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CONTENTS

THE RIGHT TO HEALTH – A HOLISTIC HEALTH PLAN FOR THE NEXT ADMINISTRATION

Barbara P. Billauer[1]

ABSTRACT

While both sides of the aisle agree that minimizing costs is a critical component in any health plan, few plans provide specifics aimed at achieving that objective. Current programs provide or extend insurance coverage to the uninsured, divest employers of a coverage requirement, and vest it, instead, in individuals. These methods would add substantial costs to the system without commensurate return. At the outset, the cost-savings of buying insurance in bulk -- by several thousand employers - - disappears, replaced by the costs of handling hundreds of millions of individual policies. One can only imagine the staff needed to process applications numbering orders of magnitude more than the current load, along with the additional bureaucratic layers needed to police legal requirements.

This plan recommends maximizing health *care*, not coverage, for those currently uninsured, and suggests preserving

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the status quo regarding health insurance where it is working, at least for the immediate future. It is, first, a market-driven plan, favoring incentives and practices that maximize profits for physicians who can demonstrate improved health (or increased wellness) in their patient population, and recognizes the financial expectations and motivations of the diligent, motivated and/or entrepreneurial physician. Second, it does away with practices that allow profits to accrue to non-medical owners, such as HMOs, where individual health providers have no financial stake (or capitalistic incentive) in the outcome of their ministrations, the satisfaction of their assigned patient group, or the overall health of the subscribers.

This plan also suggests that the government assumes non-medical infrastructure costs, similar to other low-profit operations that do not lend themselves to private enterprise, while protecting the practice of medicine from outside intervention. Thus, third, the plan creates a federally-run health facility ("*Health House*") where rental and administrative costs, supplies, laboratory services, and basic diagnostic machines are assumed by the government and/or shared by the medical members invited to join. This practice would lower overhead and maximize physician profits, without interfering in patient care or physician selection. In exchange for this financial incentive, physicians would donate a portion of their increased income in the form of medical care for the uninsured. Fourth, the plan broadens the class of those allowed to perform certain routine health services, while noting the legal implications of licensing changes. In addition, and fifth, the plan contemplates targeting specific diseases for enhanced treatment programs and allocating additional research resources, especially for diseases of the aging. Sixth, and finally, the plan contemplates regulating conduct and lifestyle choices of minors that threatens their health. This would be accomplished by broadening the reach of regulations, such as those banning access to alcohol, and tobacco, or exposure to media deemed harmful. An exposition of the last provision is outside the scope of this article.

Various means of augmenting funding for this program will be explored. These include diverting punitive damage awards to finance research or medical care, and pooling clinic fees to create a funding mechanism for catastrophic care. Selection of patients eligible for extraordinary care would be done by the physician-group caring for them.

OVERVIEW: MISCALCULATION OF COSTS DOOMS EXISTING PLANS

Current estimates place the cost of physician care at about $7,000 per patient annually.[2] However, health plans based on this factoid, such as that presented by Senator Ronald Wyden of Oregon,[3] which do not incorporate prescription costs of the aging baby boomer, laboratory tests and diagnostic imaging services, are doomed to fail, precisely because of gross financial underestimation. Current cost estimates also fail to account for the increased costs that expansion of health coverage would generate. Thus, as more people are screened, more and more positive diagnoses are made. This practice in turn results in an artificial increase in the incidence rate of many diseases,[4] at least at the outset of the program, a situation commonly referred to as "screening bias."[5]

Projections based on past years are also likely to be grossly inaccurate as the age distribution of the U.S. population continues to change. Thus, as the overall age of the population increases, a greater prevalence of Alzheimer's Disease, broken bones, hearing loss, malnutrition and other diseases of the aging such as cancer, should be expected, commensurate with an increased use of prosthetics, heart and diabetes medication, and cosmetic alterations.[6] Gross mis-estimations of either the

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[2] Steve Lohr, *Who Pays for Efficiency?*, N.Y. TIMES, June 11, 2007, *available at* http://www.nytimes.com/2007/06/11/business/businessspecial3/11save.html.

[3] Healthy Americans Act, S. 334, 110th Cong. (2007), 2007 CONG US S 334 (Westlaw).

[4] Hence, costs of the new health care regime must be based on the projected numbers of cases that will be found due to increased screening in a population that may be health-compromised to start. Thus, we must raise the question, once we decide to pay for and institute colonoscopy screening (or any other type of surveillance mechanism), are we prepared, and can we afford, to provide the treatment and surgery that additional screening will expose?

[5] *See generally* LEON GORDIS, EPIDEMIOLOGY (3d ed. 2004).

[6] Some experiences, such as in Indiana, seem to indicate that the additional costs of finding – and treating-- more diseases detected as a result of screening bias are offset by the reduced final bill, as costs of treating diseases diagnosed early are lower. However, the Indiana experience is limited in time and does not

number of persons affected,[7] or any aspect of the underlying economics[8] of the plan -- or the current cost of health care[9] doom many currently proffered plans to failure.

Plans aimed at providing universal insurance coverage -- or those seeking to divest responsibility for group coverage and transfer it to subsidized or (otherwise attractive) individual

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reflect the course of an overall aging population, augmented by immigrant influx. Edward Mitchell Roob Jr., Sec'y, Ind. Family & Soc. Servs. Admin., Policy Briefing at the U.S. Capital: The Federal Role in State Health Care Reform: What are States Already Doing and How Can the Federal Government Help (July 30, 2007).

[7] The number of immigrants has increased dramatically over the years. *See, e.g.*, U.S. Immigration Statistics, http://www.cnn.com/interactive/us/0603/charts.immigration/frameset.exclude.html?eref=yahoo (last visited Nov. 18, 2007). How immigration legislation will affect the cost estimates of any insurance based plan has yet to be addressed, along with the issue of covering illegal aliens, now numbering about twelve million. *Id.* The addition of this population to the current estimates of uninsured would result in about a 2% error. The affect of prisoner return to the population also must be examined.

[8] Another economic aspect that will affect any plan is the economic strength of the United States government. The increased 2006 poverty rate of 12.3% was tied to the half a percent increase in persons lacking coverage, based in part by a declining percentage of employers providing coverage, increasing from 15.3% in 2005 to 15.8% in 2006, or an additional 2.2 million people as noted by at least one commentator. *See* N.C. Aizenman and Christopher Lee, *U.S. Poverty Rate Drops; Ranks of Uninsured Grow*, WASH. POST, Aug. 29, 2007, at A3, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2007/08/28/AR2007082800779.html. "[N]ew census data show[s] that many of the newly uninsured are working Americans from middle- and high-income families. Of the 2.2 million people who became uninsured in 2006, 1.4 million had a household income of $75,000 or higher. About 1.2 million of the newly uninsured worked full time. 'This is about the problem of the uninsured spreading to the middle class and working people,' said Harvard Medical School professor Stephaine J. Woolhandler, a liberal advocate of creating a government-run national health insurance program. 'That's the thing that's emerging newly this time.'" *Id.*

[9] "Bad debts at hospitals from unpaid patient bills are triggering deep and growing problems within the US healthcare system as up-front costs are increasingly passed on to consumers and growing numbers of people are opting out of health insurance. Bad debts for hospitals in 2004 were estimated to be between $26bn and $30bn, representing about 12 per cent of their revenue and rising." Christopher Bowe, *US Healthcare Hit by Hospital Bad Debts*, FIN. TIMES, Aug. 5, 2007, *available at* http://search.ft.com/ftArticle?id=070805002544.

policies, are similarly problematic. Requiring individuals to purchase their own coverage, the centerpiece of many plans, only adds cost to the system. In other words, currently proposed initiatives are aimed at financing individual health care coverage and divesting procurement of group policies by employers, add costs to the system without providing commensurate benefits. The incremental costs added by billing, bookkeeping, and administration, for example, plus the addition of a middleman intermediary (such as the insurance company), must be carefully calculated before such an approach is seriously considered.

The crux of this plan then, is to reduce health care costs for those presently insured, and to provide basic direct health care, rather than insurance coverage, for those currently uninsured or underinsured. The plan will be financed by cost-saving measures incorporated into the present system without compromising physician care, physician profits, or medical judgment.

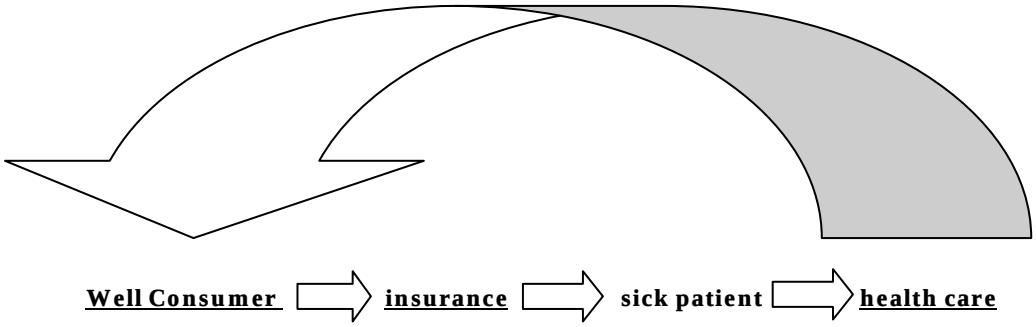
Employer-provided health premiums, as presently constituted, will be assumed to be acceptable by those involved, and considered costs society has accepted and opted to bear, and hence will not be affected. The cost-savings provisions of this plan will result from the implementation of the steps outlined below (in addition to tobacco taxes and other currently mentioned initiatives). Savings to the insurance companies or employers that result from the streamlined economics or improved population health resulting from this plan will not accrue to benefit the insurer or employer. Neither will insurance shareholders nor corporation stockholders be allowed to reap the benefits of this plan in the form of reduced premiums or bonuses. These will be capped at present-day rates and figures. Instead, additional profits will be transferred to a community fund which will be available to provide health care for the uninsured, under-served, or those overburdened by untenable premiums.

This plan does not discuss several salient aspects of the health care conundrum and should not be considered comprehensive, or perceived as a broad overhaul. Such unaddressed aspects include costs of pharmaceuticals, biotech developments, and sophisticated diagnostic testing. Also unaddressed are skewed malpractice premiums borne by a segment of the medical community, most importantly

obstetrics, due to high verdicts generated by malpractice cases gone sour. Finally, the income expectations of the average physician, (for whom, more often than not, the expectations of a more than comfortable lifestyle relative to the average wage-earner were at least a partial inducement for this career choice,) must be reckoned with. The significance of income expectations cannot be underestimated.

Specific health objectives contemplated by this plan, in addition to greater focus on aging care, include: lower deaths from influenza, better outcomes in diabetes control, fewer deaths from lung cancer and asthma, reduced mortality from hospital and food-related infections, and new regulations affecting lifestyle to improve overall health. To demonstrate:

As currently suggested:



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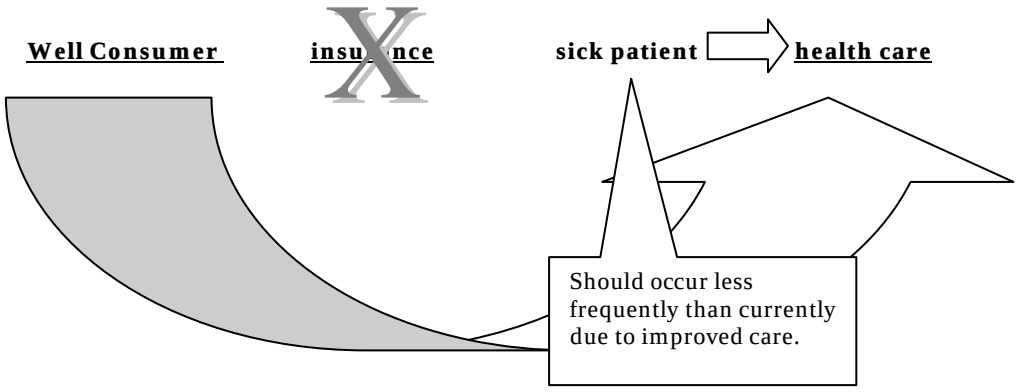

I. INTRODUCTION

OBJECTIVE: MAXIMIZE CARE, NOT COVERAGE

As many a trial lawyer will tell you, the way a question is framed and the language used influences the answer. In the current debate, the health crisis issue has been framed as the need to expand health *coverage*.[10] And while most agree the health care system is broken,[11] the discussion centers on insurance coverage[12] and the debate is over how much and how, not on whether.[13] Every candidate has offered various permutations, combinations, and amalgamations to provide health care coverage to the currently uninsured 47 million

[10] In an excellent Op-Ed piece, law professors Clark Havinghurst and Barak Richman shed light on problems generated in the current coverage-based system, most notably the lack of understanding of the true price of care. Clark Havighurst and Barak Richman, Op-Ed., *Who Pays for Health Insurance*, WALL ST. J., Sep. 6, 2007, at A17, *available at* http://online.wsj.com/article/SB118904358759518916.html.

