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Barry R. Furrow

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BARRY R. FURROW*

INTRODUCTION

The American health care system is under attack on all fronts—and for good reason. Quality is poor by many measures; too many patients receive treatments and procedures known to be ineffective, while other effective treatments are vastly underused, and tens of thousands die annually from preventable errors.[1] We have managed a very special accomplishment—we spend more than European countries like France, Italy, and Germany, yet we manage to do worse than these countries on most measures of health performance, including life expectancy and infant mortality.[2] Health care cost inflation is on the rapid ascent as managed care has receded into ineffectiveness.[3] Employee health care coverage costs continue to rise at twice the overall inflation rate, and far in excess of any wage increases that workers receive.[4] The 7.7 percent increase in 2006 was the lowest since 1999, but the average cost to

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1. *See generally* Barry R. Furrow, *Regulating Patient Safety: Toward a Federal Model of Medical Error Reduction*, 12 WIDENER L. REV. 1 (2005).

2. For a comparison of all countries across a large number of variables, see generally WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE (2000), *available at* http://www.who.int/whr/2000/en/whr00_en.pdf.

3. Robert E. Hall & Charles I. Jones, *The Value of Life and the Rise in Health Spending*, 122 Q.J. ECON. 39 (2007). The authors note that a rise in health spending is not a bad thing if we are getting life extension and reduced disability:

> The United States devotes a rising share of its total resources to health care. The share was 5.2 percent in 1950, 9.4 percent in 1975, and 15.4 percent in 2000. Over the same period, health has improved. Life expectancy at birth was 68.2 years in 1950, 72.6 years in 1975, and 76.9 years in 2000.

Id. at 39.

4. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2006 SUMMARY OF FINDINGS 1 (2006), *available at* http://www.kff.org/insurance/7527/upload/7528.pdf.

employees continued an upward trend, reaching $2,973 annually for family coverage.[5]

Finally, and most important for this Essay, access to care is a problem for increasing numbers of uninsured Americans. [6] Nearly half of all adults worry they will not be able to pay their medical bills if they become seriously ill. [7] Insecurity becomes a social cost, creating an epidemic of anxiety about coverage.[8] We are afraid to change jobs; as we enter our late fifties and worry about continued employment, we perversely wait to get old enough to be eligible for Medicare. I propose in this Essay that we attack our ideological rigidities head-on, and use our most recent evidence as a springboard for a new attempt to reform the American health care system. Instead of despairing at the possibility of change, it is time for a renewed attempt to repair our system from the top down.

I. ACCESS DENIED: THE COSTLY EPIDEMIC

> At any point in time in the next several decades, there are thus likely to be thirty to fifty million uninsured Americans—and conceivably more. At least half of the uninsured are too poor to afford state-of-the-art U.S. health care with their own resources. Many will continue to remain health care beggars in search of doctors, hospitals, and other providers willing to treat them on a charitable basis. Even if they do procure such care, their dire circumstance will rob them of the dignity and peace of mind that even the poorest patients in other nations have come to take for granted and that many people in the industrialized world—in-

5. Milt Freudenheim, *Health Care Costs Rise Twice as Much as Inflation*, N.Y. TIMES, Sept. 27, 2006, at C1, *available at* 2006 WLNR 16714358 (Westlaw).

6. Cathy Schoen et al., *Insured But Not Protected: How Many Adults Are Underinsured?*, HEALTH AFF., June 14, 2005, at W5-289; Sara R. Collins et al., *A Shared Responsibility: US Employers and the Provision of Health Insurance to Employees*, 42 INQUIRY 6 (2005); John Holahan & Allison Cook, *Changes in Economic Conditions and Health Insurance Coverage, 2000-2004*, HEALTH AFF., Nov. 1, 2005, at W5-498; Joseph S. Ross et al., *Use of Health Care Services by Lower-Income and Higher-Income Uninsured Adults*, 295 JAMA 2027 (2006).

7. Cathy Schoen et al., The Commonwealth Fund, Public Views on Shaping the Future of the U.S. Health System 9 (2006), *available at* http://www.cmwf.org/usr_doc/Schoen_publicviewsfuturehltsystem_948.pdf.

