PHYSICIAN ATTITUDES TOWARD THE UNINSURED

The Ethics of Medical Philanthropy in a Changing Health Care Environment

The Milwaukee County Perspective

A White Paper Sponsored and Presented
by
The Ethics Committee
of
The Milwaukee Academy of Medicine

Michael N. Katzoff, MD, ACP, Chairman and Editor

Donna R. Taylor, JD, MA
Milwaukee, Wisconsin
November, 1999

Acknowledgments

The Milwaukee Academy of Medicine is dedicated to the advancement of science and medicine, professional collegiality, public service and the preservation of our medical heritage.

The Bioethics Committee of the Milwaukee Academy of Medicine,

Michael Katzoff, MD, Chairman and Editor

COMMITTEE MEMBERS:
Donald Beaver, D.O.
Ray Bender, M.D.
Sheldon L. Burchman, M.D.
Arthur R. Derse, M.D.,J.D.
Phillip Dougherty, M.D.
Elaine C. Drobny, M.D.
Jeffrey Gorelick, M.D.
Michael Katzoff, M.D.
John R. Petersen, M.D.
Robyn Shapiro, J.D.
Ron Stark, M.D.

OFFICERS AND MEMBERS OF THE COUNCIL FOR 2000

Elaine Drobny, M.D., President
John Petersen, M.D., President-elect
Jay Schamberg, M.D., Immediate Past President
Elizabeth Ciurlik, M.D., Secretary
Geoffrey Lamb, M.D., Treasurer
Paul Bernstein, M.D., Newsletter Editor

COUNCIL
Marilyn Schapira, M.D.
Rebekah Wang-Cheng, M.D.
James Woods, M.D.

COMMITTEE CHAIRS
Michael Katzoff, M.D., Bioethics
Geoffrey Lamb, M.D., Finance
L. Samuel Wann, M.D., Fund Development
Jeffrey Jentzen, M.D., History
Raymond C. Zastrow, M.D., History
Ron Stark, M.D., Medicine and Society
Russell Gonnering, M.D., Membership
Kesavan Kutty, M.D., Program
George Walcott, M.D.
Public Health & Education Committee
Amy L. John, Executive Director

BOARD OF TRUSTEES
Physicians
Christina Keppel, M.D.
Mahendr Kochar, M.D.
Peter Sigmann, M.D.
Terrence Wilkins, M.D.

Non-physicians
Robert Karlman
Carl Knauer
Mary Wolverton, J.D.
Walt J. Wojcik

PRIMARY AUTHOR:
Donna R. Taylor, JD, MA Donna Taylor earned a JD degree at Loyola University, New Orleans, in 1983. She practiced extensively in public interest law in South Carolina for over 14 years. As legal counsel and clinical consultant for several medical ethics committees, she taught Bioethics courses at the Medical University of South Carolina and regularly lectured on issues health care law and ethics. Ms. Taylor was admitted to the Wisconsin Bar in 1999 and that same year completed a Masters Degree in Bioethics from the Medical College of Wisconsin. She serves as an ethics consultant, teaches at the graduate and undergraduate level, as well as lectures to professional organizations on issues in Bioethics.

Milwaukee Academy of Medicine
8701 Watertown Plank Road
Milwaukee, Wisconsin 53226
Phone: (414) 456-8249
Fax: (414) 456-6537

Table of Contents

Abstract

Although Wisconsin ranks second among states in the percentage of insured residents, Milwaukee County's uninsured rate is higher than the national mean. Until its closure in 1995, most of the county's uninsured were treated at John L. Doyne Hospital. Health care providers have since been compelled to reevaluate their response to uninsured patients. As essential members of the health care triad that also includes patients and payers, physicians must assume a role that is consistent with their calling, their traditions and the multiple mandates of professionalism.

Systemic in evolving managed care regimes is a tension between physicians' fiduciary obligations to patients and their contractual obligations to insurance programs with which they do business. Duties to Managed Care Organizations tend to decrease doctors' sense of professionalism and autonomy, resulting in diminished satisfaction with their professional calling. Despite numerous reform efforts, the practice of medicine in this environment may not be what new physicians expected as they made the enormous commitments required for medical training.

Doctors' responsibility for care of the uninsured depends on concepts of medical professionalism, and on whether health care is a patient's right, rather than a personal responsibility. Under the favored Rights Model, the manifest conclusion is that government must recognize and pay for this right. The debate is protracted and addresses neither the immediate concerns of human suffering nor the conflicting obligations encountered daily by practicing physicians.

As doctors bear a significant burden of societal decisions regarding health care, they must be a significant voice in the restructuring of the health care delivery system. In the interim, physicians' commitment to an expanded concept of professionalism requires cooperation and a shared responsibility at the patient, institutional and legislative levels in devising an equitable plan to care for the poor, both in Milwaukee County and throughout the nation.

Figures and Tables

Figures

Tables

CHAPTER ONE

Scope of the Problem of the Medically Indigent in Milwaukee County

Abstract: *The closing of John L. Doyne Hospital in 1995 initiated a three year transformation of Milwaukee County's system of caring for the uninsured. From a direct service, single site system, the county became a purchaser of services for indigent persons through the General Assistance Medical Program (GAMP). After Doyne closed, the majority of indigent persons were treated at Froedtert Memorial Lutheran Hospital (FMLH). Under GAMP, most local hospitals and a network of community-based clinics care for and admit GAMP patients at Title 19 rates. Despite Wisconsin's good record for insured residents, 14% of Milwaukee County residents are uninsured. Even with Medicaid, GAMP, and BadgerCare, the county's uninsured population is estimated at 114,000, with the majority being from families with a full or part time worker. Managed Care models of health care delivery emphasize the profit motives of medicine and the costs of employee based insurance have increased the ranks of the uninsured. Compliance with extraordinary administrative requirements influences physicians' ability to participate in the charitable practice of medicine.*

A. Charity Care at Milwaukee County Hospitals. Formerly, Wisconsin statutes required counties to provide health care access to all medically indigent persons. That law was repealed in 1995, the same year that John L. Doyne Hospital (JLDH) closed. Until then, JLDH served uninsured patients as the primary health care facility for the poor of Milwaukee County. The Medical College of Wisconsin (MCW) physicians provided all medical care at JLDH. After Doyne was lost, Froedtert Memorial Lutheran Hospital (FMLH) provided 100% of the emergency admissions under a two-year contract with Milwaukee County, which terminated on April 4, 1998.