[11] *See generally* Jacob S. Hacker, *Healing Our* Sicko *Health Care System*, 357 NEW ENG. J. MED. 733 (2007), *available at* http://content.nejm.org/cgi/content/full/357/8/733. For a comparative assessment of health statistics and costs between the United States and other countries, *see generally* Barbara P. Billauer, *Why Universal Coverage Won't Make Americans Healthier: Or "Quality, Economical & Doable Health Insurance" (QED) & Other Oxymorons of the (Insane) Political Mind*, *available at* http://ssrn.com/abstract=1028644.

[12] Perry Bacon, Jr., *A Sharp Divide on Health Care*, WASH. POST, NOV. 16, 2007, at A5. "We have a medical liability system that is completely out of control." LEWIS L. LASKA AND KATHERINE FORREST, THE COMMONWEAL INSTITUTE, FAULTY DATA AND FALSE CONCLUSIONS: THE MYTH OF SKYROCKETING MEDICAL MALPRACTICE VERDICTS (2004), http://www.commonwealinstitute.org/reports/CI-MedMalpracticeReport-Oct20041.pdf at 5, n.6 (quoting Dr. Donald J Palmisano).

[13] Barack Obama has called on businesses, insurance companies and lawmakers, to "overhaul the nation's health care system to cover every American." Anne E. Kornblut and Perry Bacon Jr., *Obama Says Washington is Ready for Health Plan*, WASH. POST, May 30, 2007, at A5, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2007/05/29/AR2007052900111.html.

Americans.[14] This contagious, single-minded focus on expanding insurance coverage as the panacea, has clouded critical analyses and obfuscated innovative approaches to raising the health bar of the nation. Even those whose mandate is health education, prevention, research and expanded care have succumbed.

By way of example, the American Cancer Society[15] (ACS) recently announced plans to devote its entire fifteen million dollar advertising budget this year -- not on healthy lifestyle education (such as smoking cessation or screening for colorectal or breast cancer) -- but on the consequences of inadequate health coverage.[16] When an institution as venerated as the ACS, enters the turf upon which political battles are waged, we lose a

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[14] *See, e.g.*, Robert Pear, *Clinton to Propose Universal Health Care*, N.Y. TIMES, Sep. 16, 2007, at A18, http://www.nytimes.com/2007/09/16/us/politics/16clinton.html (According to Robert Pear, "Clinton aides said her plan would preserve a large role for private insurance companies.").

[15] According to the website of the American Cancer Society, their mission statement does not reflect this activity. The ACS Mission Statement reads, "[t]he American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service." *See* American Cancer Society, http://www.cancer.org/docroot/AA/aa_0.asp (follow "ACS Mission Statements" hyperlink) (last visited Nov. 14, 2007).

Another primary goal of the ACS is "to provide the most accurate, up-to-date information on cancer." Even ACS's Advocacy & Public Policy section of the website does not provide for lobbying for insurance, nor can this objective be found in the section geared to Community Programs & Services. For example, the Advocacy & Public Policy section demonstrates how "ACS promotes beneficial policies, laws, and regulations for patients and families affected by cancer." The Community Programs & Services section details "the local programs established by ACS that serve to educate the public about cancer prevention, early detection, treatment, survival, and quality of life." Id.

Furthermore, the American Cancer Society Foundation, an established entity of the American Cancer Society, does not promote lobbying efforts. Its mission "is to accelerate the control and cure of cancer by securing major gifts and endowments from individuals, corporations, and foundations to support research, programs, and services of the American Cancer Society, Inc., and its Chartered Divisions." *Id.* The tax implications of varying from the elucidated mission statement for political objectives is outside the scope of this article.

[16] Kevin Sack, *Cancer Society Focuses Its Ads on the Uninsured*, N.Y. TIMES, Aug. 31, 2007, at A1.

valuable contributor to achieving our ultimate goal -- a healthier country. When their reasoning derives from facile conclusions based on "recent research linking a lack of insurance to delays in detecting malignancies"[17] and consequent presumptions of poor prognoses and bad outcomes, we are on notice that those charged with fostering novel diagnostic techniques or more efficient screening tools and treatments have abandoned their mandate. If the state of medical knowledge and health education suffers when research and education objectives are diverted into policy proposals and political debate, what many wish for -- expanded coverage -- may end up being our worst nightmare.

CAUSES, CORRELATIONS AND FAULTY CONCLUSIONS

To say that the uninsured may suffer poorer outcomes than those with coverage is to say that the insurance coverage, per se, is an effective means of preventing cancer. Surely this is a flawed proposition. Nevertheless, the lack of ability and wherewithal to procure coverage may be markers of, or surrogates for, *conditions* that represent a less than healthy population. Thus, the uninsured -- those who may be deficient in taking advantage of screening -- also tend to be less health conscious (i.e. typically they practice a less healthy lifestyle), less health-aware (of the importance of screening and hence less likely to take advantage of available programs), and/or less physically able to find the screening services, even if they had the money to pay for them. In turn, the inability to find screening services may result from a lack of proximity to sophisticated research centers, or other health infirmities that curtail travel. Further, unacceptably high percentages of false positives resulting in a surfeit of unnecessary surgical procedures (as in the case of mammography) indict the use of certain screening tools, themselves, as deterrents to continued screening. Whether a portion of the uninsured population, (notably the poverty-ridden), are disproportionately exposed to environmental causes which unduly predisposes this population group to disease, is another consideration begging investigation.

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[17] *See* Editorial, *Cancer's High Toll on the Uninsured*, N.Y. TIMES, Sept. 11, 2007, at A26.

In the "Holy Grail" quest of providing insurance coverage for all, these inefficiencies seem to be overlooked. Dogmatic prescriptions of universal health care as the antidote to our failed system divert us from considering novel solutions to the real problem – how to make Americans healthier and means to providing health care to everyone who needs it. Yet simply reframing the question, as: 'how do we increase *care*, and not coverage?' allows for broadening of curative approaches, even suggesting the innovative solution.[18]

II. GOALS AND LIMITS OF AN ACHIEVABLE, HOLISTIC HEALTH CARE SYSTEM

This plan ("Holistic Health") is predicated upon achieving an endpoint of a healthier America in the most direct, and hence cost-effective, method feasible, with measurable improvements in specific medical endpoints or health metrics as the indicators of success. By comparison, currently proffered plans measure success by numbers of persons covered by health insurance and by the amount of coverage available to them. Thus, instead of aiming to increase health *coverage* availability and affordability, this plan aims to improve health care, health habits and health practice. To be sure, existing health plans desire the same end. The major difference involves the use of middle-men, which by its very nature, increases the price to achieve the same end.

Presumably, some amorphous correlation between increased health coverage and better health is the objective underlying the political platforms promoting this approach, similar to the force driving the American Cancer Society. However, without targeting specific health-related endpoints, we risk drowning in the vortex of the system's overhaul,

[18] Kevin Sack, *San Francisco to Offer Care for Every Uninsured Adult*, N.Y. TIMES, Sept. 14, 2007, at A1, A17. ("Over the years the city officials explored ways to provide universal insurance but, like other governments, could not figure out how to pay for it. 'What we did next was profound and simple,' said Mr. Newsom, who shepherded the program with Supervisor Tom Ammiano. 'We asked a different question. We asked: How do we provide universal health care to all uninsured San Franciscans? And that one modest distinction allowed us to answer the question we hadn't been able to answer for a decade.") The very same approach was independently proffered by the author of this article in June of 2007.

achieving universal coverage as the primary goal, rather than making "A Healthier America" the focus of the health program. Defining objectives in health-metric terms and endpoints also enables assessment of expensive "prevention" programs, contemplated as an integral part of the current political roster of health coverage programs.[19] Further, to achieve better health, specific changes in medical practice and lifestyle choices must be mandated, either voluntarily or by regulation. Without targeting specific health-based endpoints, necessary changes in the way we live cannot be made (or once made, evaluated.) And the way we live is a direct cause of how – and how often -- we get sick.

HOW MUCH HEALTH CARE IS ENOUGH AND WHAT WILL IT COST?

Various indices and measures have been used to quantify the cost of national health care and calculate the cost of health insurance designed to cover basic health services. These figures are uniform in one aspect -- they engender debate. Further, and not surprisingly, currently proposed health coverage plans are vague on what would be covered. In any event, decreasing health costs will enable a greater level of health care to be provided, at a lower burden to those underwriting the program.[20]

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[19] Generally, mortality and morbidity rates such as death and sickness quotients are used as markers of the health of the nation. Death and sickness quotients, not the percentage of those with insurance, are the best measure of a nation's overall health. *See* Barbara P. Billauer, *Why Universal Coverage Won't Make Americans Healthier: Or 'Quality, Economical & Doable Health Insurance' (QED) & Other Oxymorons of the (Insane) Political Mind*, Working Paper Series, *available at* http://ssrn.com/abstract=1028644. *See generally* WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS—IMPROVING PERFORMANCE (2000), http://www.who.int/whr/2000/en/whr00_en.pdf.

[20] The plans proffered by Clinton and Edwards range hover at 100 billion. Simply eliminating the coverage aspect of the plans enables every uninsured person plus an additional 8 million who may be uninsurable/unable to afford coverage in the future, to obtain $2000 worth of medical care at the get go. *See, e.g.*, Kevin G. Hall, *Clinton's Plan Mirrors Obama and Edwards*, SACRAMENTO BEE, Sept. 18, 2007, at A1.

ASSUMPTIONS AND CAVEATS:

This is a partial plan, with an aim of increasing availability of health care beyond the status quo, but not attempting to provide universal care or universal coverage. This plan is predicated on three unalterable economic and demographic premises, and the use of free market and capitalist forces. These premises are: 1) finite resources; 2) an aging and larger population; and 3) increased immigration in the next decade.

To increase health care availability, given the above, several caveats must be honored:

a. To expand available services, overall costs will have to decrease.
b. To decrease health care costs, a healthier lifestyle will be required.
c. Decreasing costs will require down-loading the system, that is—allowing a broad range of paramedical personnel to perform many services now performed by physicians, under the aegis of, and with financial guarantees, to physician.
d. Health insurance adds to the cost of health care, but does not necessarily translate into better health. In other words, the more coverage/care available and utilized, the greater the overall costs to the system will be. This effect is likely not going to be offset by a healthier population.
e. Doctors expect to earn considerably more than the average wage earner.

Finally, amongst other lessons to be learned from past failed initiatives is the need to recognize the fervor the mandate stimulates. Stakeholders who profit from our health care system as currently practiced, whose interests and influence must be recognized, must be given legitimate forum and where possible and feasible their concerns should be honored.