8. For a moving discussion of low wage work, and what it is to live without access to health care, see SUSAN STARR SERED & RUSHIKA FERNANDOPULLE, UNINSURED IN AMERICA: LIFE AND DEATH IN THE LAND OF OPPORTUNITY (2005).

cluding a sizable minority of Americans—consider an important element in health care.[9]

The Problem of Cost

Unrelenting cost growth is pricing increasing percentages of mainstream purchasers out of the market for care and coverage. Health insurance coverage costs increased 7.7 percent in 2006, exceeding "the overall rate of inflation by about 4 percentage points and the increase in workers' earnings by almost 4 percentage points."[10] "Since 2000, the cost of health insurance has increased by 87%."[11] In the face of these rising insurance coverage costs, employers, who fully or partly subsidize the coverage of more than half of all Americans, are retreating. The Kaiser Family Foundation recently reported that between 2000 and 2006 the percentage of employers offering health coverage fell from 69 to 61 percent, an 8 percent decline in just six years.[12] It will only get worse.

Employers who still offer health benefits have cut back by narrowing coverage and by shifting more of the financial burden to their employees by requiring higher contributions to premiums and significantly higher out-of-pocket expenses. In real terms, premiums are higher for less coverage, so actual inflation rates are even higher than the numbers cited above. Even the employed baby boomers are beginning to struggle with access worries, having trouble paying their health bills, and accruing medical debt.[13] The human costs of this crisis are well-known and largely ignored. Hos-

9. Uwe E. Reinhardt, *Is There Hope For the Uninsured?*, HEALTH AFF., Aug. 27, 2003, at W3-376, W3-377, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.376v1.pdf.

10. THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, 2006 ANNUAL SURVEY: EMPLOYER HEALTH BENEFITS 1 (2006), *available at* http://www.kff.org/insurance/7527/upload/7527.pdf.

11. *Id.* at 18.

12. *Id.* at 4.

13. The Commonwealth Fund Survey of Older Adults found that 43 percent of respondents with household incomes less than $25,000 and about 30 percent in households earning between $25,000 and $59,999 reported that they had not received health care because of costs, and more than one in ten older adults with incomes above $60,000 reported health care access problems. SARA R. COLLINS ET AL., COMMONWEALTH FUND, HEALTH COVERAGE FOR AGING BABY BOOMERS: FINDINGS FROM THE COMMONWEALTH FUND SURVEY OF OLDER ADULTS 11 (2006), *available at* http://www.cmwf.org/usr_doc/884_Collins_hlt_coverage_aging_baby_boomers.pdf. The survey also found that two-thirds of older adults in working households said they were worried or very worried that they might not be able to afford needed medical care in the future, and three quarters were worried that health care would be so expensive that they could no longer afford it. *Id.*

pital emergency departments are overwhelmed by uninsured and underinsured people seeking primary care. Hospitals are increasingly closing the safety valve of emergency care by rendering emergency care too little, too late. The last Institute of Medicine report on emergency care paints an ever bleaker picture of the last source of health care for the uninsured.[14] Patients are experiencing unprecedented levels of personal debt and bankruptcy due to an inability to pay health care bills.[15] As Sara Rosenbaum has described the situation, "[T]wo-thirds of the uninsured are low income, and one-third lives in poverty; more than a third report needing health care but not getting it; and over three-quarters of the uninsured at any given time will have been uninsured for the previous twelve months."[16] The number of individuals in the United States who are unable to access medical care because they are underinsured, or lack any insurance at all, continues to increase.

It is not just the working poor who are running scared; it is also you and I. Can we hold onto our jobs, and our insurance coverage, until we are eligible for Medicare? It is truly a perverse system that makes a large part of the population want to age more rapidly, a perverse quest for the Fountain of Age, not Youth, as a source of adequate coverage for ever-growing costs of prescription drugs and treatments.

Demand for health care services continues to grow, as modern medicine promises better treatments and longer life without disability. But fewer employers are offering coverage and fewer employees are buying it, which means that fewer dollars are available to pay for health care products and services.[17] This growing mismatch between demand and resources threatens to destabilize the health care marketplace. Just ask any top executive in the American auto industry about the role health care costs play in competitiveness.

The peculiarly American system of basing insurance on employment is collapsing in the face of businesses that are no longer

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14. COMM. ON THE FUTURE OF EMERGENCY CARE IN THE U.S. HEALTH SYS., HOSPITAL-BASED EMERGENCY CARE: AT THE BREAKING POINT (2006).

15. Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 551 (2006) (estimating that 668,000 to 915,000 families filed for bankruptcy in a single year, 2001, due in part to medical-related financial distress).

16. Sara Rosenbaum, *A Dose of Reality: Assessing the Federal Trade Commission/ Department of Justice Report in an Uninsured, Underserved, and Vulnerable Population Context*, 31 J. HEALTH POL. POL'Y & L. 657, 665 (2006).