Milwaukee County's indigent healthcare program, now called the General Assistance Medical Program (GAMP) is in the third year of a five year transition. Formerly, direct services were provided almost exclusively through JLDH. Currently, GAMP supports a purchaser of services program that provides care through community clinics.[1] Milwaukee County insures GAMP patients at Medicaid Title 19 rate levels.

GAMP is not available to any individual who is insured or who is eligible for Medical Assistance, Medicaid, Medicare, Workers Compensation or an employer policy. Those whose household income exceeds a predetermined level, or who cannot prove bona fide residency in Milwaukee County are also excluded.[2]

Since the FMLH contract ended, most area hospitals have agreed to accept GAMP payments for in-patient care. Data from internal audits of the GAMP program confirm that from January 1996 through December 1997 the number of GAMP patients was unchanged (14,312 per year). However, the gross number of claims increased by 25, 266 to 130,622 during the two years of the study. As anticipated, community based clinics and other providers are providing GAMP compensated care more frequently, while FMLH is providing care less often. This trend is depicted below at Figures 1(A) and 1(B)[3]

Figure 1(A): GAMP Claims at Milwaukee Area Hospitals, 1996

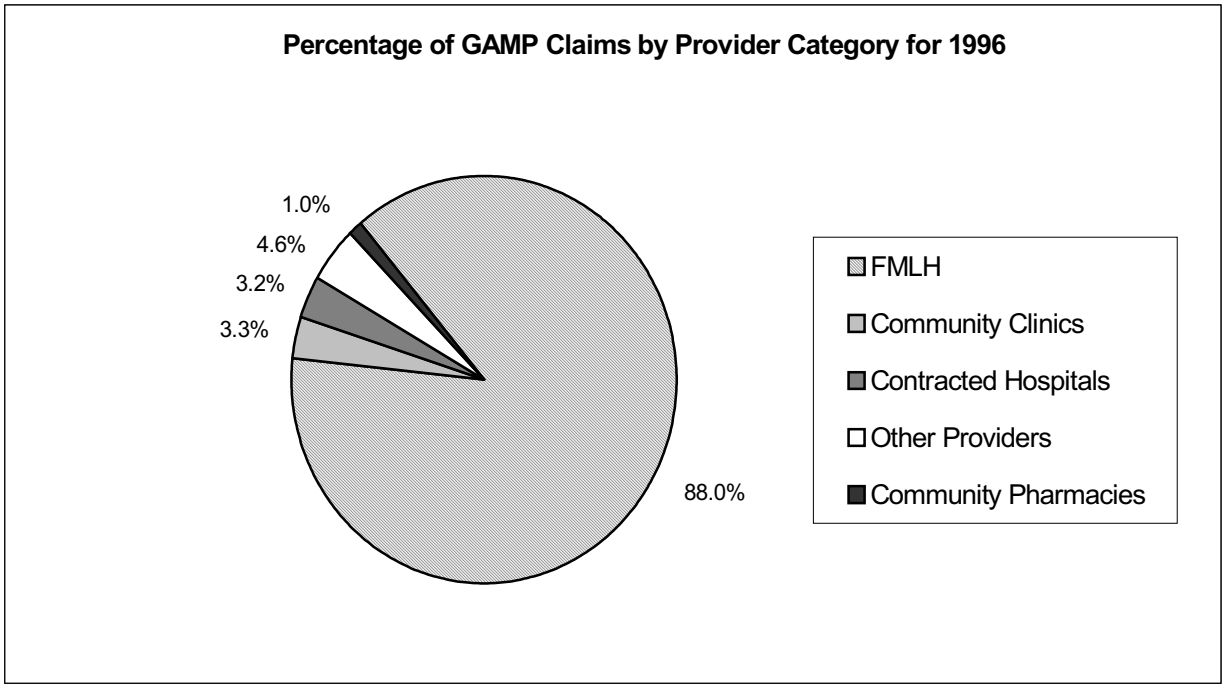
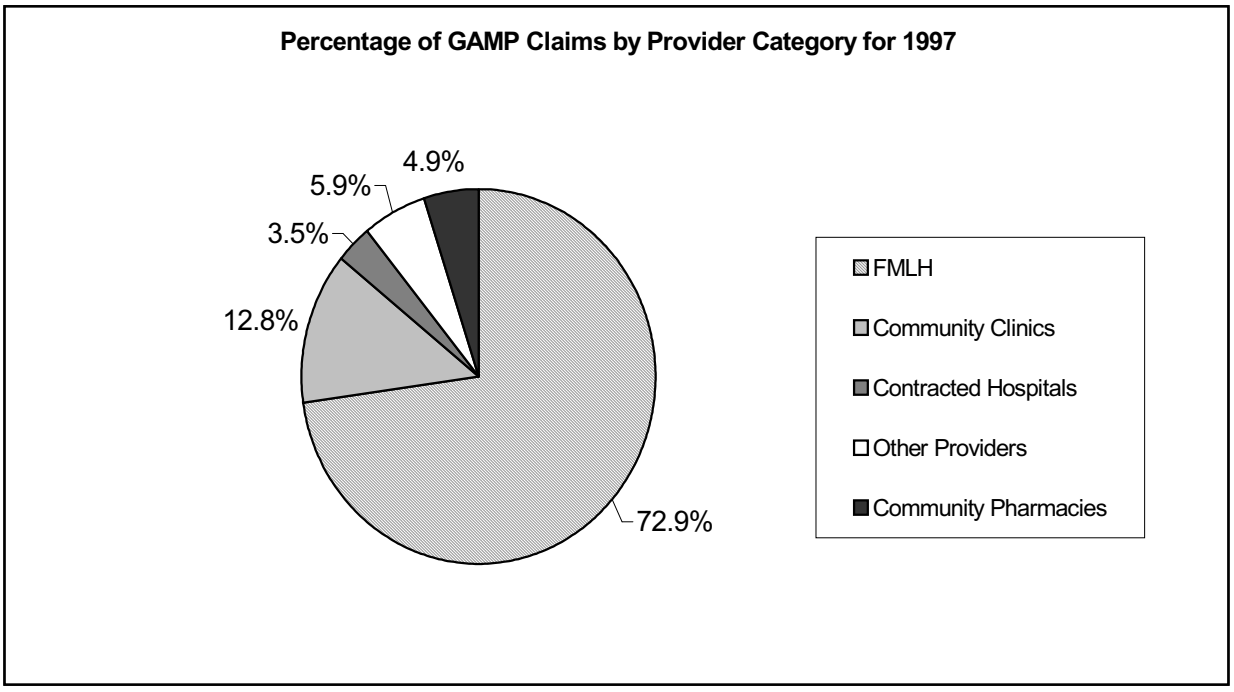