These stakeholders include physicians and other health care providers, malpractice attorneys, malpractice insurance companies, pharmaceutical companies, medical device companies, venture capitalists, the biotech industry, and laboratory equipment makers and personnel. Some stakeholders have an interest in preserving or improving the existing system, and the drag that these forces will contribute to changing the system must be recognized. This includes currently insured patients, health insurance companies, and the

nursing and physician-assistant communities who depend on the health care system for their livelihood without making a significant profit.

III. GOVERNMENT SUBSIDY OF MEDICAL INFRASTRUCTURE

The essence of this plan is the creation of neighborhood clinics serving the uninsured or those for whom coverage is prohibitive, whether due to prior medical conditions, self-employment or otherwise. Services to which the participant ("member") is entitled vary depending on whether they elect a 'partial payment' option or a 'minimum fee' option, as described below, but highlight the development of a strong health care provider/member relationship. The funding derives from reducing or eliminating non-medical overhead, supplemented by various non-tax contributions, and draws its medical care from the private medical community who derive financial benefits from the arrangement which equal or surpass those to which they would receive in the ordinary course of their practice.

Shortly after a rudimentary version of this plan was first informally circulated[21] and published,[22] the economic feasibility of the plan was demonstrated by a private physician who had implemented the conceptual underpinnings of the plan into his own practice.[23] Similarly, on September 17, 2007 the City of San Francisco announced the launch of the "Health Access Program," which embodies several critical features of this plan, and demonstrates that operation of a government funded

[21] This plan was informally circulated in June 2007.

[22] Barbara Billauer, *The Right to Health – A Holistic Health Plan: 2008-16*, Working Paper Series, *available at* http://ssrn.com/abstract=1002630. (The present article is an expansion of the Working Paper Series published on SSRN.)

[23] Brian R. Forrest, *Breaking Even on 4 Visits Per Day*, 14 FAM. PRAC. MGMT. 19 (2007), *available at* http://www.medscape.com/viewarticle/561524.

neighborhood clinic for the uninsured could be undertaken at no additional taxpayer cost.[24]

A basic prototype for direct health care would establish federally run Health Houses,[25] i.e., medical buildings where doctors rent space at cost. In addition to providing and maintaining the physical plant at cost, the government subsidizes a laboratory, EKG and X-ray machines, and other basic medical devices and tools. It also provides medical supplies at a discount by ordering in bulk, furnishes common waiting areas, receptionist and laundry services. No profit is made on any administrative expense, automated services (such as simple laboratory tests), or unskilled or semi-skilled labor. All doctors at the federally run Health House would share medical equipment, laboratory services, and medical research.

Doctors maintain their own practices, utilizing nurse practitioners (and/or other health professionals at their discretion, as will be discussed below,) under a system that augments responsibilities each allied medical practice is allowed to practice. The system allows physicians to profit from using para-professionals to provide routine care, check-ups, wellness visits and simple routine procedures, akin to that provided by dental hygienists.[26] The use of allied professionals envisions persons with medical training, under the employ of a physician, who develop and maintain an ongoing relationship with the

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[24] *See* Sack, *San Francisco to Offer Care for Every Uninsured Adult*, *supra* note 18, at A1, A17.

25 In 1889, Jane Addams, the first woman to win the Nobel Peace prize founded Hull House. Ms. Addams believed that if people –of any age, race, gender, ethnicity - were allowed to develop their skills, that person could not only make a better life for himself but contribute to the community as a whole...,[and] that *ignorance, disease, and crime are the result of economic desperation*. (This program extends the philosophies of Ms. Addams to the concepts of maximizing health, using her credo of "neighbor helping neighbor.") See generally Jane Addams Hull House Association Home Page, http://www.hullhouse.org/ (last visited Nov. 18, 2007).

[26] Thus, the convenience care centers which now run independently, could be acquired by physicians, and operated out of the physician's office while allowing the physician to be onsite virtually 100% of the time.

patient, which includes periodic monitoring, supervision of treatment protocols, and regular contact.[27]

The San Francisco program describes a philosophy closely akin to that used here: Thus, "[t]he ... Program shall use the 'Medical Home' model in which a primary care physician, nurse practitioner, or physician assistant develop and direct a plan of care for each Health Access Program participant, coordinate referrals for testing and specialty services, and monitor management of chronic conditions."[28]

As discussed below, however, this plan offers an augmented and more disease-specific eradication/amelioration focus than that offered by the San Francisco program. These refinements should result in measurable improvements in health metric scores and vital statistics, as well as in the quality and length of life of the sufferers of some of the more prevalent diseases. Finally, rather than stressing wellness and prevention, this program focuses on curing or alleviating medical conditions and reducing the likelihood of specific diseases in persons most at risk.

QUID PRO QUO

Electing to locate one's practice in a government Health House requires a "donation" the equivalent of one day of the physician's time per week in exchange for the significantly lowered overhead cost, a construct, which, at minimum should equal the physician's current income. However, as conservative estimates place the cost of physician overhead at working two

[27] Thus the paraphysician sees the patient often, and hence is able to recognize a baseline level of optimal health for each patient, thus allowing for early recognition of illness or disease. This program does not recognize or condone use of nurse practitioners as triage agents, where the nurse substitutes for the doctor on an episodic basis and does not have an ongoing relationship with the patient for which the nurse assumes responsibility. Such a setup so often found in managed care facilities fosters an assembly-line like attempt at standardizing health care. Moreover, without developing of the essential "fiduciary" type relationship contemplated under the physician-patient privilege philosophy, legal privileges of confidentiality covered by this rubric may not apply, thereby chilling full disclosure between patient and health care provider.

[28] Sack, *San Francisco to Offer Care for Every Uninsured Adult*, *supra* note 18, at A1.

out of a five-day week[29] this give-back should result in a financial gain for the provider. In return for the lower overhead, which translates into greater profits, doctors are required to "donate" eight hours per week to serve: 1) the uninsured, such as part time workers; 2) the unemployed; 3) self employed persons with prior health conditions for whom established medical coverage is prohibitive; 4) the indigent; and 5) preschool children. Care for pregnant women would also be available to anyone seeking it.[30]

Under the plan, the physician is allotted an average of three-quarters of an hour with each patient, 50% more than the current half an hour average. This would allow doctors (or their health care surrogates) to educate, as well as treat, a population-base that is likely to be medically illiterate, in addition to having a history of deficient medical care. Assuming the physician spends three-quarters of an hour with each patient over an eight hour day, 50 days a year, yields 300 patient visits a year. Further, assuming three visits per patient, per doctor, means the physician can take on an additional patient load of about 100 persons annually.

The program also envisions use of nurse-practitioners (and/or other health professionals) to perform basic diagnostic tests, initial health assessment interviews, health counseling, monitoring of "healthy life" programs such as weight loss, cigarette cessation, and exercise, and also perform limited treatment such as dispensing antibiotics. The nurse-health professionals can become the basic health intervention agent, essentially "referring" the patient to the physician who employs them only in the event of emergency, necessity, or for consultation where the treatment protocol devised for the patient is not working. Assuming the same average time

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[29] F. Michael Arnow, *Ask FPM: Acceptable Overhead*, 9 FAM. PRAC. MGMT. 78 (2002), *available at* http://www.aafp.org/fpm/20021100/ask.html.

[30] On the theory that pre-natal care translates directly into improved neonatal survival, this health tactic theoretically would translate into the improvement of at least one seminal health statistic: neo-natal mortality. *See generally* Barbara P. Billauer, *Neonatal Mortality as a Function of Secular Events During Pregnancy: Changes in Statistical Modeling Needed to Improve Obstetric Care & Neonatal Health, available at* http://ssrn.com/abstract=1023613, presented at the Annual Army College of Applied Statistics Conference, Houston, T.X., Oct. 2007.

allotment, the nurse-health practitioner can render care for an additional 100 patients per year.

A Health House with 500 physicians and 500 nurses could serve 100,000 patients, or require 500 clinics across the country to serve 50 million persons. The construct should aim to increase physician profits significantly, while simultaneously improving the health of the patient population. While the costs of maintaining the 500 Health Houses would vary depending on its geographic location, it is safe to assume that the yearly cost would not exceed 200 million dollars, the amortized cost of the Clinton and Edwards plans,[31] and likely would be an order of magnitude less.

This program would be executed with the underlying philosophy of encouraging excellent care for every consumer. Under the proposed plan, payment is based on a fee for services plus a premium for excellent care. Further, doctors get paid for time spent with a patient, not for the specific services provided. Financial incentives and motivation are provided for demonstrated improvement in patient population health. And finally, patients are encouraged to stay with one primary health care physician, who may or may not be an internist, but one most likely to address the most significant of the patient's medical needs (sometimes referred to as the "home team" approach).[32]

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[31] 100 billion dollars divided among 500 centers.

[32] John Donnelly, *Harvard Economist Proposes Team Approach on Healthcare: Focus Would Shift to Central Services*, BOSTON GLOBE, Mar. 14, 2007, *available at* http://www.boston.com/yourlife/health/other/articles/2007/03/14/harvard_economist_proposes_team_approach_on_healthcare ("Michael E. Porter, a specialist in competition and strategy at Harvard Business School, said that doctors should work together in teams and measure their performance afterward to help fix the national health system. Porter outlined his ideas at a briefing in Washington and in an article published... in the Journal of the American Medical Association. His coauthor was Elizabeth Olmsted Teisberg of the University of Virginia."). *See also*, Michael E. Porter & Elizabeth Olmsted Teisberg, *How Physicians Can Change the Future of Health Care*, 297 JAMA 1103 (2007).

ADDITIONAL STAFFING FOR HEALTH HOUSE

Legally, expanding allowable nursing responsibility would allow nurses to perform many tasks and procedures now undertaken by interns and medical students in the hospital setting. This, in turn, would free the young doctor and would-be doctor to serve at the Health House, perhaps as part of their rotation, giving the medical neophyte a chance to learn the practice of medicine where it is most commonly done -- in the doctor's office -- not in the hospital. The use of medical school and health-related graduate school students to write notes and assist in record keeping, and to research and aid in clinical drug trials should also be investigated. Visiting home services can be augmented by the use social work, nursing psychology and divinity student/interns.

IV. FUNDAMENTALS OF PLAN PHILOSOPHY

Wellness programs, at great expense, are now the rage. Most commonly, these programs provide diet-counseling, smoking cessation, exercise regime, and mediation programs. Many of these services can be, and are, provided by the government free of charge, and available via the internet. Nevertheless, the best wellness program is ineffective unless patient compliance is guaranteed. Health prevention thus requires permanent life-style and health habit changes, which research indicates are both notoriously difficult to begin, and once begun, almost impossible to sustain. Accordingly, improvement in health is not dependent merely upon the existence of these programs, but on continued compliance, which will require major paradigm shifts in our health culture. Methods of sustaining life-style changes must be devised for them to be effective in practice, rather than attractive on paper, a subject outside the scope of this paper. Some ideas might include interactive internet-programs designed to promote patient interaction, compliance and support groups convened through schools, churches, and civic clubs.

TARGETED DISEASES AND RESEARCH PROGRAMS

Instead of focusing on creating wellness programs and instituting lifestyle practices that would prevent disease, this

program focuses on targeting a core group of specific diseases and conditions for treatment, research, and outreach. In addition to a projected reduction in mortality and morbidity, this approach should give us a greater insight into causes that can then be translated into the most effective means of prevention. Core disease groups would be selected initially based, in-part, on outcomes that can be modified by changes in patient behavior.[33] Thereafter, additional diseases can be targeted which would be affected by changes in societal practices, e.g., air pollution reduction, and environmental pollution.[34] Finally, emphasis must be given to care of the aging and improved quality and productivity of life for senior citizens. Such programs would include a focus on caring for and treating Alzheimer's, orthopedic injuries, osteoporosis, hearing deficiencies, loss of range of motion, and arthritic diseases.V. Cost Cutting[35] and Better Care

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[33] These might include: neonatal mortality and birth defects, diabetes and heart disease, and sexually transmitted diseases such as HPV, syphilis, Chlamydia, Gonorrhea, and HIV.

