-of-network physicians). Covered individuals would have the freedom to choose their own physician. The new “health care system would be fundamentally accountable to the public, so decisions about the allocation of healthcare resources (e.g., how much to spend, what to pay for, whom to pay for) would be public decisions.” Such freedom will ultimately expand participant choice as well as increase consumer power.

iv. Disadvantages of a Single Payer System
Concerned consumers raise privacy concerns that the government could access this central database of medical and personal information. While this “single repository” benefits public health planning and allows for efficient medical treatment between different providers, citizens fear that the government would track individual health care outcomes, leading to discrimination.

A single payer system in the United States would also be vulnerable to the prevailing political party. For example, opponents of the single payer system may underfund it. In addition, physicians worry about lower reimbursements due to the government’s increased bargaining power. Yet, any income reduction a physician might experience could be mitigated by decreased overhead and malpractice costs.

Finally, a single payer system with few financial barriers may encourage over-consumption of resources, straining the capacity and effectiveness of health care delivery. Under a pure single payer system, the government might provide only one basic insurance plan without coverage options; thus, those who prefer a different option may view the pure single payer system as a disadvantage.

B. Multi-Payer Systems
While the term “universal health care” generally refers to a single payer system, it can also be achieved through a multi-payer system. In a multi-payer system, health care services are financed by both public and private contributions. Citizens are protected by a “safety net” (the minimal public insurance plans available to all persons). They also may purchase alternative private plans in place of the public insurance options. The government is not responsible for administering private plans; however, it does ensure that private plans contain the same options as public insurance plans.

i. Examples of Multi-Payer Systems
a) Germany
In 1883, Germany became the first country to develop a national health insurance system. Germany’s annual health expenditures account for 10.6 percent of its GDP, approximately $3,171 per person. The infant mortality rate is five per 1,000 live births, and life expectancy is 76 years for men and 82 years for women. Every German citizen is eligible for public health insurance, and individuals above a specified income level may purchase private coverage. Only 0.2 percent of the population lacks health insurance.

The German health care system employs Sickness Insurance Funds (SIFs). SIFs receive funding through compulsory payroll contributions (14 percent of wages), equally shared by employers and employees. Also, SIFs cover 92 percent of insured individuals and 81 percent of health expenditures overall. Citizens who are affluent, self-employed, or civil servants are covered by private insurance, financed by voluntary individual contributions.

b) France
France’s annual health expenditures account for 10.5 percent of its GDP, approximately $3,040 per person. The infant mortality rate is five per 1,000 live births, and life expectancy is 77 years for men and 84 years for women.

Similar to Germany, the French health care system is primarily funded by SIFs financed through compulsory payroll contributions – 70 percent of the GDP.
from employers and 30 percent from employees. France’s system operates as an autonomous, not-for-profit, government-regulated entity with national headquarters and regional networks.63 SIFs cover 99 percent of the population and account for 75 percent of health expenditures. The central government, patients’ out-of-pocket payments, and Mutual Insurance Funds (MIFs) pay the remaining health expenditures. MIFs cover 80 percent of the population, and account for 6 percent of health expenditures.64

Patients are free to choose their own providers and are not limited to the number of services they may receive. General practitioners do not serve as gatekeepers. Private physicians are paid on a fee-for-service basis and patients are subsequently partially or fully reimbursed as appropriate.65

c) Japan

Japan’s universal health care program began in 1958.66 Its annual health expenditures account for 7.8 percent of its GDP, approximately $2,293 per person.67 The infant mortality rate is four per 1,000 live births, and its life expectancy at birth is 79 years for men and 86 years for women.70

Japan’s program contains two principal systems. First, similar to both Germany and France, Japan has an Employee Health Insurance System financed by compulsory payroll contributions (8 percent of wages). These contributors are equally shared by employers and employees and cover employees and their dependents.71 Second, there is a National Health Insurance System that covers self-employed individuals or pensioners and their dependents.

In both systems, the local government acts as the insurer. Premiums are based on (1) the individual income; (2) the number of individuals in the insured household; and (3) assets. These premiums fund 57 percent of health expenditures, while the federal government contributes 24 percent and local governments contribute 7 percent.72

About 80 percent of hospitals and 94 percent of clinics in Japan are privately owned and operated. Some public not-for-profit hospitals do exist, but the law prohibits investor-owned, for-profit hospitals.73 Patients are free to choose their own general practitioners who do not serve as gatekeepers. Medical and pharmaceutical practices operate jointly; thus, prescription fees generate a large portion of physician income.