Figure 1(B): GAMP Claims at Milwaukee Area Hospitals, 1997.



Even prior to GAMP, local hospitals had already provided certain levels of charity care to Milwaukee County patients at no charge to the patient or a third-party payer. Charity care is distinguished from "bad debt" which is the cost of service for which the provider expected to be paid, but was not. On August 16, 1999, the Business Journal reported that among a dozen hospitals in Milwaukee County, total charity care was $43.9 million dollars in 1998, an increase of 2.1 percent from $43 million in 1997. Total bad debt increased 13.7 percent to $58 million in 1998.[4]

There are no uniform criteria for institutions to characterize uncompensated care as either bad debt or charity. Therefore, comparisons among the institutions may not precisely distinguish charitable intent. Currently, the Center for Public Representation in Madison Wisconsin is collecting and analyzing 1997/1998 data on charity care. The data tabulated for Hospital FY 1995-1996 evidences that Milwaukee County general medical/surgical hospitals provided charity care at levels ranging from less than 1/2 of 1% of gross revenue to 1.75% of gross revenue. See Figures 2(A) and 2(B).[5]

Figure 2(A): Charity Care in Milwaukee County's Hospital FY 1995-1996

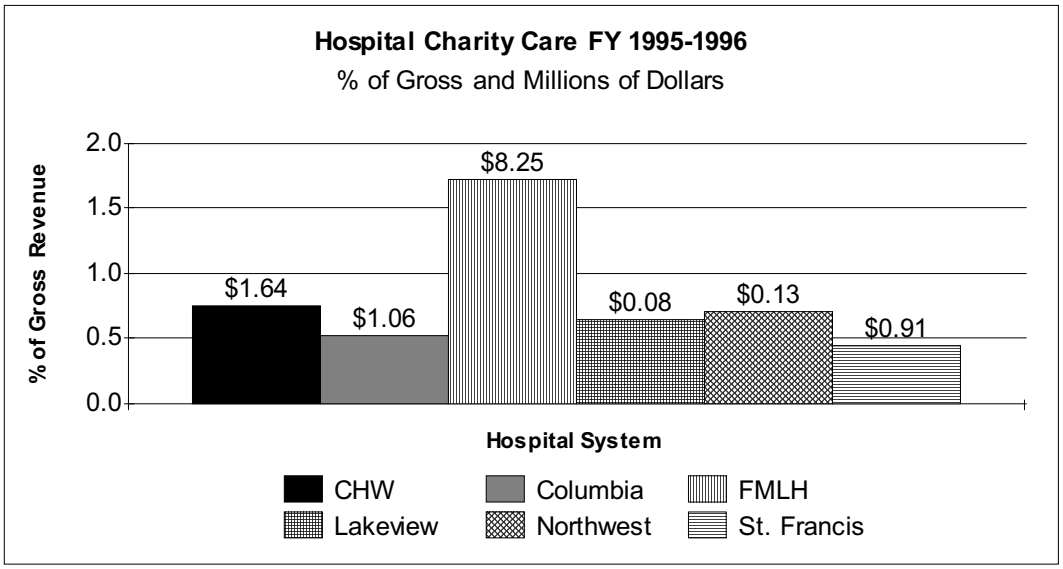
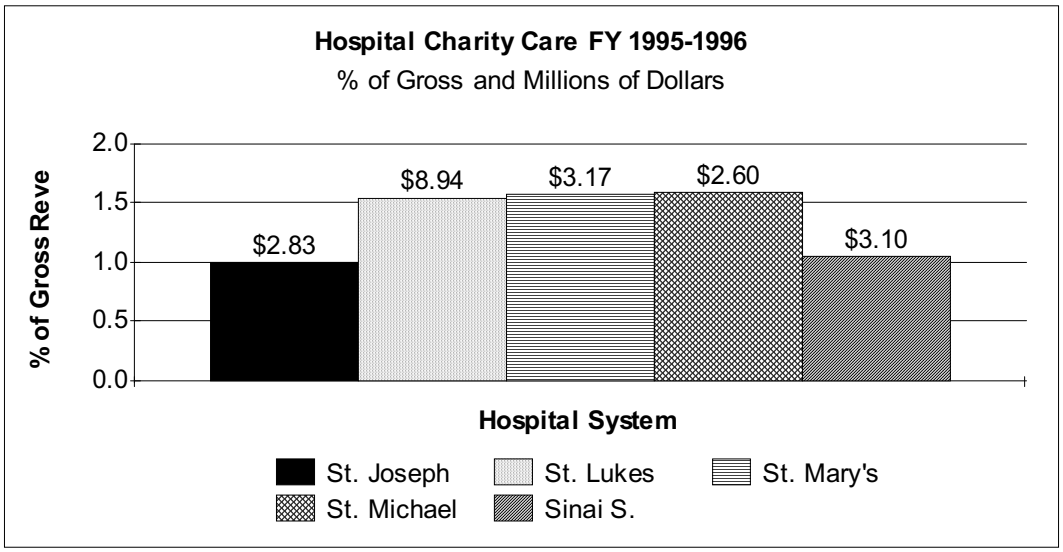


Figure 2(B): Charity Care in Milwaukee County's Hospitals FY 1995- 1996 (cont.)