[34] These might include drug-resistant diseases due to the over-prescription of antibiotics, asthma, and food poisoning.

[35] Other cost-saving provisions would investigate eliminating the costly but futile procedures. Thus**,**

a. all diagnostic tests after initial baselines are established remain uncovered expenses in the terminally ill. MRIs, CAT scans, etc. are excluded. The use of expensive cancer drugs in late stage cancers are discouraged in the elderly, especially where they impair quality of life. (For example, after my father was diagnosed with terminal prostate cancer and metastatic bone cancer, and given a prognosis of two months, he was still given a half dozen MRI and CAT scans. Also, the seriousness of his condition precluded his taking any cancer drugs. He lived two years and two months after his initial diagnosis;
b. all procedures to extend life in the terminally ill); and
c. Since very low birth weight (less than 500g) pre-term babies account for a disproportionate share of neonatal deaths, heroic actions may be counterproductive and economically draining. *See* Billauer, *Neonatal* Mortality, *supra* note 30. *See also* Emily Lyons, *Underweight Babies Carry Big Burden*, WASH. POST., Jun. 19, 2007, at HE4 (reporting on a study release by the University of Michigan which track the consequences of low birth weight in adulthood). Sophisticated diagnostic tests and screening tools would be available only under certain conditions and testing and fishing expedition diagnostics would be discouraged without outcome specific

HOLISTIC HEALTH: AN INTEGRATED SYSTEM

Because health conditions today are more complex and system-interrelated than ever before, the "Home Team" approach has been favored as offering the most holistic type of care. Accordingly, one vision of the Community Health House would allow the patient to choose his or her own physician based on the most pressing medical problem, or the most common risks associated with the patient age group.[36] In other words, the driver of treatment would be selection of physician by predominant medical condition, if one exists, rather than the generalist, internist, or family medicine practitioner. Further, patients with complex, multi-system diseases, such as diabetes and obesity, would see specially trained health professionals in related allied fields acting under the aegis of a medical specialist, as their primary caretaker.[37] Because of the lower cost of using trained allied professionals to provide ongoing care or monitoring, it is anticipated that patients will see their care giver more often. Because it is contemplated that the medical staff utilized by the specialist would be augmented, all health practitioners will have more time to spend with each patient. Finally, services provided to patients by trained allied health-care givers on a routine and frequent basis would be more useful to the patient and more effective than services rendered ad hoc by a medical doctor.

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expectations outlined and consented to in advance. EMGs used as general information gathering tools without deciding in advance the ultimate outcome that will be based on that information are cost-guzzlers. Consequently, if the procedure is to be used to rule out a condition which can only be treated by surgery, the patient would have to consent to surgery in advance.

[36] A vision of a ten story Community Health Center is composed of ten offices per floor, each housing a medical practice with five doctors and five paraprofessionals, employed by the medical group. Each floor is devoted to a particular disease or risk category and would include specialists commonly involved in treating patients suffering the designated disease or in a particular age category. The appendix contains a possible set up.

[37] This could be a pharmacist in the case of patients being treated for drug dependency or an infectious disease. A chiropractor, under a physician's supervision, could treat patients diagnosed with osteo-arthritis, and a physical therapist might be the lead practitioner for someone with rheumatoid arthritis.

MAXIMIZING SUPPLY

The practice of medicine has changed, simultaneously becoming both simpler and more complex.[38] This has resulted in increased physician dissatisfaction[39] as well as increased number of iatrogenic deaths. According to the Institute of Medicine, (IOM) medical errors are now one of the leading causes of death, resulting in 44,000 deaths per year.[40] This is roughly the same number of American women dying from breast cancer,[41] the second leading cause of cancer death in women in the United States.[42] Most errors have been found to be systems-based, rather than due to medical negligence, and the IOM report concludes that: "the key to reducing errors is to focus on the system of delivering information."[43] Patient satisfaction is lagging as well,[44] with the sick often going without

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[38] ENVIRONMENTAL PROCESS SYSTEMS, LTD., EVIDENCE-BASED MEDICAL PRACTICE IN THE 21ST CENTURY (2006); Lars Viktrup, *Addressing the Need for a Simpler Algorithm for the Management of Women with Urinary Incontinence*, MEDSCAPE GEN. MED. EJOURNAL, Aug. 1, 2005, at 62,http://www.medscape.com/viewarticle/506898.

[39] R. J. Lilford et al., *Medical practice: where next?*, J. ROYAL SOC'Y MED. Nov. 2001, at 559-62. The assertion that the implementation of socialized medicine would improve health care in the United States is called into question by the extremely high level of physician dissatisfaction in the United Kingdom. *See* Richard Smith, *Why are doctors so unhappy?*, 322 BRIT. MED. J. 1073, 1073-74 (2001), *available at* http://www.bmj.com/cgi/content/full/322/7294/1073?ijkey=c060ff0865f62211a4a0be2acd36b96ed9944c37&keytype2=tf_ipsecsha. Apparently, an unhappy doctor is likely an ineffective one.

[40] INST. OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000), *available at* http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf.

[41] AMERICAN CANCER SOCIETY, BREAST CANCER FACTS & FIGURES, 2007-2008, http://www.cancer.org/downloads/STT/BCFF-Final.pdf.

[42] National Cancer Institute, Types of Cancer Statistics, http://surveillance.cancer.gov/statistics/types/ (last visited Nov. 14, 2007).

[43] *See* INST. OF MEDICINE, *supra* note 40. *See also* Manoj Jain, *Putting Pay on the Line to Improve Health Care*, N.Y. TIMES, Sept., 4, 2007, at D5.

[44] Editorial, *America's Lagging Health Care System*, N.Y. TIMES, Nov. 1, 2007, at A26.

care because of cost. One recent study[45] reported that 37% of a large group surveyed said that they chose not to visit a doctor when sick, skipped a recommended test or treatment, or failed to fill a prescription in the past year because of the cost—well above the rates in other [comparative] countries.

In essence, it is time for a paradigm shift in the training of doctors and the utilization of nurses.

Nurses, for example, perform lifesaving interventions such as defibrillation and diagnostic[46] techniques such as endoscopy. Their increased responsibility and role in decision-making is reflected in nurse prescribing [medications] and nurse-led clinics. At the same time, many [allied] professions have sought to challenge the dominant status of medicine and argued that they are equipped to give certain aspects of care in better or more cost-effective ways. The maternity services, for example, have seen a reawakening of old tensions between obstetricians and midwives.[47]

One method of both increasing the availability of care and doctor revenue is to increase the utilization and responsibility of nurses and other medical professionals acting under the aegis of a doctor, even those in general practice, much akin to the way dental hygienists relieve dentists of preventive health care. Doctors would hire nurses and other health professionals[48] with advanced training, such as pharmacist, to educate, monitor treatment, assure compliance with orders, perform basic tests, and prescribe a circumscribed spectrum of drugs. Doctors' incomes would be augmented by revenue generated by the para-physician pool,[49] which, in turn, would free the doctor to devote

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[45] Cathy Schoen, et. al., *Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007*, HEALTH AFF., Oct. 31, 2007, at w717–w734, http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=568237#area.

[46] Editorial, *America's Lagging Health Care System*, *supra* note 44, at A26.

[47] *See* Lilford et al., *supra* note 39, at 559-62.

[48] Thus, in addition to the use of nurses and physician's assistants to furnish quotidian care, podiatrists, physical therapists, optometrists, and chiropractors could be used to furnish care for relevant conditions. *See infra*, at appendix regarding diabetes, as an example.

[49] *See, e.g.*, Brian R. Forrest, *supra* note 23, at 19.

more time to consultation and treating fewer, but more complex cases.[50] Again, utilization of nurses would be extended in hospitals, so tasks now performed by medical students and first year residents would be reassigned to the nursing staff. As stated previously, this would enable medical students to spend more time at the community direct care clinic. Interns would serve a part of their rotation at the clinic as well.

THE HIFI (HEALTH IMPROVEMENT FINANCIAL INCENTIVE) AWARD SYSTEM

The Community Health House concept operates along the same lines as a traditional co-operative venture.51 Thus, in addition to payment or financial benefit purely for services rendered, the health provider is given a stake in the outcome of his or her ministrations, i.e. bettering the health of the patient population. Rather than getting paid for a visit where the health provider prescribes a smoking cessation or weight loss program, then, the physician is given additional financial incentives based on the actual results of his or her patient population. The precise manner by which these steps (intervention, education, encouragement and monitoring) are implemented is left to the practitioner, but suggested measures are outlined below.

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[50] *See* Lilford et al., *supra* note 39. "In our opinion, the consultation will reassert itself as the central encounter of health practice, and special education (see below) will be needed for those who consult. The consultation is the intellectually and emotionally most demanding part of clinical practice. It is here that the most value turns—in both human and financial terms. Hence, it is also the aspect of practice that encapsulates the greatest risk to patient and doctor; we regard it as the apotheosis of responsibility. It is the most enduring feature of healthcare, with roots that go back to the origin of human life itself. We predict that in the future, those who consult, while bearing the greatest responsibility, will receive commensurate rewards." Thomas S. Huddle, M.D., Ph.D. et al., *American Internal Medicine in the 21st Century Can an Oslerian Generalism Survive?*, 18 J. GEN. INTERNAL MED. 764-67 (2003).

[51] *See generally* JOHN RAWLS, A THEORY OF JUSTICE 523 (Cambridge: Harvard University Press 1997) (1971).

PAYMENT FOR HEALTH HOUSE CLINIC SERVICES

Each participant seeking care at the Direct Treatment Clinic may choose the level of care they wish. All such persons are charged according to the following two-tiered system. The monies collected are deposited in a Community Wellness Fund, which provides for additional surgical care, catastrophic hospitalization and sophisticated testing when needed or indicated, as follows:

a.) $5.00 co-pay: Patient is entitled to medical care from a doctor on site, and all tests that can be performed on site. Patient is ineligible for sophisticated tests such as MRIs and CAT scans unless the condition is deemed to be life-threatening or presents a clear and present danger for which the test can be directly related to affordable treatment. Surgery for non-life threatening conditions is not provided unless it is of the type that can be rendered by a first year surgical resident. Patients are seen on a triage and first-come/ first-served basis. Surgery is performed at designated centers (perhaps hotels donating space in return for a tax credit) or VA hospitals. The patient is limited to those physicians and their staffs who are on-call or available at the time the patient seeks treatment.

b.) Half-rate: Patient pays half the "going rate" for the physician/specialist they choose to visit. (For an internist, e.g., a patient could expect to pay $100.00 per visit.) Patient is entitled to mid-level sophisticated tests, e.g. MRIs and CAT scans and complex surgery which a third year resident is capable of performing. At the discretion of the participating physician, the patient can make appointments directly with the MD. Income from patients paying half-rate goes into the "care pool" described below, but the physician is provided a tax credit for the amount of money he or she would have received. The patient may choose the physician designated as prime-caretaker, and see whatever allied professionals they choose, according to cost, compatibility, experience, effectiveness, or personal preference.

The Care-Pool:

Physicians may satisfy their *give-back* obligation by seeing either co-pay or half- pay patients, but the physician must

demonstrate that he or she is now seeing the designated number of non-insured patients. Clearly, it is more financially beneficial to the physician to see the half-pay segment. It is presumed that physicians providing the best care will be the ones able to fill their quota with these patients, as physician selection is entirely voluntary, and based on normal market forces such as product excellence and cost.

All monies received from the uninsured population group, as well as any additional unearned income provided by the government or private groups are kept in a "Care-Pool." This fund is managed by an elected group of physicians whose practices are located at the *Health House*, and is used to fund additional care for sophisticated services which are not covered by the fees paid, or which a member is not able to afford. The Care-Pool would of course be finite, and designation of who should receive the benefits would be made on a medical/humanitarian basis, but also decided by the group of physicians rendering care to the population group. Theoretically, the fund could be invested, but the decisions regarding the beneficiaries remain in the control of the designated agents of the treating physicians.