ii. Advantages of a Multi-Payer System

For both public and private consumers, the chief advantage of having a multi-payer system is freedom of choice. Each person has the right to health care and has access to necessary services regardless of employment, age, socioeconomic status, or health. Those who desire additional coverage may purchase it from private companies. Patients opting for publicly funded plans would not be restricted in choosing their doctor. In addition, government administration of public insurance will decrease spending by eliminating duplicate administrative activities and negotiating reasonable reimbursement rates for providers. A multi-payer system may be more practical than a single payer system because it does not completely eliminate insurance companies or the revenue generated from the insurance marketplace.74 Competition will still remain between companies to provide supplemental insurance plans.

iii. Disadvantage of a Multi-Payer System

Despite scaling back the for-profit insurance industry, competition between insurance carriers, motivated by increased profits, will still exist.75 Additionally, stratification between socio-economic groups is less likely to diminish.

C. Federalist Approach

The federalist approach is a system incorporating a partnership between federal and state governments. States receive federal funding to provide universal health care to their residents. To receive funds, states must design systems according to specific federal guidelines. Administering the plan would be based on local conditions and terms. In this manner, states may have the opportunity to customize an insurance program that most efficiently meets the needs of their residents.76

i. Advantages of the Federalist Approach

The federalist strategy recognizes varying social and political climates in different geographical areas. Accordingly, one federal solution cannot apply to every state. States will have autonomy to implement plans over a period of time, allowing for incremental changes, by collecting data from earlier ventures to determine ideal solutions.

ii. Disadvantages of the Federalist Approach

Some argue that large businesses will ultimately prefer a uniform, federal solution to achieve consistency rather than a system with 50 different sets of regulations. Then again, state regulations can lead to a national program. For instance, Canada’s national health care system was developed province-byprovince and
demonstrates that building a health care system state-by-state can eventually lead to a national universal health care system. Accordingly, a universal health care system in the United States could also develop from a state-by-state system.

D. Alternative Financing Options for Universal Health Insurance Programs

In addition to reducing the number of uninsured individuals and increasing the affordability of health insurance as outlined above, proponents of universal health care suggest tax credits, medical savings accounts, and managed competition to fund a universal health care program.

i. Tax Credits

Under the current health care system in the United States, self-employed individuals and workers who do not receive health benefits from their employers generally pay higher insurance premiums and have higher co-payments. Allowing income tax credits to subsidize the cost of insurance would eliminate a portion of this financial burden. In addition to incentivizing individuals to purchase health insurance, tax credits would be easy to implement and insurance plans, overall, would be more affordable for the average person. Additionally, insurance companies would not have to surrender their economic interest in the marketplace. Tax credits also retain citizens’ freedom of choice and do not hinder personal autonomy.

Tax credits alone can only provide increased access. People who do not want to purchase health insurance would not be required to do so. Consequently, tax credits do not guarantee that all persons will have coverage. In addition, tax credits will reduce, but not eliminate, the cost of health insurance. Moreover, tax credits would only apply to those persons who are employed and file income taxes. People who are not employed, or do not earn enough money to file tax returns, will not benefit.

ii. Medical Savings Accounts

Medical Savings Accounts (MSAs) are based on the theory that the cost of health care is inflated because people are over-insured. Broad insurance coverage encourages people to use medical resources more frequently. Since they have already paid for insurance, patients do not hesitate to see doctors for even the smallest problem because medical care is covered by their insurance plan. This results in over-consumption of medical resources, which results in higher costs. In alternative MSAs, employers (or the government) deposit money into an account on the insured’s behalf and the money is used to purchase basic coverage. Some of the money in the MSA is used to purchase a high-deductible, low-premium catastrophic insurance plan. The remaining money is used for other health care expenses. Costs that exceed available MSA funds are paid for by individuals out-of-pocket. Any unspent money remains in the account for future use. Accordingly, people have an incentive to reduce costs when forced to pay out of their own pocket.

Minimizing costs is not an option when serious medical problems arise, leaving individuals extremely vulnerable. MSAs attempt to balance economic efficiency and patient protection. Utilizing fewer medical resources will reduce prices, making care more accessible for everyone. Yet people are still secure in knowing that they will be protected if something critical happens. MSAs do not solve the problems of the low-income uninsured population who will still likely be unable to pay for out-of-pocket costs. Persons who cannot afford health care will have access to emergency treatment but will have little-to-no access to preventive or basic medical care. MSAs also discourage patients from seeking medical care, unless there are clear signs of illness.

iii. Managed Competition

Managed competition is a system that combines market forces with patient pooling to improve access. Employers and individuals join health-care purchasing groups (or health alliances) which negotiate

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benefits with different private insurers. The theory of managed competition is that grouping people into certain “alliances” gives them bargaining power to obtain insurance at reasonable prices. The government establishes a minimum set of benefits that insurance plans must offer. Every member in the plan is charged the same premium rate regardless of health status. Employers may cover most of these premiums; public subsidies cover the remainder. If people want additional coverage, they must pay out-of-pocket for all services exceeding minimal coverage. Requiring companies to offer a standard set of minimum benefits ensures that patients will not select a low-quality plan simply to save money. Consequently, health care becomes more affordable and more accessible.