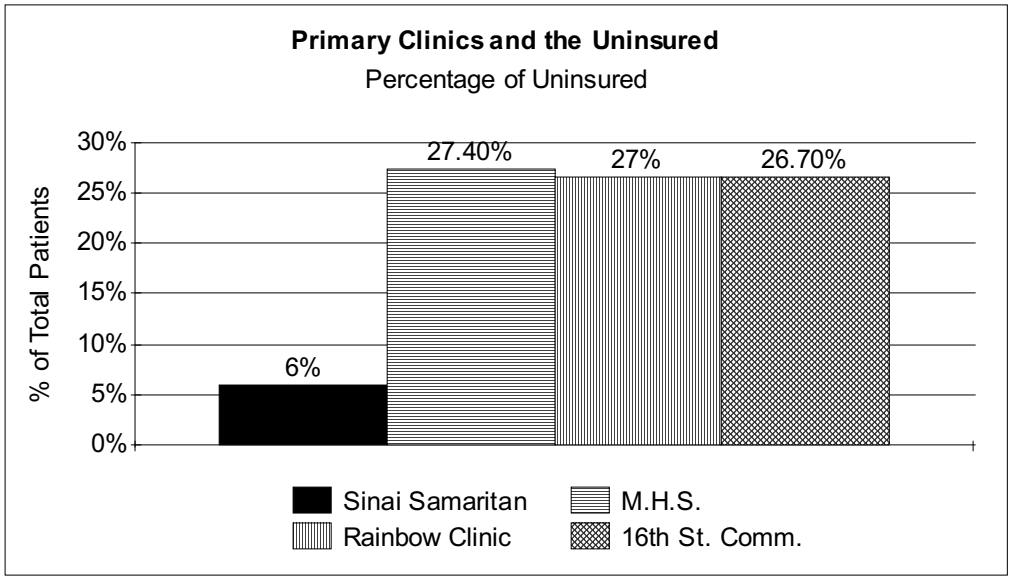
Preliminary information from the Center For Public Representation suggests that gross patient revenue for Milwaukee County hospitals increased for 1996-1998, as did actual dollars spent on uncompensated patient care (bad debt and charity care). However, the ratio of uncompensated patient care as compared to gross patient revenue actually decreased during that period.[6]

A report released March 14, 1999 by the Wisconsin Policy Research Institute proposes that hospitals establish a commitment to contribute at least three percent of their gross patient revenue to charity care.[7] No area hospital donates care near that suggested level. FMLH contributions appear disproportionately higher than other providers but this may be because its data includes care provided by the Medical College of Wisconsin (MCW), which operates and manages its outpatient clinics. However, FMLH did pay for GAMP patients' treatment at the MCW clinics until 1998.

The data from Sinai Samaritan Hospital, which cares for a high number of low income, inner city patients, appears lower than what may have been expected. However, that facility employs a large professional social work department. Its social services department is vigilant in securing prospective insurance coverage though Medicaid or GAMP for patients who may be uninsured at the time of admission. Data for other providers may be similarly explained by differences in administration or accounting practices.

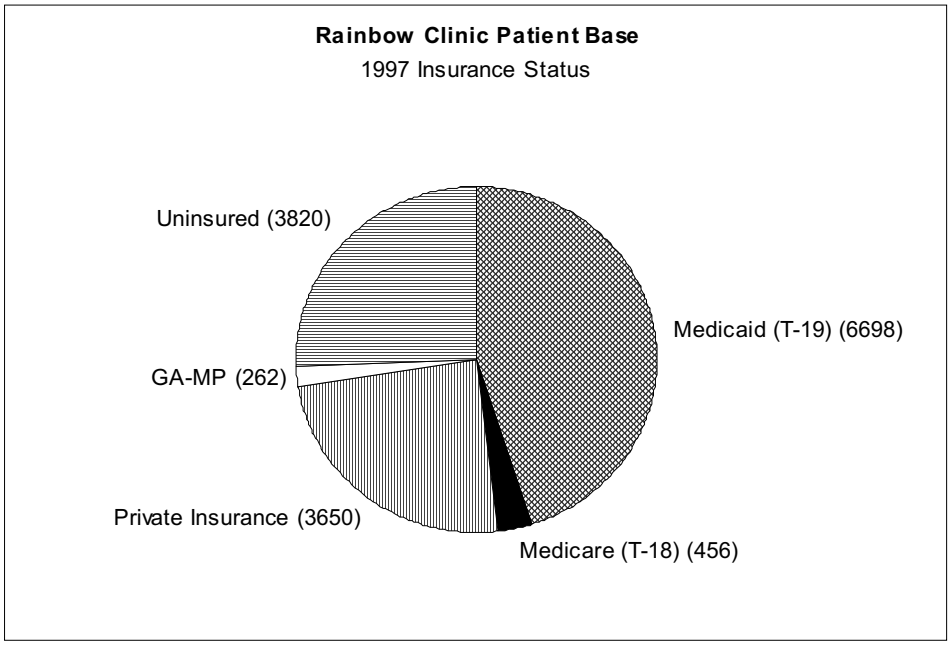
B. Charity Care at Community Clinics. With the MCW Clinics, a network of 16 community-based clinics provided the majority of primary care for Milwaukee County's uninsured population. Ten clinics provided data for a 1997 GAMP survey.[8] The Sinai Samaritan system includes three satellite clinics, *i.e.* Johnson Primary Healthcare Clinic, Mitchell Point Clinic and Clark Square. The Milwaukee Health System (MHS) includes two satellites, *i.e*. Isaac Coggs and Martin Luther King Heritage Health Center. The Rainbow Community Health System had the broadest presence with four clinics, *i.e.* the 27th Street Clinic, the West Lisbon Ave. Clinic, the North Plankington Road Clinic and the Rainbow Indian Community Health Center. The Sixteenth Street Clinic provides care at a single site. Anecdotal evidence indicates that the MCW Clinics, Mary Mahoney Clinic, Sethi Medical Services Clinic and Shafi Medical Center also have significant charitable care components. However, those clinics did not provide data requested. (See figure 3).[9]

Figure 3: Uninsured Populations at Primary Care Clinics in Milwaukee County, 1996.