On an aggregate basis, when the health of all subscribers improves, so does the state of the Nation's health, as demonstrated by standard health measures.[52] This, in turn lowers the national health cost quotient, which translates into lower health costs for individuals and hence lower insurance premiums for subscribers. Windfalls from the Healthy America Initiative should not accrue to the insurance companies (who are basing premiums on the current state of health), who would normally benefit should overall health costs plummet, and hence lower than projected. Any additional profit over a baseline established prior to the time the initiative is implemented that would be attributed to the results of the HIFI system would be channeled back into that system. The funds would be assigned to the Care Pool and allocated as discussed above.

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[52] Such as the Health Metrics Network as provided by the World Health Organization. *See* Press Release, World Health Organization, New global partnership will focus on strengthening health information systems to better address health needs worldwide: Health Metrics Network is launched at World Health Assembly (May 17, 2005), *available at* http://www.who.int/ mediacentre /news/releases/2005/pr20/en/index.html.

This moral mandate of the proposed health plan and cooperative health venture system is diametrically at odds with the premises upon which most HMO's are operated, and hence the plan suggests that they be eliminated by legislative fiat.[53]

DIABETES AS A CASE STUDY FOR COMMUNITY HEALTH HOUSE CARE

Adult onset diabetes affects 18 million persons in the United States, approximately 6% of the population, and is the seventh leading cause of death, (after influenza) accounting for 1.8% of all deaths with experts predicting that the incidence rate will triple in twenty years.[54] The total cost, both direct and indirect, including disability, work lost and premature mortality, attributed to diabetes is $132 billion.[55]

Causes of death in diabetics most commonly arise not from the disease itself but as a sequelae of disease-related complications. These include heart disease and stroke (which accounts for 65% of deaths in people with diabetes), blindness[56]

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[53] HMO's and similar group health services are based primarily on increasing profits to the investor/owner group, rather than those providing medical care. This system encourages sloppy, impersonal physician services, rewarding doctors who "just show up," – as the normal market forces that supply a patient population based on total voluntary patient selection and satisfaction is eliminated. Loss to follow up becomes an accepted standard of practice, (depreciating the value of traditional medical care) as there is no motivation to check in and monitor assigned patients. The system also adds administrative costs without providing better physician attention or encouraging doctor patient relationships fostering compliance with doctor's orders.

[54] AM. ASS'NS OF LIVER DISEASES, ANTIRETROVIRAL THERAPY AND THE PREVALENCE AND INCIDENCE OF DIABETES MELLITUS IN THE MULTICENTER AIDS COHORT STUDY (2005), *available at* http://www.natap.org/2005/AASLD/aasld_1.htm. *See also* University of Iowa Health Care, *There is news – both bad and good*, WELL & GOOD (2000), *available at* http://www.uihealthcare.com/news/wellandgood/issue2/diabetes.html.

[55] *See* National Cancer Institute, *supra* note 42; AM. ASS'NS OF LIVER DISEASES, *supra* note 54.

[56] Diabetes is the leading cause of new cases of blindness among adults aged 20 to 74 years. Press Release, American Optometric Association, Diabetes is the Leading Cause of Blindness Amongst Most Adults (Date to be supplied) *available at* http://www.aoa.org/x6814.xml.

(12,000 to 24,000 new cases of blindness each year), and kidney disease, accounting for 44% of new cases in 2002, affecting almost 154,000 persons.[57] Nervous system diseases incident to diabetes, such peripheral neuropathy,[58] cause more than 60% of non-traumatic lower-limb amputations.[59] Periodontal disease and complications of pregnancy are also diabetic related, resulting in an increased rate of neo-natal deaths and birth defects.[60] Poorly controlled diabetes before conception and during the first trimester of pregnancy can cause major birth defects in 5 to 10 percent of pregnancies and spontaneous abortions in 15 to 20 percent of pregnancies. Poorly controlled diabetes during the second and third trimesters of pregnancy can result in excessively large babies, posing a risk to both mother and child.

Hence, proper care for the diabetic depends on a coordinated approach involving multiple disciplines and health practitioners. For example, "ideally all people with diabetes should have access to podiatry. Unfortunately resources often do not permit this."[61]

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[57] "Diabetes is the leading cause of kidney failure, accounting for 44 percent of new cases in 2002. In 2002 in the United States and Puerto Rico, 44,400 people with diabetes began treatment for end-stage kidney disease." National Diabetes Information Clearinghouse, National Diabetes Statistics, http://diabetes.niddk.nih.gov/dm/pubs/statistics (last visited Nov. 15, 2007).

[58] "About 60% to 70% of people with diabetes have mild to severe forms of nervous system damage. The results of such damage include impaired sensation or pain in the feet or hands, slowed digestion of food in the stomach, carpal tunnel syndrome, and other nerve problems. Almost 30 percent of people with diabetes aged 40 years or older have impaired sensation in the feet (i.e., at least one area that lacks feeling)." American Diabetes Association, Complications of Diabetes in the United States, http://diabetes.org/diabetes-statistics/complications.jsp (last visited Nov. 15, 2007).

[59] "In 2002, about 82,000 nontraumatic lower-limb amputations were performed in people with diabetes." Tuscon Medical Center, Diabetes Complications, https://www.tmcaz.com/?q=TucsonMedicalCenter/Diabetes_Education/Diabetes_Complications (last visited on Nov. 15, 2007).

[60] *See* National Diabetes Information Clearinghouse, *supra* note 57.

[61] Nishan Wijenaike, Managing Diabetes, Looking After Your Feet (Oct. 2002), http://www.diabetesuffolk.com/ManagingDiabetes/Looking%20after%20your%20feet.htm (last visited Nov. 15, 2007).

A diabetic-care physician-specialist may choose to staff her practice with podiatrists, dentists, nurse-practitioners, optometrists and/or midwives who are trained to perform other functions required in caring for the diabetic, such as glucose monitoring and insulin testing. The medical staff of the diabetic practice may be augmented by young professionals beginning their careers or interns filling a clinical training requirement under the direction of an experienced specialist. In addition to housing medical specialists in diabetes treatment and diagnosis, the diabetic floor would also include specialists in other related fields, such as a cardiologist, a neurologist, an ophthalmologist and a urologist, thus giving the diabetic medical specialist easy and instant access to experts in related fields.[62]

A NATIONAL HEALTH SERVICES CORPS, SIMILAR TO THE PEACE CORPS OR AMERICORPS

Increased use and augmented training for allied health professionals also could provide the seed-core of a National Health Services Corps, similar in mission to the Visiting Nurses of old, and capable of "riding circuit" to provide home-care to the elderly, infirm, and those residing in remote locations. Retired and/or students in training in allied health fields such as, pharmacy, dentistry, midwifery, nursing, podiatry, physical therapy, and chiropractic practice, would thus be incorporated into a '*National Health Service Corps,*' (NACHOS= National Concern for Health Organization and Service), maximizing persons able to provide services. Visiting health services staffed by trained students, EMTs and medically-specialized social-workers, could dispense care to the elderly or infirm. Telecommunicated or remote contact with a "high-tech" service center and links to expert physicians would be used for supervision and to direct care for complicated cases. Dental hygienists, medical assistants, pharmacists, and other paraprofessionals could be recruited to make home care visits,

[62] Similarly, chiropractors could be included in the geriatric practice, certified for dealing with osteoporotic conditions and orthopedic conditions; physical therapists could be certified for care of chronic rheumatic conditions e.g. chronic fatigue syndrome, fibromyalgia, osteoarthritis, and cardiac wellness; social workers could be trained in basic geriatric care and dentists could be trained in infection control and prevention.

to dispense drugs, monitor vital signs, vaccinate in case of epidemic, and follow-up with patients on smoking cessation, exercise, weight loss, and other programs geared to the chronically ill.

The auxiliary National Health Care Corps also would be available to help staff the Community Health House. Their use in the event of a bioterrorist attack or infectious disease pandemic would allow for a planned method of disseminating medications and vaccinations at home, thereby preventing the unnecessary cloistering of persons during a time when fear of contagion would be at its highest.

LIABILITY

The high cost of medical care in the United States has been attributed to many causes,[63] including the high cost of malpractice premiums needed to cover what is claimed to be a multiplicity of frivolous lawsuits. This position is countered[64] by the plaintiff's bar,[65] which asserts the need to protect patients

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[63] "There are too many frivolous lawsuits against good doctors, and the patients are paying the price," Bush said, generating a standing ovation by his physician audience. Joel B. Finkelstein, *Bush to AMA: Tort Reform a Must*, AM. MED. NEWS, Mar. 17, 2003, *available at* http://www.ama-assn.org/amednews/2003/03/17/gvl10317.htm (last visited Nov. 15, 2007). The federal government loses $28 billion a year from the direct cost of liability insurance and the indirect cost of defensive medicine, he added. *Id.* "Something which affects our budget so significantly requires a national solution." *Id.*

[64] Medical malpractice payouts are less than one percent of total U.S. health care costs. All "losses" (verdicts, settlements, legal fees, etc.) have stayed under one percent for the last 18 years. Moreover, medical malpractice premiums are less than one percent of total U.S. health care costs as well. Dropping for nearly two decades, malpractice premiums have stayed below one percent of health care costs. The Congressional Budget Office found that "malpractice costs account for less than 2 percent of [health care] spending," and that a 25 to 30% reduction in malpractice costs "would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small." Limiting Tort Liability for Medical Malpractice, 1 Congressional Budget Office 6 (Jan. 8, 2004), *available at* http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-Medical Malpractice.pdf (last visited Nov. 15, 2007).

[65] According to a group called the Americans for Insurance Reform, "[m]edical malpractice payouts are less than one percent of total U.S. health

from careless practitioners and shoddy practices.[66] To be sure, outrageous and freak verdicts have generated more than their fair share of outcry, and attention must be given to reducing verdicts which unfairly tax the entire system. While this article does not address the propriety, legality or morality of caps on general damage awards, the awarding of punitive damage awards in the medical malpractice context must be viewed with some suspicion. Punitive damage awards, in many cases not even covered by malpractice policies, need bear no relationship to the damage suffered or claimed.[67] They are designed to deter outrageous, egregious or socially undesirable conduct. In other words, they are intended to prevent systematic, organic or institutionalized conduct deemed objectionable. Their place in medical malpractice claims,[68] where a plaintiff's verdict, itself, is

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care costs. All 'losses' (verdicts, settlements, legal fees, etc.) have stayed under one percent for the last 18 years. Moreover, medical malpractice premiums are less than one percent of total U.S. health care costs as well. Dropping for nearly two decades, malpractice premiums have stayed below one percent of health care costs." Americans for Insurance Reform, Think Malpractice is Driving Up Health Care Costs? Think Again, http://www.insurance-reform.org/pr/AIRhealthcosts.pdf (last visited Nov. 15, 2007).

[66] Protection of HMO's from such litigation, while driving costs down, may in part be blamed for lack of attentive practice. In short, the threat of liability does serve a purpose, it encourages careful practice. To be sure, outlandish awards and freak results taint the system, and a means to eliminate these must be found. The claim, however, of the multiplicity of frivolous lawsuits may be addressed be simple measures, and much can be learned from the New York experience following the medical malpractice crisis of the 1980s. Thus, the requirement to include an affidavit of merit by a physician reviewing the case had positive effects on caseload reduction, while the pre-trial, mandatory but not binding medical malpractice arbitration panels had no effect, other than to drive up litigation costs.