17. Schoen et al., *supra* note 6, at W5-289.

making this same commitment to their employees. Clemans-Cope, Garrett, and Hoffman found:

> Between 2001 and 2005 the share of employees who were covered by employer-sponsored insurance (ESI) decreased by almost four percentage points . . . . Declines in employer sponsorship over the four year period were deepest among poor and near-poor employees, those working in small businesses, and those under age 35, further widening the existing gaps in access to ESI. By 2005, nearly 15% of employees had no ESI available to them, either through their own job or that of a family member—an increase of 2.5 percentage points from 2001. Between 2001 and 2005, the number of uninsured employees grew by 3.4 million, two-thirds of whom were from low-income families. Almost 19 million employees . . . were uninsured in 2005.[18]

At large employers like Wal-Mart, the corporate goal is to shift employees into part-time status to avoid the need to offer insurance coverage—what I would term "Walmarting" their employees to the greatest extent possible.[19] Fifty-six percent of employees in firms with between ten and twenty-four employees had employer-based coverage in 2005.[20] Another recent report indicates that the number of uninsured U.S. citizens increased by six million between 2000 and 2004, with this increase primarily due to declines in employer coverage, and suggests that this trend is likely to worsen given the continued increases in health care costs and health insurance premiums.[21] The number of citizens who will lose their coverage when Medicaid recipients have to produce proof of citizenship after June 30, 2006, is predicted to add to the rolls of the uninsured.[22]

Millions of individuals are unable to gain access to care because of numerous barriers including geography, racial disparities, and immigrant status. Those who lack access to needed care, which may include primary care, chronic care, specialist care, or timely

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18. LISA CLEMANS-COPE, BOWEN GARRETT & CATHERINE HOFFMAN, THE HENRY J. KAISER FAMILY FOUND., CHANGES IN EMPLOYEES' HEALTH INSURANCE COVERAGE, 2001-2005, at 2 (2006), *available at* http://www.kff.org/uninsured/upload/7570.pdf.

19. Wal-Mart has indicated it wants to move its workforce from 20 percent to 40 percent part-time. *See* Paul Krugman, *The War Against Wages*, N.Y. TIMES, Oct. 6, 2006, at A25, *available at* 2006 WLNR 17303298 (Westlaw).

20. CLEMANS-COPE, GARRETT & HOFFMAN, *supra* note 18, at 10.

21. *Id.* ("The number of uninsured nonelderly adults grew by 6.3 million between 2000 and 2004 and 3.8 million (60%) were working adults. The majority of the growth in uninsured workers was among poor and near-poor workers.").

22. Robert Pear, *Medicaid Rule for Immigrants May Bar Others*, N.Y. TIMES, Apr. 16, 2006, at 1, *available at* 2006 WLNR 6371006 (Westlaw).

emergency or urgent care, risk serious health consequences. Lack of health insurance is associated with significantly decreased use of recommended health care services for cancer prevention, cardiovascular disease risk reduction, and diabetes management among lower-income as well as higher-income adults.[23] In addition to the concerns, burdens, and stress directly related to their illness, patients who are uninsured or underinsured also face high levels of debt, bullying from collection agencies, worry, and possible bankruptcy.

Why is it we have fumbled the opportunity for some form of universal access to health care?[24] We fail to provide universal access to care in spite of compelling arguments for such access. Rights-based arguments for universal access to health care fall on deaf American ears, in spite of powerful and persistent arguments in its favor.[25]

The evidence—as to what will work, and what will be most efficient and fair—is increasingly uncontroverted, but the path to reform is impeded by three bramble bushes: the history of our health care system and its resulting fragmentation; the entrenched interests tied to employment-based health insurance; and ideology. The history of American public health programs—Medicare and Medicaid in particular—offers one explanation for our current troubles. History matters in policy making. The history of American health care coverage is a story of progressive fragmentation of care, in spite of good intentions.[26] One observer describes Medicare as both a blessing and a curse: "This is essentially the story of universal health coverage first being subordinated to old age insurance, repeatedly blocked by organized medicine, and then crowded out by deeply entrenched, vested interests and the astronomical growth of Social Security's and Medicare's costs."[27]

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23. Jack Hadley, *Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income*, 60 MED. CARE RES. & REV. 3S (Supp. June 2003).

24. *See generally* RICK MAYES, UNIVERSAL COVERAGE: THE ELUSIVE QUEST FOR NATIONAL HEALTH INSURANCE (2004).