On April 2, 1999, the Rainbow Community Health System filed for bankruptcy. Its clinics stopped seeing patients on April 15, 1999. In 1997, the last year data was analyzed, Rainbow treated 3,820 uninsured patients. Only 27% (3,912) of Rainbow Clinic's 14,886 patients were paid for at market levels by private insurance or Medicare. All other care (73% or 10,974 patients) was paid for either at Title 19 rates, representing a net loss to the clinics, or went unpaid altogether (See Figure 4).[10] Although the figures have not yet been collected, by 1998 the number of uninsured patients seen by Rainbow Clinics had increased.

Figure 4: Insurance Status of Patients at Rainbow Clinic, 1997.

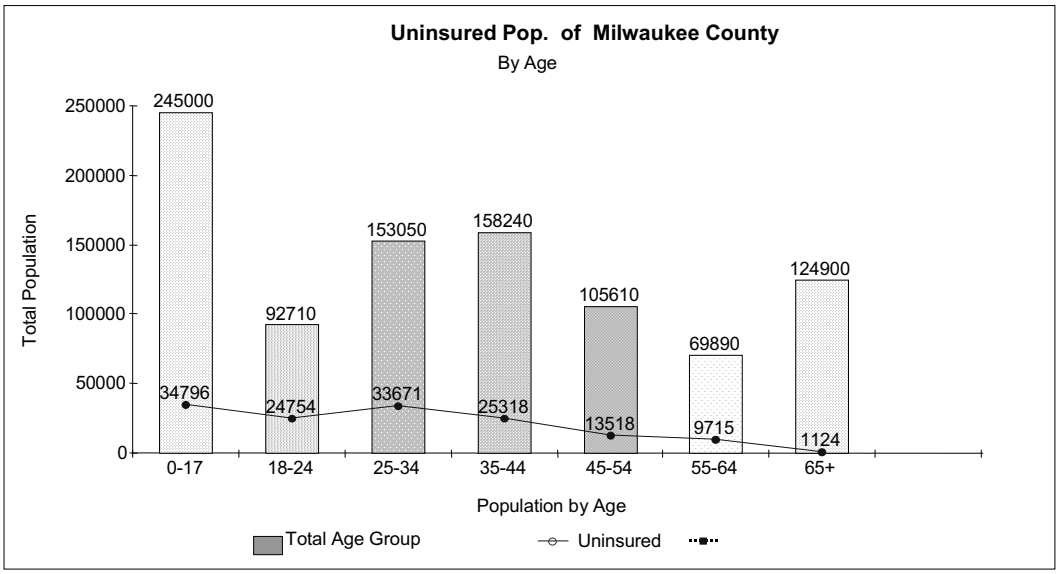


Presumably, Rainbow's privately insured patients will not have significant problems finding other care providers. The remaining 11,000 plus underinsured and uninsured patients must find other sources willing and able to take a loss on their medical treatment. Even if the patients are distributed equally among the remaining three clinic systems dedicated to community service, each clinic will need to assimilate approximately 3,666 new patients who are unable to pay sufficiently to meet clinic expenses. Already tenuous resources will be strained further. Existing public clinics and individual physicians will be asked to absorb significant numbers of patients to their own financial detriment, as disenfranchised residents either go untreated or struggle to find care.

In 1998, 43 million Americans—or 18% of our non-elderly population—are without health insurance coverage. Over the last decade, the number of uninsured people has grown by nearly 10 million.[11] Among the states, Wisconsin ranks second in the nation in rates of health insurance coverage, with only 8.6% of its population uninsured. However, in 1995 the uninsured population of Milwaukee County was estimated to be 13-15%. This represents between 113,000 and 144,315 people (See Figure 5).[12] Even if those eligible

for coverage by the GAMP program are removed from the uninsured range, the remaining uninsured population of Milwaukee County is estimated to remain at a low of 54,087 and a high of 125,402. Children comprise the largest demographic group.

Figure 5: Uninsured Population of Milwaukee County, 1995



The growth in the uninsured population reflects a decreasing percentage of Americans with employer-sponsored health insurance coverage as a worker or dependent of a worker. Among the 43 million uninsured Americans in 1997, 84% were from families with a full or part time worker.[13] In the U.S. the majority of non-elderly insured are covered through widely varying employment based plans. With increasing frequency, coverage declines due to increased co-payments, significant limitations of service or restricting eligibility for benefits. Coverage declines have led to a widening gap between low and high wage workers. The intimidating complications created in a system with innumerable delivery alternatives and financing plans increases the barriers to adequate insurance for low and moderate wage employees.

C. Mental Health Care in Milwaukee County. Similar but overlapping problems arise in the delivery of mental health care to indigent persons. Milwaukee County Mental Health Complex (MCMHC) has traditionally provided mental health care in much the same was as medical/surgical care was provided at JLDH. Fees were assessed on a sliding scale. Title XIX was billed when appropriate, but for the most part, psychiatric care was paid for by GAMP or the cost was absorbed by the Milwaukee County.