[67] *See, e.g.*, Bryant v. LaGrange Mem'l Hosp., 803 N.E.2d 76, 78 (Ill. App. Ct. 2003). In *Bryant*, the jury awarded a 30 million dollar verdict to the plaintiff based on a claim the infant suffered a Cerebral Palsy injury during birth where the obstetrician allegedly delayed performing a Caesarian section. *Id.*

[68] Some states, such as Indiana, bar punitive damage awards in malpractice cases, although in 2001 almost 5% of cases generated some type of punitive damage award. *See* Michael Rustad & Thomas Koenig, *Reconceptualizing Punitive Damages in Medical Malpractice: Targeting Amoral Corporations, not "Moral Monsters,"* 47 RUTGERS L. REV. 975, 1009 (1995).

often traumatizing to the doctor sued, is questionable. However, the argument is made that while the concept of the award might be necessary, the purpose is not to benefit the plaintiffs (or their attorneys, who typically receive one third of the allocated award), but to recompense society for the reprehensible conduct of the defendant.

These awards, the legal purpose of which is deterrence and not unjust enrichment, should be accumulated and deposited in the Community Health Fund to be used to fund surgery or provide for basic research. Plaintiffs' attorneys should be given a tax credit to make up for this "donation." Psychic rewards can be offered by naming the Community Center or a particular research project after the attorney responsible for funding that particular initiative.

DEFENSIVE MEDICINE DRIVES UP THE COST OF CARE

The malpractice litigation climate may or may not be responsible for a rise in health care costs through increased malpractice premiums needed to pay for the awards and for litigation costs. Nevertheless, the malpractice climate has influenced the cost of health care in a more indirect, but fundamental way -- the practice of defensive medicine -- much of which is spent on expensive diagnostic imaging services. As one radiologist has stated, "[m]ultimillion dollar payouts for idiopathic disease states, medical noncompliance, and a lack of personal responsibility for one's health have led to the origin of the innovative field of defensive medicine. Defensive medicine, with its associated increased utilization of medical imaging, is not sustainable."[69] Another motivation for the excessive use of diagnostic imaging, including X-rays, can be attributed to the financial incentive[70] accruing to doctors who own these units,[71]

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[69]Chris R. Hancock, *Medical Tort Reform: A Novel Approach*, 3 J. AM. COLL. RADIOLOGY 829 (Nov. 2006).

[70] Robert Pear, *Study Says Fees Are Often Higher When Doctor Has Stake in Clinic,* N.Y Times, Aug. 9, 1991, *available at* http://query.nytimes.com (search "NYT Archive Since 1981" for "stake in clinic;" follow article hyperlink).

[71] *See* Reinhard Busse et al., *Which Factors Determine the Use of Diagnostic Imaging Technologies for Gastrointestinal Complaints in General Medical Practice?*, 15 INT'L J. TECH. ASSESSMENT HEALTH CARE 629

or obtain financial incentives from pharmaceutical companies. Nevertheless, even when these sources of income are eliminated, other remunerative procedures are often substituted.[72]

The basic structure of the Community Health House would avoid the temptation to increase physician income through unnecessary testing, drugs or procedures. The funding to pay for these ministrations, would be limited to that available in the Care Pool at any given time, and the physicians as a group deciding which patient would be the most appropriate candidate. This practice, on a microcosmic level, would cost proportionally less than the aggregate practice of medical care in the United States. Objections are not generally raised, as the costs are not directly paid by the patient, but by the insurer.

Present day costs of premiums and insurance profits account for this practice in calculating premiums. Should the Community Health House practice of apportioning resources be allocated to those most medically needy or those for whom it will have the best effect, medical care costs would be reduced across the board. If insurance company profits and premiums are capped at today's levels and futile or counterproductive tests are no longer covered, the costs to the system would be reduced. Instead of being received as profits to the insurance companies, these savings would be transferred to the Community Health Clinic.

However, the malpractice issue must be dealt with legislatively. It must be done with the support of both the medical establishment and the plaintiff's bar. This plan suggests we use a system where awards are limited to out-of-pocket expenses and actual lost income for the uninsured, i.e. those who take advantage of the Health House System, thus eliminating - claims for pain and suffering when the care accrues from the physician's "give-back" activities. This would be akin to a Workers' Compensation system, and would derive

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(Oct. 1999). "Physicians use diagnostic imaging technologies for patients with gastrointestinal complaints according to severity and knowledge about the diagnosis, but ownership of technology is the most predictive factor." *Id.*

[72] Doctors paid for each procedure, not patients' hours, are tempted to game the system. Alex Berenson, *A Stubborn Case of Spending on Cancer Care*, N.Y. TIMES, June 12, 2007, at C1, C8, *available at* http://query.nytimes.com (search "NYT Archive Since 1981" for "stubborn case of spending on cancer care;" follow article hyperlink).

from a legal fiction that patient-subscribers were, in effect, co-employees of the same entity, (the Community Health House,) and that care provided by the physician is, to a large extent, governed by the enacting legislation.[73] Regular malpractice claims would continue, unaffected for those currently insured.

The reasoning would be akin to the quid pro quo that served as the predicate for workers' compensation legislation. Thus, in exchange for sure and swift awards, employees opted out of the traditional negligence liability structure. Here, in exchange for the heretofore unavailable service of being afforded broad spectrum medical care, in the event of an iatrogenic or careless error causing harm, the uninsured or underinsured patient accepts a lower award than would be granted had he or she been able to afford standard coverage.

PORTABILITY

Unlike traditional insurance this plan does not provide complete portability. However, unlike the San Francisco plan, it needn't end at the clinic door either. As more and more states create Health Houses, each would have reciprocal status with all others. A Health House member traveling within the United States would simply visit a reciprocal facility in whatever jurisdiction the illness or accident occurs. However, the plan would not be available to cover medical services needed outside of the United States, at least until an international arrangement could be composed.

VI. JUSTIFICATION BASED IN LAW AND ECONOMIC POLICY:

Governmental assumption of payment for infrastructure costs is not an uncommon situation, but occurs in situations where a low profit margin discourages private enterprise. The infrastructure required for dispensing basic medical services should fall under the same rubric. This would involve the

[73] Barbara P. Billauer, *Will Workers' Compensation Protect the Company Doctor?* N.Y. LAW J., Feb. 1, 1985 at 1; *as reprinted in* N.Y. ST. B.A. J., June 1, 1985, at 12-17; Barbara P. Billauer, *The Legal Liability of the Occupational Health Professional*, J. OF OCC. MED. Vol. 27, No. 3, March, 1985, at 185-88.

government paying outright or subsidizing the costs of all services and equipment other than highly trained labor or professional services, such as:

a. Rent, premises insurance, electricity, water;
b. Simple laboratory equipment;
c. Computers for billing;
d. Simple or unsophisticated x-ray equipment, EKG machines, scales;
e. Personnel for staffing computers;
f. Billing/receptionist/or other untrained or semi-trained labor;

Plans currently being circulated range from those barely distinguishable from socialized medicine as practiced in Canada or the United Kingdom, to genuine free market initiatives.[74] Most plans focus on maximizing insurance coverage, and many aim to provide "universal health care" at government (taxpayer) expense, in essence socializing the practice of medicine. While it could be argued that health is a national entitlement, akin to a public good,[75] thereby justifying government intervention, the assumption of non-medical costs by government is not the same as socialized medicine. In fact, it more closely approximates the proper response to the concept of a public good - as is currently

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[74] *See, e.g.*, Norman Kurland's Private Sector Strategy for Universal Health Care, E-mail from Norman Kurland, Center for Economic and Social Justice, Arlington, Virginia, to Bob Marshall (Aug. 23, 2007, 08:32 EST) (on file with author).

[75] Siegfried G. Karsten writes: "Any valid and meaningful model must, presumably, reflect socioeconomic reality. This may imply that no socioeconomic structure is permanent; it may need to adapt itself to changing circumstances . . . . The question arises how socioeconomic policies should be evaluated. Leo Rogin suggested that theories or policies be judged according to their relevancy to socioeconomic issues and the likelihood of their enactment. Policies have 'meaning' if they address problems of concern to people and enterprises. Their chances for implementation determine whether or not they possess 'validity.' Hence, for a socioeconomic policy to have meaning and validity, it must focus on how people and businesses perceive and conduct their 'ordinary business of life.'" Siegfried G. Karsten, *Heath Care: Private Good vs. Public Good*, 27 AM. J. OF ECON. & SOC. 129, 130 (Apr. 1995). *See also* R. Douglas Scott II et al., *Applying Economic Principles to Health Care*, 7 EMERGING INFECTIOUS DISEASES J. (Mar.-Apr. 2001) (special issue of publication from the Centers for Disease Control, Atlanta, Ga.), *available at* http://www.cdc.gov/ncidod/eid/vol7no2/scott.htm.

manifested and detailed below– than does providing socialized or government-underwritten medical care.

Public goods are defined as:

> [t]hings that can be consumed by everybody in a society, or nobody at all. They have three characteristics. They are:
> • non-rival – one person consuming them does not stop another person consuming them;
> • non-excludable – if one person can consume them, it is impossible to stop another person consuming them;
> • non-rejectable – people cannot choose not to consume them even if they want to.[76]

The last criterion, non-rejectability, is problematic in the context of health care. One could imagine a situation where a homeless person, suspected of having a communicable disease, is cared for against his or her will at public expense. However, in the aftermath of SARs, Bioterrorism, Monkey Pox, Avian Flu, and highly resistant strains of infectious diseases, such as TB or 'meth resistant' staph, along with any of the other nine diseases specified as quarantineable,[77] the spectre of involuntary vaccination or quarantine applies universally. This externality (in economic jargon) or secular trend (as it would be called in the public health vernacular), has changed societal expectations regarding delivery of health services, thus rendering health a public good,[78] at least under certain conditions.

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[76] "Examples include clean air, a national defence [sic] system and the judiciary." Economist.com, Research Tools – Economics A-Z , http://www.economist.com/research/Economics/alphabetic.cfm?letter=P&CFID=23926918&CFTOKEN=71626216#publicgoods (last visited Nov. 17, 2007). Based on the proposed nature of this plan, and the use of general economic terms, the Economist.com is appropriate. For more detailed information on these economic terms, *see generally* PAUL A. SAMULESON & WILLIAM D. NORDHAUS, ECONOMICS (2005).

[77] *See* Exec. Order No. 13,295, 68 Fed. Reg. 17,255 (Apr. 4, 2003), *as amended by* Exec. Order No. 13,375, 70 Fed. Reg. 17,299 (Apr. 5, 2005) (setting forth a complete revised list of quarantinable communicable diseases).

[78] Michael Merson, *SARS Proved Health is Global Public Good*, YALEGLOBAL ONLINE, Sept. 24, 2003, http://yaleglobal.yale.edu/display.article?id=2503. *See also* Ilona Kickbusch, *SARS: Wake-Up Call for a*

Another societal imperative driving health care expectations is the recognition that the unhealthy among us, especially the uninsured, drive the national health care cost quotient up, derivatively increasing the taxpayer burden.[79] This desire to have all Americans avail themselves of screening services and preventive lifestyle practices, such as smoking cessation, manifesting in requiring every American to procure health insurance, is another societal "*abnorm*" (paradigm shift). This situation can be said to transform health care into a public good, as those who refuse to afford themselves the benefits of preventive health care service increase the national burden and force it upon the taxpayer. Hence, the American Cancer Society's position that those who not subscribe to screening diagnostics inflate the cost of care, translates into fulfilling the third requirement of a public good -- preventing "opt-out" of the system by requiring all Americans to procure health insurance.

THE FREE-RIDER DILEMMA

The constituency of uninsured and unscreened (leaving the country to assume their higher costs of treatment upon a diagnosis now delayed) can be compared to the economic status of a "free-rider," another manifestation of a product designated as a "public good." "Consumers ... can take advantage of public goods without contributing sufficiently to their creation. This is called the free rider problem, or occasionally, the "easy rider problem" (because consumer's contributions will be small but non-zero),"[80] which can also be called the "free-loader" problem, in reality or in common parlance.

Strong Global Health Policy, YALEGLOBAL ONLINE, Apr. 25, 2003, http://yaleglobal.yale.edu/display.article?id=1476.

[79] Sometimes called the Freeloader phenomena in plain jargon.