25. JULIUS B. RICHMOND & RASHI FEIN, THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT (2005). For a powerful right-based argument, see TIMOTHY S. JOST, DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE (2003).

26. *See* JILL QUADAGNO, ONE NATION, UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE (2005).

27. MAYES, *supra* note 24, at 141.

Large-scale, comprehensive reform is made more difficult by this history, as Medicare "permanently fragmented the nation's health care system. It cemented the pattern of having different programs—along public and private paths—collectively meet the majority of the population's need for medical care."[28] The result of this fragmentation has been that we have a mix of private, tax-subsidized employer based programs along with public programs that cover specific groups—Medicare for the elderly, Medicaid for the poor, the VA system for veterans, and nothing for those in the gaps. The current government insurance systems—Medicare, Medicaid, the Veterans Health Administration system and other military health care programs, and the Federal Employees Health Benefits program—exclude large numbers of uninsured citizens by their definitions of eligibility. The forces of inertia created by these large programs are extremely potent. Our system, in Rick Mayes's words, "has shown an extraordinary ability to muddle through one crisis after another. In the process, it has successfully repelled every attempt at comprehensive reform."[29]

We have a private health insurance industry second to none in the world. Most countries use government-provided health insurance to avoid the problems of private insurance, as we do with Medicare for seniors, and Medicaid, using means testing to provide insurance for the poor and near poor. We let the nonelderly, nonpoor Americans rely on employer-based insurance.[30] This historical accident worked reasonably well, until the cost escalation of health care began to unravel it. Employers struggle to cut back on their health care costs by passing them on to employees; employees search for jobs with good coverage if they have health conditions that will be expensive to treat. And the insurers hire by the thousands in order to develop methods of avoiding coverage of their subscribers. As Krugman and Wells write, "[R]ising health care costs are undermining the institution of employer-based coverage. We'd suggest that the drop in the number of insured so far only hints at the scale of the problem: we may well be seeing the whole institution unraveling."[31]

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28. *Id.* at 142.

29. *Id.* at 175.

30. *See* RICHMOND & FEIN, *supra* note 25.

31. Paul Krugman & Robin Wells, *The Health Care Crisis and What To Do About It*, N.Y. REV. BOOKS, Mar. 23, 2006, at 40, *available at* http://www.nybooks.com/articles/18802 (reviewing HENRY J. AARON & WILLIAM B. SCHWARTZ WITH MELISSA COX, CAN WE SAY NO? THE CHALLENGE OF RATIONING HEALTH CARE (2005); RICHMOND

Ideology is the third set of brambles blocking our path.

II. CHOICE AND THE CARTOONS OF IDEOLOGY: OVERVALUING THE PONY

Americans love efficiency and consumer choice. Since the days of Frederick Winslow Taylor and his obsession with industrial efficiency,[32] and later W. Edwards Deming[33] and his program of quality control and efficiency, the ideological appeal of such value-free models has been strong. Health service researchers are as prone to the siren song of efficiency as are doctors, academics, and researchers generally. From President Clinton's "managed competition" in his Health Security Act,[34] to the current FTC report *Improving Health Care: A Dose of Competition*,[35] the market reigns—or at least the idealized market as target, goal, light at the end of the tunnel, religious icon of life lived without waste. The market means efficiency, reduction of waste, and choice—lots of choice. In consumer goods, it is a positive good. The proponents of a move to a more competitive health care market argue that an improved market might produce higher quality care at lower cost, and they may be right, for some percentage of the well-insured marketplace. As Sherry Glied notes, "Many people in this group might choose to take advantage of basic health care services offered at lower prices.

& FEIN, *supra* note 25; JOHN F. LOGAN, R. GLENN HUBBARD & DANIEL P. KESSER, HEALTHY, WEALTHY, AND WISE: FIVE STEPS TO A BETTER HEALTH CARE SYSTEM (2005)).

32. Frederick Winslow Taylor was an American industrial engineer who came to be

> called the father of scientific management. His management methods for shops, offices, and industrial plants were successfully introduced in many industries, notably steel mills. He was the author of *The Principles of Scientific Management* (1911), *Shop Management* (1911), *Concrete Costs* (with S. E. Thompson, 1912), and *Scientific Management* (C. B. Thompson ed., 1914).

Answers.com, Columbia Encyclopedia, Frederick Winslow Taylor, http://www.answers.com/topic/frederick-winslow-taylor (last visited Mar. 9, 2007).