By the mid 1990's, the county began to curtail both its outpatient and inpatient services. Inpatient units closed down at MCMHC. Freestanding clinics closed or consolidated. Drug and alcohol detoxification and rehabilitation services were drastically cut. The hope that "community based" facilities would fill the gap left by the county's withdrawal did not materialize. Most for-profit facilities, such as Charter Behavioral Health System, cannot accept Title XIX payments. The mechanisms to reimburse those facilities for care of indigent patients has not been implemented. Many nursing homes and skilled care facilities are also for-profit ventures. The do accept the mentally ill, but there is little incentive to admit uninsured persons.

Most pressing is the problem of caring for an uninsured patient who has *acute* psychiatric illness. As late as 1996, these patients were brought to MCMHC for inpatient and outpatient care. Since the cuts, many patients have been transported to psychiatric units at private hospitals, which has resulted in significant loss of revenue for these facilities. Many of these hospitals do not have the emergency or psychiatric staff to deal with the sickest of these patients, indigent or not. They are faced with a choice: either improve their physical plant and hire more staff or get out of the mental health care business altogether.

Good mental health care is good preventative medicine. Where mental health care is readily available to all, emergency room abuse is lower. Moreover, inpatient stays for psychiatric *and* medical treatments are shortened. Across the board, the treatment of

depression and anxiety alone reduces morbidity. It has been said that it is "much easier and cheaper to get a gun and kill yourself than to get treatment."[14] Accessible mental health care is the only way to prevent suicide, which favors no socioeconomic class.

Further, alcohol and drug abuse (AODA) and their sequelae consume considerable psychiatric and medical resources. This problem—or set of problems—is prevalent in uninsured populations. Milwaukee County has no coherent system to address AODA issues. While AODA problems are truly multidisciplinary, they are handled by the health care delivery system in the same manner as acute mental illness.

The Mental Health Parity Act of 1996 requires that since January, 1998, annual and lifetime dollar limits for mental health care must be equal to annual and lifetime limits for physical illness. This applies to all US group health plans that offer mental health benefits and serve more than 50 employees.[15] However, the law allows insurers to charge higher deductibles and copays for persons with mental illness and to restrict hospital stays and outpatient visits. Further, substance abuse is not covered. Even this weakened coverage is due to sunset on September 30, 2001.[16]

D. Insufficiency of Current Responses. In 1996, GAMP served 18,913 patients. However, it is estimated that in 1996, between 11,000 and 25,000 ill or injured people in Milwaukee County (20.5%) went without medical attention. Those surveyed report that they went without medical attention because they could not afford the costs.[17] With inadequate access to medical care, indigent patients in ill health may be forced to consider forgoing treatment, in hope that their condition will resolve on its own. However, lack of treatment may aggravate health problems, which may ultimately require far more expensive emergency treatment. In 1996 the average cost of treating a patient in the emergency room was hundreds of dollars per person, while an initial visit at a

neighborhood clinic cost only $35.77.[18] It is unrealistic to assume that all emergency medical treatments can be avoided by adequate primary care. However, emergent treatments prevented by primary care may result in savings exceeding $1,200 dollars each.

In 1998, after protracted lobbying and legislative negotiations, the Federal government approved an expansion of Wisconsin's Medicaid Program, called Badger Care, which became effective on July 1, 1999. For 1998, the Federal Poverty Limit Guideline (FPL) for a family of three was $13,880 per year.[19] Wisconsin families with incomes less than 185% of the Federal Poverty Guideline ($25,678) are eligible for the plan. It is estimated that an additional 12,800 Milwaukee County Residents will be covered by Badger Care. However, at the upper estimates of the poverty demographics of Milwaukee County, as many as 82,000 county residents will remain uninsured.[20]

The Emergency Treatment and Active Labor Act (EMTALA) requires treatment of emergencies and active labor.[21] The Eighth Amendment to the Constitution requires that prisoners have access to adequate medical treatment.[22] States are obligated to provide medical care to children in its custody.[23] With those explicit exceptions, there is no defined right to health care in the United States. No current legislation requires physicians or the medical system itself to provide non-emergency care for those who cannot pay.

Even without a legal mandate, it is widely assumed that most doctors take to heart their responsibility to care for the poor and infirm as a professional obligation rising from their elevated stature as professionals. However, Managed Care models impact the practice of medicine in Milwaukee County and the nation. These new systems are creating enormous tension between the contractual obligations doctors have under their agreements with their Managed Care organizations and the fiduciary duties owed to their patients and the public. By 2005, an estimated seventy-five percent of all health insurance beneficiaries will participate in a managed care plan (PPO, POS, HMO, etc.).[24] Thus, as Managed Care becomes the dominant third party payer mechanism, no physicians will escape the strains on their practice styles and traditions created by new commercial

tensions. These strains impede physicians' ability to provide care for which there is no compensation and are specifically addressed in Chapters Three and Four.

Notes

[1] Jerome Heer, "Uninsured Populations, Medicaid Benefits and Uncompensated Care in Milwaukee County: Information for the Milwaukee County GAMP Program", (County Health Related Programs, Feb. 2, 1998) photocopied.
[2] *Eligibility Determination Requirements, Milwaukee County GAMP Policies and Procedures*, Policy No. E-4, (Jan. 20, 1998).
[3] Elizabeth Larson and Susan Tragesser, et. al. "A Description of the GAMP Population and Medical Claims: Comparisons Between 1996 and 1997," Milwaukee, WI: Planning Council for Health and Human Services, September 1998, photocopied).
[4] Julie Sneider, "Hospital's Bad Debt on the Rise," *The Business Journal*, Sept. 16, 1998, Sec. ____, pg. ____.
[5] Office of Health Care Information, Office of the Commissioner of Insurance, Wisconsin Legislative Audit Bureau, *Unreimbursed Care at Milwaukee Area Hospitals, Hospital Fiscal Year 1995-1996,* in *Uninsured Populations, Medicaid Benefits and Uncompensated Care in Milwaukee County: Information for the Milwaukee County GAMP Program,* table 9(Planning Council for Health and Human Services, 1998) 24.
[6] Louise Trubeck and Mary Meehan-Strub, "Medically Uninsured and Underinsured: 1999 Initiatives and Obstacles Forum" Center for Public Representation, Inc., Madison, Wisconsin, (Sept. 1999).
[7] Sammis White, "*The Medically Uninsured in Milwaukee,"* Policy Research Institute Report 12(2): 7, 1999.
[8] Elizabeth Larson and Patricia Batemon, "An Inventory of the Community-Based Primary Care Clinics," (Milwaukee, WI: Planning Council for Health and Human Services, 1997, photocopied), 21
[9] *Ibid.*
[10] *Ibid.*
[11] Kaiser Commission on Medicaid and the Uninsured, "Trends in Coverage for the Nonelderly Population, 1987-1997. Employment Benefit Research Institute, 1998.
[12] White, 7.
[13] Kaiser, 1.
[14] _____, "Guns Used More for Suicide Than Homicide," NY Times, October 17, 1999, pg. 16.
[15] The Mental Health Parity Act of 1996 (PL 104-204).
[16] The Coalition for Fairness in Mental Health and Substance Abuse Insurance in Wisconsin supports proposed parity legislation, already enacted by 27 states which would remove many of the loopholes in the current Act.