[80] "For example, consider national defense, a standard example of a pure public good. A purely rational person (also known as *homo economicus*) is an individual who is extremely individualistic, considering only those benefits and costs that directly affect him or her.... Suppose this purely rational person thinks about exerting some extra effort to defend the nation. The benefits to the individual would be very low, since the benefits would be distributed among [everyone in the country]. Further, there is a very high possibility that he could get injured or killed during the course of his or her military service. On the other hand, the free rider knows that he or she

Accordingly,

> [p]ublic goods give such a person incentive to be a free rider... The benefits to the individual of this effort would be very low, since the benefits would be distributed among all of the millions of other people in the country. . . . On the other hand, the free rider knows that he or she cannot be excluded from the benefits . . . regardless of whether he or she contributes to it. There is also no way that these benefits can be split up and distributed as individual parcels to people. So the free rider would not voluntarily exert any extra effort, unless there is some inherent pleasure or material reward for doing so.[81]

Under some lenses, whether the matter is considered a public good is determined post hoc and on the basis of political self-interest. "When a market left to itself does not allocate resources efficiently[, i]nterventionist politicians usually allege market failure to justify their interventions."[82] Where "public goods are regarded as an example of market failure...in most countries they are provided at least in part by government paid for through compulsory taxation",[83] a suggestion soundly

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cannot be excluded from the benefits of national defense....So the free rider would not voluntarily exert any extra effort.... In the case of information goods, an inventor of a new product may benefit all of society. But hardly anyone is willing to pay for the invention if they can benefit from it for free." Wikipedia.com, Public Good, http://en.wikipedia.org/wiki/Public_good (last visited Nov. 17, 2007). Based on the proposed nature of this plan, and the use of general economic terms, Wikipedia.com is appropriate. For more detailed information on these economic terms, *see generally* PAUL A. SAMULESON & WILLIAM D. NORDHAUS, ECONOMICS (2005).

[81] *Id.*

[82] Definition of "Market failure." Economist.com, Economics A-Z, http://www.economist.com/research/Economics/alphabetic.cfm?term=marketfailure#marketfailure (last visited Nov. 15, 2007). Another factor contributing to "market failure" are "externalities." These occur "when the market does not take into account the impact of an economic activity on outsiders." *Id.*

[83] Definition of "Public goods." Economist.com, *supra* note 76.

rejected by the proponents of capitalism, leaving a defined economic problem unresolved.[84]

The consequences of calling health care a public good, of course, affect the manner of addressing it. Levying taxes to finance a government run program -- the typical manner of addressing the public good -- smacks of socialism, pre-empts free market enterprise, and significantly affects physician earnings. On the other hand, failure to recognize the inherent idiosyncratic health issues generated by the life of today leads to millions of persons who are not being cared for, and ultimately, this problem inures to the taxpayers detriment.

Before attempting to reconcile the conundrum, another feature of the pubic good feature needs to be recognized: Profit. Profit is

> the main reason firms exist. In economic theory, profit is the reward for risk taken by enterprise, the fourth of the factors of production – what is left after all other costs, including rent, wages and interest. Put simply, profit is a firm's total revenue minus total cost. Economists distinguish between normal profit and excess profit. Normal profit is the opportunity cost of the entrepreneur, the amount of profit just sufficient to keep the firm in business. If profit is any lower than that, then enterprise would be better off engaged in some alternative economic activity. Excess profit, also known as super-normal profit, is profit above normal profit and is usually evidence that the firm enjoys some market power that allows it to be more profitable than it would be in a market with perfect competition.....The Profit margin is expressed as a percentage of its turnover or sales." [emphasis in original].[85]

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[84] For example, externalities may cause a market failure in a situation where "the market . . . ignore[s] the costs imposed on outsiders by a firm polluting the environment." Economist.com, *supra* note 82.

[85] Definition of "Profit." Economist.com, Economics A-Z, http://www.economist.com/research/Economics/alphabetic.cfm?letter=P#profit (last visited Nov. 15, 2007). For more detailed information on these economic terms, *see generally* PAUL A. SAMULESON & WILLIAM D. NORDHAUS, ECONOMICS (2005).

One view, at least according to one economic theorist, Ted Sizer, says that private enterprise should not be allowed to undertake provision of the public good, when the profit motive outweighs accomplishing the primary objective, and where the investor is the one most protected in the system. It is suggested that his views against the privatization of education and health care[86] can be said to apply equally to some health care programs, such as HMOs and providing Universal Insurance Coverage.

The health care system however, differs from education in one significant respect. Furnishing first-rate quality education and health care both devolve around the similar use of various goods and services, and are dependent on a multitude of similar infrastructure requirements (real estate, maintenance, secretarial, bookkeeping). However, the practice of medicine involves the services of a member of a bone fide learned profession, the private physician, who, while certainly concerned with the profit motive, is sworn to place the art of healing at the apex of the hierarchy of his or her occupational needs. In a sense then the doctor serves two masters, the profit motive and the imperative to heal. It is this second safeguard that should preempt the first from private intervention, and

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[86] Ted Sizer is a leader of educational reform in the United States. He is a professor emeritus at Brown University and former dean of Harvard's Graduate School of Education, where he is currently a visiting professor. He founded the Coalition of Essential Schools in 1984 and is currently serving as its Chair Emeritus. He has also served as headmaster of Phillips Academy in Andover, MA, and is the founding director of the Annenberg Institute for School Reform. When asked if he had a position on the idea of running schools for profit, Sizer answered: "Yes — which is I'm opposed to it, simply because it puts the investor at the head of the list. Under a system of compulsory education, and the compulsion provided by the state, the children should be at the head of the list. When there is any kind of financial shortfall, they should be at least risk. In a for-profit business, the investor's at least risk . . . I'm not against private business being involved in public education. If I was, I wouldn't be buying textbooks from the likes of Houghton Mifflin and the rest. There are plenty of ways that private for-profit industry can support public education. In many, if not most cases, they do it wonderfully. But the notion that the whole system is, in fact, driven, where the investor is the one most protected — that's something different." Interview by PBS Frontline with Ted Sizer (Dec. 2002), *available at* http://www.pbs.org/wgbh/pages/frontline/shows/edison/interviews/sizer.html (last visited Nov. 15, 2007).

given the underlying influence of the medical profession's expectations, a free market[87] should only provide greater incentives to do well, both financially as well as in the rendering of healing.

HEALTH CARE AS A HYBRID PUBLIC GOOD/FREE MARKET DRIVEN ENDEAVOR: ECONOMIC ISSUES

The decision not to procure health insurance may be voluntary (the true-freeloader) or involuntary, due to financial considerations. Usually, capitalistic societies accept the notion that a small segment of the population may require government care at taxpayer expense. Hence underwriting the costs of medical care for uninsured persons below the "poverty" level is tolerated as an accepted mores of the civilized society, socialistic or capitalistic.

Today, however, we face a third situation. In some instances, the cost of medical care has becomes so prohibitive, (perhaps due to the existence of a prior medical condition,) that bone fide members of the middle class can no longer afford what has come to be accepted as basic, or routine medical care. While this scenario is involuntary, it is not brought about by the typical free-rider or the poverty-stricken. Hence, dichotomous categorization of whether a service is or is not a public good may no longer be appropriate, and the categorization process requires reexamination.

Other instances of today's amorphous situation may occur when those who do have health insurance choose not to avail themselves of the same screening procedures which result in

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[87] "Adam Smith, you might say, wrote the book on corporate social responsibility. It is entitled, 'Wealth of Nations' . . . Smith did not worship selfishness. He regarded benevolence as admirable, as a great virtue, and he saw the instinct for sympathy towards one's fellow man as the foundation on which civilised [sic] conduct is built (he wrote another book about this: 'The Theory of Moral Sentiments'). But his greatest economic insight — and indeed the greatest single insight yielded by the discipline of economics — was that benevolence was not in fact necessary to advance the public interest, so long as people were free to engage with each other in voluntary economic interaction. That is fortunate, he pointed out, since benevolence is often in short supply. Self-interest, on the other hand, is not." *Profit and the Public Good*, ECONOMIST, Jan. 20, 2005, *available at* http://www.charleswarner.us/articles/EconomistTheGoodCompany.htm (last visited Nov. 15, 2007).

earlier diagnoses and reduced costs.[88] Thus, while we may wish to compel procurement of insurance, we must enquire whether we will then require compulsory medical examinations, screenings, and testing to which the coverage would entitle the recipient. And if so, how far down the slippery slope will we go in terms of compelling aggressive or prophylactic treatment which has shown to reduce the risk of further disease?

Further, other than diseases that pose a risk to others by virtue of their transmissibility and contagion, forcing health care, or alternatively requiring procurement of health insurance coverage, trespasses on the bioethical imperative of *autonomy*.[89] This constraint, then, along with the desire of the aging to retain youthful prowess and powers, has resulted in a health-conscious America, unusually concerned about nutrition, exercise, and preventive care, including wellness services. This results in a system that has elements of both a public and private good amenable to free-market initiatives -- acting at the same time, and even in the same population.

Because the present situation simultaneously presents elements of both public good and private good, or as this author calls it, "*the public good-hybrid*," a hybrid approach is called for. It is this predicate which sustains the concept of the government underwriting the non-medical aspects of the health care system, while allowing free-market forces to regulate those aspects amenable to professional medical judgment.

HEALTH CARE AS A HYBRID PUBLIC GOOD/FREE MARKET DRIVEN ENDEAVOR: LEGAL ISSUES

A similar dichotomy exists in the laws regulating the provision of *goods* compared to those regulating the provision of *services*. This rubric supports the notion that the furnishing of

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[88] The logical step in the slippery slope of required health insurance as a predicate to increasing cancer screening, is to require compulsory mammograms, colonoscopies and pap smears. Whether we then require aggressive intervention such as prophylactic mastectomies, aggressive colon surgery, and total hysterectomies as a further predicate to reducing overall health care remains an open question under this exercise.

[89] Bruce L. Miller, *Autonomy and the Refusal of Lifesaving Treatment, in* ETHICAL ISSUES IN MODERN MEDICINE 202, 205-211 (John D. Arras & Bonnie Steinbock eds., 4th ed. 1983).

the goods incident to a service, i.e. real estate, medical devices, drugs, administrative equipment, and incident upkeep should be considered a public good, an activity assumed by the government and free from profit-making potential. By comparison, activities involving providing specialized care, such as practicing medicine and rendering health care should be considered a service, exempt from the constraints attached to providing public goods, and subject to the demands of the market place. Thus, the manufacturer of drugs that do not perform as expected may be sued under the doctrines of both common law negligence, as well as products liability (strict liability in tort). Under the former cause of action, a breach of the generally prevailing standard of care must be established before liability can attach.[90] Under the latter, no negligence or fault need be established on the part of the manufacturer; only a showing that the product did not perform as expected and that the product proximately resulted in the defendant's injuries is required.[91] Claims for improper rendering of medical care have been explicitly ruled as outside the purview of product liability claims, as are claims for supplying the wrong blood type, etc.[92]

In summary, then, it can be argued, that optimal provision of health care should be classed as a hybrid construct, a public good with free market force initiatives for the medical community who help achieve the desired national goal: a healthier America.

Given the claim by some that health care can be classified as either a public good in its entirety, or as this plan proposes, as a

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[90] *See, e.g.*, Ryan v. N.Y. Cent. R.R. Co., 35 N.Y. 210, 210 (1866) ("It is a general principle that every person is liable for the consequences of his own acts. He is thus liable in damages for the proximate results of his own acts..."); McCahill v. N.Y. Transp. Co., 94 N.E. 616, 617 (N.Y. 1911) ("...[O]ne who has negligently forwarded a diseased condition and thereby hastened and prematurely caused death [cannot] escape responsibility even though the disease probably would have resulted in death at a later time without his agency."); Gagne v. Bertran, 275 P.2d 15, 20 (Cal. 1954) (stating the general rule that "those who sell their services for the guidance of others in their economic, financial and personal affairs are not liable in the absence of negligence or intentional misconduct").