33. Total Quality Management (TQM) was developed by W. Edwards Deming after World War II for improving the quality of goods and services. The Japanese adopted Deming's TQM in 1950 to revitalize their industrial production, and by 1980 their products had dominated world markets. ANDREA GABOR, THE MAN WHO DISCOVERED QUALITY: HOW W. EDWARDS DEMING BROUGHT THE QUALITY REVOLUTION TO AMERICA (Penguin 1992) (1990).

34. *See, e.g.*, National Health Security Plan, Executive Summary, Table of Contents and Supporting Documents, *available at* http://www.ibiblio.org/nhs/NHS-T-o-C.html (last visited Mar. 9, 2007).

35. DEP'T OF JUSTICE, FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004) [hereinafter IMPROVING HEALTH CARE: A DOSE OF COMPETITION], *available at* http://www.usdoj.gov/atr/public/health_care/204694.pdf.

Some would undoubtedly decide to contract for limited insurance coverage and lower-quality providers in exchange for predictable, guaranteed access to some health care."[36] This would be choice combined with efficiency. But this idealization of choice is irrelevant to the underinsured and the uninsured, since they do not have the luxury of choosing levels of care or other forms of consumption instead.

Ideology has always mattered in political discourse.[37] In debates over providing and financing health care in the American health care system, it has come to matter a great deal. The rhetoric of both efficiency and patient choice echo through the debates over national health insurance and the dilemma of the uninsured. The debate generates visceral responses in the public, at the level of cartoon emotions and cartoon ideology. Cartoons caricature a political position, and overstate it as a part of the art of cartooning.[38] They also tap an emotional vein in a national culture and set of political values. Cartoon sentiments are part of a rich set of devices

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36. Sherry Glied, *Side Effects: A Dose of Competition and Access to Care*, 31 J. HEALTH POL. POL'Y & L. 643, 654 (2006).

37. HAROLD WALSBY, THE DOMAIN OF IDEOLOGIES 142-43 (1947), *available at* http://www.gwiep.net/books/doi22.htm.

> Besides the *cognitive* aspect—the logically implied assumptions—there is another and equally important aspect to be taken into account in defining an ideology, since it is an essential and necessary ingredient, characteristic of all ideologies. It is, namely, the emotional or *affective* aspect—that aspect which is connected with morals, values etc.—and we may consider it as complementary to, and as mutually interpenetrating with, the cognitive aspect. Using a very crude analogy, we can say that the affective element is the mortar which binds the bricks of the cognitive element together to form a whole. Just as the cognitive aspect of an ideology is characterised by a particular set of logically implied assumptions, so, similarly, the affective aspect is characterised by a particular set of emotional ties or "identifications." These identifications—which vary in their strength from one ideological group to another, and from person to person in the same ideological group—attach themselves to a whole range of things: from general assumptions, abstract principles and ideas, to concrete facts, forms, symbols, and even particular objects or persons.

Id.

38. As Herb Block has written in *The Cartoon*,

> [W]hat I'm talking about here is the cartoon as an opinion medium. The political cartoon is not a news story and not an oil portrait. It's essentially a means for poking fun, for puncturing pomposity. Cartooning is an irreverent form of expression, and one particularly suited to scoffing at the high and the mighty. If the prime role of a free press is to serve as critic of government, cartooning is often the cutting edge of that criticism.

Herb Block, *The Cartoon*, http://www.loc.gov/rr/print/swann/herblock/cartoon.html (last visited Mar. 9, 2007). *See generally* WILLIAM FETSKO, COLONIAL WILLIAMSBURG PRODUCTIONS, USING AND ANALYZING POLITICAL CARTOONS 3 (2001), *available at* http://ali.apple.com/ali_media/Users/1000323/files/others/Political_Cartoons.pdf.

that can paralyze further analysis by generating a crude viewpoint that resonates without nuance and blocks further thought. Like political attack ads that use background noise and images to pick up viewers' prejudices and project them onto a candidate, a cartoon replays and therefore reinforces preexisting values—cartoon values.