[17] *The Health Status of Uninsured Milwaukee Area Residents: Further Analysis of the 1996 Milwaukee Health Status Survey Data*, (Planning Council for Health and Human Services, April 15, 1997, photocopied).
[18] White, 8.
[19] *Annual Update of the HHS Poverty Guidelines*, U.S. Department of Health and Human Services (Washington, D.C.: Government Printing Office, 1999).
[20] White, 9.
[21] *Emergency Medical Treatment and Active Labor Act, U.S. Code.* Vol. 42, sec. 1395dd, 1986.
[22] U.S. Constitution, amend. 8. See also *Custody of State Offenders Act, U.S. Code* vol. 18. sec. 5003 (1996).
[23] 12 *Juvenile Justice Code, Wisc. Stat.* 938.02, (1998), Where "legal custody" means a legal status created by the order of a court, which confers the right and duty to protect, train and discipline a juvenile, and to provide food, shelter, legal services, education and ordinary medical and dental care, subject to the rights, duties and responsibilities of the guardian of the juvenile and subject to any residual parental rights and responsibilities and the provisions of any court order.
[24] Reginald M. Hislop, III, "Managed Care: Ethical Implications of Balancing Cost v. Quality." (Milwaukee, WI 1998, photocopied).

CHAPTER TWO

Medical Tradition of Caring for the Needy

Abstract: *Physicians have a mixed tradition of caring for the needy. Until the mid 1800's care for indigent patients was usually provided by a kinship network, supplemented by certain practitioners and philanthropies. As the professional status of doctors rose, charity care diminished. By the end of the 19th century, before specialization gained favor, free medical aid was often provided by government sources. Even so, the concept of compulsory government insurance failed and private voluntary insurance created a two tied system. The chasm was minimized with the emergence of employer based benefits with charitable clinics often treating the medically indigent. Most physicians report donating time to care for those who cannot pay consistent with their concept of professional responsibility. However, new obligations created by Managed Care systems may limit the time and inclination toward professional altruism.*

Historically, physicians have a mixed tradition of care for the needy.

> *Although the Hippocratic corpus (460-475 BC) is often self-contradictory, (some sections propose impressing patients by dress and bearing to earn larger fees) the trend is to interpret Hippocrates as completely eschewing an actual fee. Some writings note that since physicians save people from death, 'no fee, not even a large one, is adequate for the physician, but it is with God Almighty that his remuneration rests—and what he may receive should be reckoned as a gift, a present.* [1]

In dialogues similar to those in Grecian history, in Roman law a *medicus* practiced one of the liberal arts and was therefore officially prohibited from charging a fee, although able to accept honoraria.[2]

In the West, until the mid 19th century, care for indigent patients was provided by the patient's family or kinship network with some supplementation by an assortment of practitioners. Most often, they were older women, self-taught empirics, and loosely trained doctors.[3] Well-educated physicians tended to practice among the social elite. Due to increased potential for infections and less attentive care than was provided at home, hospitalization was reserved for the poor and for those without familial caregivers. In the mid 19th century, hospital utilization increased with funding by philanthropic

foundations to pay for the working poor. Many beds were free, but patients were expected to provide clinical experiences for medical apprentices. Indigent persons were cared for at a community almshouse.[4]

The growth of medicine between 1870 and 1920 saw American physicians securing professional status with commensurate medical licensing standards and regulations. By the early twentieth century, only formally trained and licensed physicians had authority to practice medicine. Effectively, this initiative improved the quality of care and limited competition for doctor services. Licensure also increased practitioners' income potential and rendered them less willing to locate in poor communities. Medical costs increased, enlarging the barriers to access for that population which previously relied on non-physician practitioners.[5] An AMA study in the 1920's found distribution of physicians closely correlated to per capita income of community. The report concluded, "doctors behaved the way all 'sensible people' do. They do business where business is good and avoid places where it is bad."[6]

During the second half of the 19th century, free medical aid and home care to the poor was delivered by government and non-profit institutions through outpatient care centers called "dispensaries" which in most instances were associated with private hospitals. Young volunteer physicians obtained clinical experience in dispensaries when internships were not an established element of a medical curriculum.[7] While the concept of medical specialization burgeoned, the dispensary concept failed.