Managed competition programs would be particularly beneficial to small employers, who currently are unable to offer benefits, and those individuals who pay for health care out-of-pocket. Insurance companies would still be motivated to maximize profit, even at the patients’ expense. The cost-cutting practices they presently employ, such as requiring patients to stay within a particular network of physicians, will likely continue. Physicians will face similar limitations on patient treatment and resource utilization. As a result, administrators will closely scrutinize their medical decisions, emphasizing cost effectiveness rather than medical efficacy.

Insurers have an incentive because insurance providers will most likely need to accept both sick and healthy patients. When sick patients choose among available plans, they will select the one that offers them the best care for their illness. The patient will likely not select a plan that has poor treatment options. The result is that the insurance company saves money by not treating a patient’s potentially expensive ailment. Similarly, insurance providers will have little reason to improve technology and treatment for the unhealthy. Most of their focus towards the sick will be trying to convince those who are ill not to enroll in their plan.

III. Conclusion: Is America Ready for a National Universal Health Care System?

Experts and citizens agree that our current health care system is inefficient. The United States has the financial power and advanced technology to support an excellent health care system but, in reality, today’s health care system is simply a repository of unused potential. As statistics show, Americans have more negative health outcomes, such as higher infant mortality rates and lower life expectancies than other countries.

In theory, universal health care would be ideal. The United States has the ability to save lives but, with so many people unable to afford health insurance, a healthy life is only reasonably attainable by some. With a national health care system, all citizens would have coverage regardless of their ability to pay, thus replacing the current unjust system with one of fairness, equity, and quality.

The real issue is precisely how the United States could implement a meaningful, effective, and sustainable change. In the United States, citizens prefer as little government involvement in their lives as possible. Thus, a strict single payer system is unlikely to gain the necessary support from American voters. A hybrid of the methods implemented in other countries, and similar to the MHRA, is likely to lower health care costs to consumers and reduce the health disparities present across the lines of ethnicity, race, and financial status.

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5. See id.
7. See id.
16. See id.
text/109/h/hf7676.pdf.
25 See id.
29 See id.
30 See id.
31 See id.
34 See id.
37 See id.
38 See id.
42 See id.
43 See id.
45 See id., ch. 58 §15(c); see also THE HENRY J. KAISER FAMILY FOUND., KAISER COMM’N ON MEDICARE AND THE UNINSURED, KAISER COMMISSION ON MEDICARE AND THE UNINSURED, KEY FACTS ON MASSACHUSETTS, MASSACHUSETTS HEALTHCARE REFORM PLAN: AN UPDATE (2007), http://www.kff.org/uninsured/upload/7494-02.pdf. (stating that the proposed Medicaid expansion will cover an additional 92,500 people).
46 See Massachusetts Health Reform Act, ch. 58 §13(b).
47 See id., ch. 58 §45(3)(a). Size of the government-funded subsidies has not yet been determined.
48 See id., ch. 58 §48(2).
50 See Massachusetts Health Reform Act, ch. 58 §101(1).
51 See id., ch. 58.
52 See THE HENRY J. KAISER FAMILY FOUND., KAISER COMM’N ON MEDICARE AND THE UNINSURED, KAISER COMMISSION ON MEDICARE AND THE UNINSURED, KEY FACTS ON MASSACHUSETTS, MASSACHUSETTS HEALTHCARE REFORM PLAN: AN UPDATE (2007), available at http://www.kff.org/uninsured/upload/7494-02.pdf (noting Massachusetts Governor Mitt Romney vetoed the employer mandate and that the legislature has the votes to override the veto).
55 See id., ch. 58.
57 See id. at 4.
58 See id.
59 See id., ch. 58.
62 See id. at 28.
63 See id. at 26.
67 See id.
70 See id.
71 See Physicians For A National Health Program

72 See id.
73 See id.
75 See id.
76 See id. at 5; see also Don McCanne, Why Incremental Reforms Will Not Solve the Health Care Crisis, 16 J. of the American Board of Family Practice 257-261 (2003).
80 See id. at 17.
81 See id. at 20.
82 See id. at 6.
83 See id. at 5.
84 See id.