Consider the cartoon by Bud Blake, reprinted by David Hyman as part of his endnote to a special issue of the *Journal of Health Policy, Politics and the Law* devoted to the Federal Trade Commission Report on Health Care and Competition.[39] The cartoon shows two small boys talking to one another as they play. One, riding on his wooden sawhorse—his play horse—says, "We're not very rich are we?" The other responds, "No, but look at it this way: You've got your health." To which the first boy responds, "Well, I'd be willing to swap a little health for my own pony." Very cute. What does it capture? The centrality of choice in one's life, the merits of allowing people to make their own decisions about their preferences, and the ultimate point that we might want some things more than further spending on health. In its purest sense, as Hyman undoubtedly uses it, it means that the best of all possible worlds is one in which individual choice in a well-functioning economic marketplace maximizes individual welfare and satisfaction, and therefore social satisfaction. Perhaps a health savings account to shift our choices from government to consumers? Perhaps some other reform that is based on the market and empowerment of consumers? Exciting stuff—plausible in the abstract but flawed for too many Americans who need health care, yet still appealing to those ideologically blinded to the costs of the market in health care and the human waste generated by ideology ungrounded in complex reality.[40]

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39. David A. Hyman, *Endnote*, 31 J. HEALTH POL. POL'Y & L. 704, 705 (2006).

40. *See, e.g.*, DEAD MEAT (On the Fence Films 2005), *available at* http://www.onthefencefilms.com/video/deadmeat. The On the Fence Films website aims to attack the single-payer model, the Canadian system, and to spread the vision of market-based care. On the Fence Films, http://www.onthefencefilms.com (last visited Mar. 9, 2007). It demonstrates a hard-core Ayn Rand ideology of choice over any form of government system. *See id.* The website features a film, *Dead Meat*, produced in this attack mode. On the Fence Films, http://www.onthefencefilms.com/video/deadmeat (last visited Mar. 9, 2007). The website also lists a string of books in a similar vein, including: John C. Goodman, Gerald L. Musgrave & Devon M. Herrick, *Lives At Risk: Single Payer National Health Insurance Around the World* (2004); Sally Pipes, *Miracle Cure: How to Solve America's Health-Care Crisis and Why Canada Isn't the Answer* (2004); Joseph L. Bast, *Why We Spend Too Much on Health Care . . . and What We Can Do About It* (1993); David Gratzer, *Code Blue: Reviving Canada's Health Care System* (1999).

III. TANGLED IDEAS AND CLARITY OF NEED: RESHAPING IDEOLOGY

A. *The Value of Health Care to the Uninsured*

Ideology matters in health care as in so much else in our political system, perhaps more than in most European countries. [41] The free market ideology—migrating from areas of the economy where it makes sense, to the health care economy, where it doesn't—has been one of the stumbling blocks to improvement of access to care. Health care reform based on such market initiatives has been pushed in spite of its mismatch with reality. Ideology of course has remarkable power; we define ourselves through our beliefs, and define political action by broad ideas. *Choice* is one of those strong ideas, hard to dislodge even when it makes little sense.

Part of the success of the ideology of personal choice in health care is that it has appeal for a certain kind of trade-off. If we have generous last-dollar coverage for care of marginal value, then we have no incentive to refuse such care. A system in which one chooses levels of coverage means that one can trade good care for platinum care, or decide to pocket the difference, and buy the pony. This assumes the decreasing marginal benefit of further care and the likelihood of waste in the system, of little benefit for money spent. If all of this is true, then a market-based system in which consumers control some of their dollars will give them choice at little health risk to them.

The analysis is wrong for two reasons. First, it assumes care of marginal value, with the critical care already well covered and the remainder more about amenities such as no waiting, free choice of name-brand prescription drugs over generics, boutique clinic or hospital care, and so on. It also assumes that medical care at the margin has little impact on aggregate population health, which is

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41. *See* Kant Patel & Mark E. Rushefsky, *The Health Policy Community and Health-Care Reform in the U.S.*, 2 HEALTH 459, 472 (1998).

> Respondents' political ideology is found to be strongly related to what specific reforms liberals and conservatives support. . . . For example, an overwhelming majority of liberals and a majority of moderates support comprehensive reform of the US health-care system while a majority of conservatives oppose such a move. Liberals (unanimously) and moderates (strongly) support the notion that any health-care reform should provide universal coverage, while only a slight majority of conservatives support such an idea. Similarly, a strong majority of liberals support a single-payer system and employer mandates while conservatives oppose those ideas.