[91] *See* Detwiler v. Bristol-Myers Squibb Co., 884 F. Supp. 117, 121-22 (S.D.N.Y. 1995).

[92] Perlmutter v. Beth David Hosp., 123 N.E.2d 792, 795-96 (N.Y. 1954).

hybrid model, objections are sure to be made by those furnishing ancillary services. In any case, encouraging and even fostering conduct conducive to good health -- including increasing available and affordable health care for all -- would be considered a noble and laudable objective by both sides of the aisle, conservative, liberal and libertarian. Encouragement of routine physicals, wellness programs and prevention plans, diagnostic screening tools such as mammograms, pap smears, PSA monitoring, colonoscopy, flu shots, vaccination for childhood diseases and tobacco cessation programs are all socially beneficial activities which we seek to foster and promote. Maximizing the use of these programs is the goal of most public health organizations and politicians. Would that all Americans avail themselves of these health care services!

VII. HEALTH IS A RIGHT – NOT A RISK: THE FLAW IN INSURANCE

An argument can also be made that health coverage is not the proper vehicle to address any routine problem and should be available only to address serious, medical and surgical issues which fall into the realm of the relatively rare,[93] but not of the realm of the bizarre.

"Insurance is, in actuality, a social vehicle for spreading the *risk* of financial loss among a large group of people, thus making a loss manageable for any one person of that group."[94] Furthermore, "there are two types of risk, only one of which can be insured; speculative risk and pure risk. *Speculative risk* affords the opportunity for gain as well as the possibility of loss....This type of loss is not insurable."[95] In contrast, "*[p]ure risk* has the possibility of loss only; thus, it is insurable."[96] "As

[93] Perhaps this would include those of the nature that would be amenable to Poisson regression in biostatistical analysis. *See generally* LLOYD D. FISHER & GERALD VAN BELLE, BIOSTATISTICS: A METHODOLOGY FOR THE HEALTH SCIENCES 211-12 (1993).

[94] Financial Web, History of Insurance, http://www.finweb.com/insurance/history-of-insurance.html (last visited Nov. 15, 2007).

[95] *Id.* "Gambling and stock market investments are two common examples" of such losses which are not insurable. *Id.*

[96] *Id.*

opposed to the risk associated with investments, risk with regard to insurance matters refers to the possibility of loss. Note that it is not the loss itself, but the *possibility* of a loss."[97]

These principles would render any type of preventive care, scheduled visits, or wellness programs, which are the crux of cost-cutting in many of the so called plans, uninsurable. It would also exclude certain types of screening, such as pre-engagement Tay-Sachs tests, post-surgical rehabilitation, and post-mastectomy plastic surgery, where there is no risk of loss, as the harm or damage has already occurred, and hence is certain.

The concept of using insurance to achieve the objective of better health then, is, by definition, flawed, and designs providing for universal coverage as a means or vehicle to guarantee health care, are similarly flawed and sure to fail. As stated at the outset, cost estimates are based on partial data. But, more importantly, the vehicle of insurance is not suited to fund activities designed to be consumed or used by everyone, or to fund activities we wish to encourage, rather than avoid. It may be argued that good health is not a "right," and no one would assert that good and comprehensive health care is not costly. But no one would consider good health -- even with all its incident costs -- a risk to avoid.

The fallacy of providing Universal Health Coverage at a cost of 100 billion dollars or so, now becomes obvious. Medical care is currently estimated at costing an average of $7,000 or so per person each year.[98] The value of this insurance in terms of how

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[97] *Id.* *See also*, Wall Street Instructors, Lesson 1 – Purpose of Insurance, http://www.wallstreetinstructors.com/courses/enrollment/sample/life_health/index.html (last visited Nov. 15, 2007) ("Insurance is based on 'risk pooling' and the 'law of large numbers', the principles that allow insurers to spread risks among thousands of individuals and to predict losses with reasonable accuracy. Insurance transfers risk, which is one of the most effective ways to deal with risk and its losses. Not all risks are insurable, however. A risk must contain certain elements before it can be insured: for example, it must be a pure risk.").

[98] Some argue that the costs of medical care in this country are inflated due to unnecessary tests, costly drugs, and ineffective and expensive diagnostic techniques. Basic medical care packages do exist for some segments of the country that are charged with budgetary constraints and hence motivated to avoid some of the egregious overcharges to which the ordinary private system is heir. These range from three thousand dollars a year the cost expended on federal prisoners, many of whom have significant

much health care it will buy falls far short of the costs of what society would humanely consider to be, basic ordinary medical care. Assume that the 100 billion dollars currently allocated by the prevailing political plans was divided amongst all 48 million uninsured. Further assume that this is done without subtracting the costs of procuring, underwriting, managing, and administering the policy. These costs are estimated to be about 40% of the cost.[99] At this coverage administration-factor, each uninsured person would be allocated about $2000 in health care benefits, but would actually receive about $1600. This amount is less than a third of the care consumed by the currently insured, and about 50% less than the cost of care provided to criminal inmates in federal prisons! At the end of the day then, current plans for universal care provide "an insurance certificate" to everyone who wants one, the actual value of which -- in terms of health care it buys -- is questionable.

Another approach to handling the health care crisis is via a self-insurance vehicle, perhaps a health savings account for quotidian medical expenses[100] and providing insurance only for catastrophic situations; those that result in financial disaster. The accident suffered by Christopher Reeves comes to mind. However, this scenario, too, fails to comport with the risks that the basic system of insurance is designed to manage. Generally speaking, contractual language excludes from most insurance policies catastrophic events[101] (e.g. Acts of War, Acts of God, and

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medical problems, to upwards of seven thousand dollars. *See generally* Geraldine A. Ferraro, *How to Mend a Sick System: A Politician Learns Firsthand the Need for Healthcare Reform*, NEWSWEEK, Oct. 29, 2007, at 66.

[99] Accordingly, 40% of 100 billion dollars leaves 60 billion dollars to be allocated amongst the 48 million uninsured, plus the 12 million illegal aliens, for whom we would require at least immunization and vaccination, or 1000 dollars per person.

[100] *See* David S. Broder, *A Market Makeover for Health Insurance*, WASH. POST, Oct. 14, 2007, at B7. (noting the Bush Administration's interest in this method). *See also* Holman W. Jenkins Jr., Editorial, *Wising Up to Health Care*, WALL ST. J., Oct. 3, 2007.

[101] It can also be argued that genetic diseases which are the attributable cause of various illnesses, such as Huntington's chorea, Tay Sachs, and cystic fibrosis are excludable under standard insurance dogma, as the "The loss it entails must be due to chance...." Wall Street Instructors, Lesson 1 – Purpose

Natural Disaster).[102] Also, diseases resulting in vague, disparate symptomatology and varying in severity, and hence disability, across patient groups, such as multiple sclerosis and rheumatoid arthritis, or newly discovered syndromes with undefined population characteristics, may pose a challenge for conventional underwriting wisdom. Unquantifiable conditions, in terms of the number of persons affected and severity of the condition chafe against the maxim that "the loss must be definite and measurable."[103] Finally, it might be suggested that that those who disregard basic health maxims (e.g. refraining from smoking, avoiding unprotected sun exposure, avoiding physical activity, drinking to excess, and failing to consume a nutritious diet) are recklessly endangering their lives and demonstrating a rank disinterest in preserving their own health. In such cases, it might be argued that they would not be entitled to insurance, or that their actions would void any existing coverage.[104] This group is probably most in need of health care, and certainly health education. Yet, since some of the very conditions for which they would seek recompense are under their control to avoid, it is foreseeable that insurance companies would seek to avoid payment.

VIII. CONCLUSION

Recent commentary by the medical community demonstrates a ripeness and willingness to entertain new

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of Insurance, http://www.wallstreetinstructors.com/courses/enrollment/sample/life_health/index.html (last visited Nov. 17, 2007).

[102] Cleverly put, "the loss must be predictable; the loss cannot be catastrophic." *Id.*

[103] *Id.*

[104] Where, because of past abuses where the insured was responsible for causing the loss for which he was claiming coverage, "... a basic governing rule of insurance was instituted which states that an individual must have a legitimate interest in the preservation of the life or property insured, before that individual cam benefit from its insurance. This requirement is known as *insurable interest*." Financial Web, *supra* note 94.

approaches to accomplish their Hippocratic mission.[105] However, the problems we face with health care -- those doctors are sworn and committed to redress or ameliorate -- relate to the state of the nation's health, the practice and delivery of medical care, secular trends increasing the risk of illness such as glitches in food and drug safety and rapid advances in technology and the understanding of disease. Addressing these seeds of illness require major paradigm shifts in medical training, medical practice, expectations of patients, and in the delivery of health care. Further, to effect measurable changes in our health care standing, we will need to take a hard look at the *root* causes of disease in this country and determine—on a disease by disease basis—effective interventions.

While insurance may provide some comfort level for unexpected costs due to unforeseen illness, general preventive measures for keeping well, along with routine maintenance and screening, do not constitute "risks of disease" in insurance parlance. Thus, in the final analysis, insurance may not be the best vehicle to deal with the societal adjustments needed in the pursuit of wellness, the precursor to a Healthier America.

"There are several [other] ways of managing, or coping with, risk. It may be reduced or avoided altogether by examining its causes and eliminating them where possible."[106] This feature conjures up the concept of cost-cutting by the health improvement financial incentive (HIFI) awards, giving physicians and medical care personnel a financial inducement to improve health outcomes in their patient population. Since the free-market initiative is so basic to our society, in the end, its use may prove to be the best solution.

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[105] Jacob S. Hacker, *Healing our* Sicko *Healthcare System*, 357 NEW ENG. J. MED 733-735 (2007).

[106] Financial Web, *supra* note 94.

APPENDIX: POSSIBLE SET UP OF A COMMUNITY HEALTH HOUSE

Basement: Infectious Diseases and Tuberculosis
Including negative air rooms.

Ground Floor: Laboratory services, EKG, X-ray, other bulk diagnostic tools

Second Floor: Diabetes
Six medical practices would be invited to join, each specializing in geriatric medicine. The remaining four suites, each containing five medical offices would be assigned to Independent Allied specialists such as:

1. Podiatrist
2. Ophthalmologist
3. Vascular Surgery
4. Endocrinologist
5. Nutritionist
6. Periodonist
7. Urologist
8. Neurologist

Third Floor: Obstetrics, Gynecology and Neonatal services
Eight medical practices would be invited, with the remaining offices filled by:

1. Dermatology
2. Fertility Specialists
3. Psychological Services
4. Plastic Surgery

Fourth Floor: Geriatric medicine

1. Orthopedic Surgeon
2. Prosthetist
3. Neurologist
4. Audiologist
5. Urologist

Fifth Floor: Rheumatology and Allergy

1. Orthopedist

2. Physical Therapist
3. Neuropharmacologist
4. Dermatologist
5. Cardiologist

Sixth Floor: Oncology and Immunology
1. Pain specialist
2. Radiologist
3. Rehabilitation
4. Plastic Surgery
5. Toxicology

Seventh Floor: Cardiac Service
1. Gastroenterology
2. Surgery
3. Exercise physiologist
4. Pharmacologist
5. Psychiatrist

Eight Floor: Asthma and Pulmonary Diseases
1. Poisoning and Toxicology
2. Pulmonologist
3. Occupational Medicine
4. Allergist
5. Gastroenterology

Ninth Floor: Exercise and Rehab Center

Tenth Floor: Aids, HIV, Sexually Transmitted Diseases/ Genetic Counseling

Pediatrics and Teen Care would be housed in public schools.

While patients are free to select any specialist they wish to see outside those assigned to the designated primary care floor, it is anticipated that doctors will form coalitions with the allied physicians on their floor and work in a team setting to set up individual treatment regimens.