Id.

clearly not true, particularly for the average uninsured person. This person may be sicker than the average insured person and may consume less medical care. One recent study found that "the percentage of uninsured persons taking medications for their illnesses [was] far lower than those with employment-based insurance or Medi-Cal (California's Medicaid program)."[42] The authors also found that Medi-Cal beneficiaries were more likely to take medications than those with employment-based insurance.[43] This was explained by the growth of co-payment and deductible requirements, which were successfully deterring people from buying necessary medications.[44] "Some of the most dramatic figures were for heart disease, where medication rates were 27 percent for the uninsured, 42 percent for employment-based coverage, and 60 percent for Medi-Cal."[45]

Jack Hadley notes that "the uninsured receive fewer preventive and diagnostic services, tend to be more severely ill when diagnosed, and receive less therapeutic care."[46] The uninsured have a much higher relative risk of death than the privately insured, and improving the health of the uninsured "could increase annual earnings by 15% to 20%."[47] Hadley notes that the cumulative effect of the more recent studies is that health insurance (or some other form of reliable access to health care) will have a strong effect on health. Reasonable people can no longer argue that the uninsured either don't have medical problems, have problems for which health care won't help, or manage to get the care that solves their health problems.[48]

B. *Selling Products: The Problem of Health Insurance Markets*

What then does consumer choice, reflected in control of a larger share of discretionary spending, mean for competition? Many insurance companies providing complex insurance coverage choices allow insurers to slice and dice the subscriber market for insurance, as "competition increases distinctions within a beneficiary population. Under competition, advantaged consumers have

42. Thomas Rice et al., *The Impact of Private and Public Health Insurance on Medication Use for Adults With Chronic Diseases*, 62 MED. CARE RES. & REV. 231, 234 (2005).

43. *Id.*

44. *Id.* at 232.

45. *Id.* at 234.

46. Hadley, *supra* note 23, at 3S.

47. *Id.* at 65S.

48. *See* Richard Kronick, *Commentary*, 60 MED. CARE RES. & REV. 100S (Supp. June 2003).

incentives to distinguish themselves from the disadvantaged."[49] But this fictive choice of insurance policies is irrelevant to improving access to the kind of expensive care that the small percentage of the population will need. The use of co-payments, deductibles, and other favorable devices for shifting choices onto consumers means mostly cutting back on consumption of small ticket health care; it saves very little in terms of waste, since these items do not account for most medical costs.[50] Since most medical expenses are caused by a small percentage of the very sick who need expensive care, consumer choice models like consumer-driven health care are ineffective in promoting savings. Such models are an ideological distraction from a properly designed system that guarantees access for everyone, and particularly for the high utilizers. Private insurance uses large numbers of employees to devise ways to sort out the high users from the low users, and either price the product too high for the high user, or find ways to avoid paying that user. In Krugman's words, "[P]rivate insurance companies spend large sums not on providing medical care, but on denying insurance to those who need it most."[51] The idea of choice is that it promotes efficiency and a wider range of options for everyone, but the evidence is to the contrary.

C. *Providing New Ideological Underpinnings*

Advocates of the market and its improvement, like the FTC report of Hyman and his staff, are talking to a certain segment of the market. They are not addressing the needs of those with little or no insurance. For the uninsured, the choice of health or pony is not a real choice, but a bitter fiction. And for them, access to some level of care buys real benefits—longer life with less discomfort and disability. Health insurance means better health for those currently uninsured. So the moral argument of social solidarity with our fellows, so eloquently put by Timothy Jost in his comparative work on European systems, pulls in tandem with the conservative argument that more health care is better for the economy.[52]

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49. Glied, *supra* note 36, at 654.

50. Krugman & Wells, *supra* note 31, at 39.

51. Paul Krugman, *Health Economics 101*, N.Y. TIMES, Nov. 14, 2005, at A21, *available at* 2005 WLNR 18365895 (Westlaw).

52. *See generally* JOST, *supra* note 25.

The conservative ideology of choice can be enriched by evidence-based arguments for universal access.[53] Such arguments should be particularly attractive to the business community, increasingly crippled by rising health care costs. First, health care is necessary in order for people to take care of themselves. "When people are ill, individual liberty and personal responsibility are quickly compromised."[54] The high cost of hospital and health care is a major contributor to personal bankruptcy in the United States, as medical bills pile up unpaid.[55]

Second, the high level of cost-shifting in the health care economy, as the volume of uncompensated care is provided through hospital emergency rooms and physicians, raises the costs of premiums for all. It might be argued that a form of direct provision of services, or direct government payment to providers, reduces cost-shifting and free-riding and promotes transparency, all key conservative values. The FTC report in fact comments on this problem directly: "[I]t is more efficient to provide subsidies directly to those who should receive them, rather than to obscure cross-subsidies and indirect subsidies in transactions that are not transparent. Governments should consider whether current subsidies best serve their citizens' health care needs."[56]

Third, private health insurance in a competitive market has failed miserably at generating health, although it does generate profits for the companies themselves.[57] The current system is inefficient and wasteful. The right to choose a pony over high levels of health care in a competitive insurance market is an appealing idea to conservatives and probably to Americans generally, whose ideology has been shaped by a consumerist attraction to "choice," mobility of labor, and flexibility in employment, as opposed to solidarity with others in sharing responsibility for health. As Menzel and Light note, however, "Such a claim . . . needs to reckon with the

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53. Paul Menzel & Donald W. Light, *A Conservative Case for Universal Access to Health Care*, HASTINGS CTR. REP., July-Aug. 2006, at 36.

54. *Id.* at 40.

55. Jacoby & Warren, *supra* note 15, at 536.

56. IMPROVING HEALTH CARE: A DOSE OF COMPETITION, *supra* note 35, at 465.

57. *See, e.g.*, Menzel & Light, *supra* note 53, at 40-41.

> The $420 billion (31 percent!) paid for managing, marketing, and profiting from the current fragmented system could be drastically cut and the difference used either to pay for medical costs of the underinsured or uninsured or to keep the profits of companies and the savings of individuals from being drained.

Id. (citations omitted).

inherent limitations of voluntary, competitive insurance in carrying out its principal function of helping seriously ill individuals regain their capacities to take care of themselves."[58]

The risk aversion principle of insurance companies means that few people can get coverage at an affordable price. This has particularly damaging effects for small businesses and entrepreneurs. The result has been loss of coverage for those with disabilities and chronic conditions, and cost shifting to employees in higher numbers. "The result is that those with greater need and modest income are forced to use up their savings and impoverish themselves."[59] Our system forces the insured—the working poor and increasingly the middle class—to confront this bitter trade-off between health care access and other necessary spending. Is this the pony that Hyman has in mind?

CONCLUSION

How does a rooted ideology change? It may not change, grounded as it is in decades of repetition—its chant, like the singing of the *Star Spangled Banner*, brings a warm and nostalgic feeling to the hearts of those hearing it. The ideological differences run deep, even in the health policy community, which has an important voice in American agenda setting.[60] But arguments based both on principle and on evidence are the only tools we have to reshape ideology to better serve human needs. One can only hope that as the volume of unmet health care needs grows in our population, we may finally reach a "critical juncture,"[61] where the rigidities of ideology may be forced to confront the complex costs imposed by our failure to provide universal access to health care. If conservatives are pragmatic and liberals are caring, surely the two values can be fused into a set of goals to promote access.[62] The pundits are quite depressed

58. *Id.* at 40.

59. *Id.*

60. Patel & Rushefsky, *supra* note 41, at 480. Patel and Rushefsky note that "fragmentation within the health policy community over the nature of proposed reforms may well be one additional explanation for failure to achieve comprehensive change and for instability in the health policy agenda. Policy fragmentation, at least over proposed solutions, is partially a function of ideological differences." *Id.*

61. MAYES, *supra* note 24, at 145.

62. Paul Krugman and Robin Wells argue that the Veterans Administration (VA) successes with the health system will justify a more comprehensive reform as the obvious improvement in the VA system is contrasted with the market niche segmentation and claim denials of the private insurance industry. Krugman & Wells, *supra* note 31, at 42.

about the possibilities, given the sheer stickiness of the forces of inertia, vested interests, and thoughtless ideology.[63] They may be wrong. We see some states tackling the problem of access, for example. Recent initiatives are innovative experiments that may represent viable solutions in some states, such as the legislation in Massachusetts that will provide nearly universal health care coverage, and the Illinois program extending health coverage to all uninsured children in Illinois.[64]

Perhaps a starting point is a new cartoon to project a new and more complex reality, one that substitutes, for the two small boys of Blake (and Hyman), two middle-aged employees of Wal-Mart leaning on their brooms. One says: "We're not very rich are we?" The other responds, "No, but look at it this way—you get no insurance at work, but at least you can buy an expensive private policy that won't cover your diabetes treatment costs." To which the first man responds, "Well, I'd sure be willing to swap a little of this kind of choice for my own health." It is not as cute a punch line, but in its painful depiction of the world for too many, it is a reminder that ideology can be remade.

63. Reinhardt, *supra* note 9, at W3-376.

64. Pam Belluck & Katie Zezima, *Massachusetts Legislation on Insurance Becomes Law*, N.Y. TIMES, Apr. 13, 2006, at A13, *available at* 2006 WLNR 6212167 (Westlaw); Rod R. Blagojevich, Governor, State of Ill., Answers to Your Questions About All Kids, *available at* http://www.allkids.com/assets/060706_akbooklet.pdf (last visited Mar. 9, 2007).