Similar to the current erosion of entitlement programs in the United States, and in particular the Wisconsin Works (W-2) program, the early 20th century saw the foundation of charity itself attacked as a vestige of paternalism.[8] Many physicians and

legislators proposed that charity demoralized the individual and encouraged laziness and pauperism.[9] Early reformers, including Teddy Roosevelt, encouraged self-funded compulsory government medical insurance. This was defeated and insurance emerged on a private, voluntary basis, guaranteeing separation of financing of medical care for the poor from those more self-sufficient.[10]

Escalating costs and unemployment during the great depression gave rise to the need to finance health care. Until the end of World War II, 33.5% of low-income people received no medical care as compared with 7.5% of those in higher income brackets.[11]

> *Growth of health insurance plans tied to employment increased during World War II when there was a labor shortage and wage controls. Health insurance escaped wage controls and continued to become a common feature of employment. That relationship involved financing of health care only, with no element of control or review.* [12]

The emergence of employer sponsored health insurance brought working class families closer to the middle class in terms of access to medical care. This effectively eliminated medical care on credit or a sliding fee basis.[13] However, the prevalent institutional racism of the period found that despite employment status, African-Americans saw physicians 50% less often than did Whites.[14]

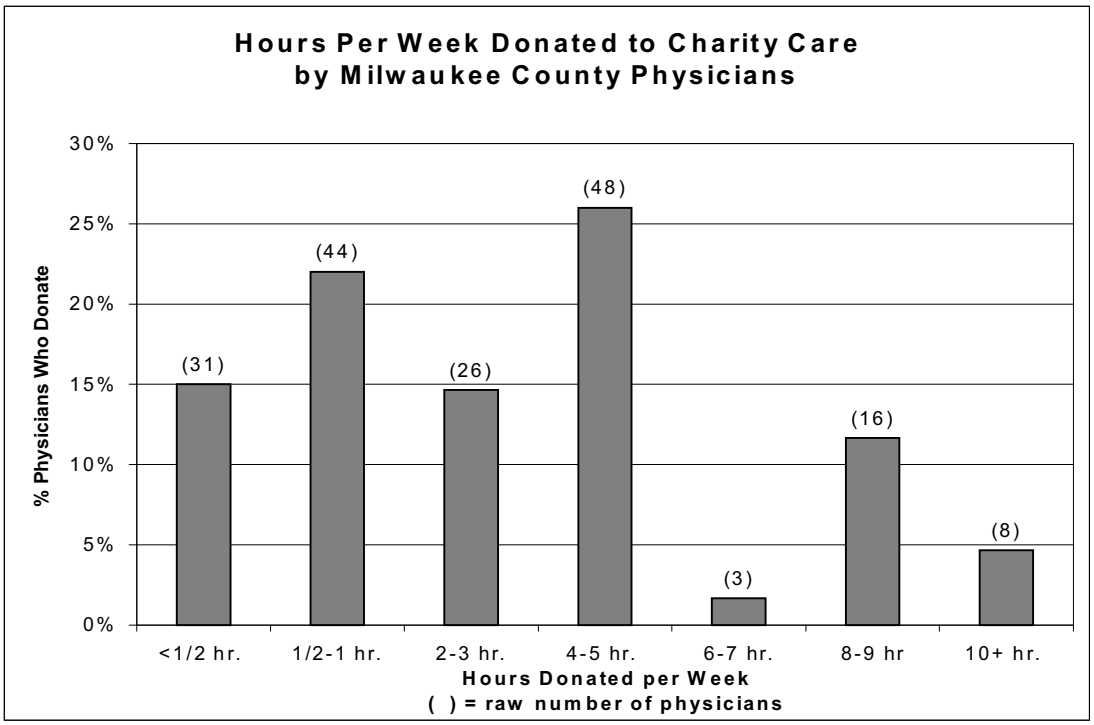
The social enlightenment and reorganization of the 1960's saw local health centers providing care and attempting to raise awareness of health issues in poor communities. However, the development of Medicare and Medicaid as health care delivery systems to the needy did not reform, but only maintained, the existing pattern of subsidizing medical care only for those unable to secure private insurance.[15] Still, federal programs held the advantage over piece-meal programs because of the entitlement status of those publicly insured, institutional compatibility and nondiscretionary funding.[16]

The past 150 years has witnessed the transfer of control of patient care from the family and lay community to highly skilled professionals who control the market and the medical hierarchy. Care has moved from the home to the hospital and outpatient clinics, creating a greater emotional distance between the sick and those responsible for their care.[17] The drive toward economic efficiency created by market forces has further reduced the number of volunteer cases undertaken by physicians. As Girt Brieger, MD, Ph.D., writes, "when the charitable impulse runs afoul of the medical market place, economics have usually dominated philanthropy."[18]

A decade ago in Wisconsin, *JAMA* reported that physician group practices reported that they provided uncompensated medical care representing 7.6% of their total billings for the year.[19] This figure designated 1.65% as charity care, 3.0% as bad debt and 3.0% as discounted Medicaid care. These figures represented a significant increase from five years earlier. From the survey sample, individual physicians assumed responsibility on average for $4,300 of charity care, $9,100 in bad debt and $7,500 in Medicaid discounted services for a yearly physician average total of $20,900. The results of that survey also suggested that the burden of providing uncompensated care tends to fall disproportionately on those group practices that are also providing relatively high levels of service to Medicaid recipients.[20] If levels of charity care have remained consistent, extrapolating that data to 1996, where doctors' income had increased by only 11%, it may be inferred that in Wisconsin, individual physicians average care donation to the medically indigent is a minimum of approximately $23,200.[21] It is estimated that nationally, in 1994, physicians provided uncompensated care valued at $11 billion.[22]

Perhaps more significant than the dollar value of professional services donated by physicians is the time they spend caring for uninsured patients. In 1998, the Milwaukee Academy of Medicine conducted an informal survey of Milwaukee County physicians regarding certain professional attitudes and habits related to the practice of charitable medicine.[23] A copy of the survey instrument is attached at Appendix I. Of 291 physicians responding to the inquiry on the survey instrument, 176 physicians reported that they provided averages of less than ½ hour per week to over 10 hours a week to care for uninsured patients. Figure Six represents those responses.[24]

Figure Six: Time Donated to Charity Care by Physician in Milwaukee County by mean per week hours.



By any standard, individual physicians have made tremendous contributions to the care of the needy. Historically, this was a construct of a personal commitment to ideals

within a medical system that supported professional freedom and autonomy. Within the guidelines and legal obligations created by a managed care system however, autonomy is abridged. New contractual relationships have emerged that limit the time, assets and perhaps even the inclination to practice professional altruism.

---

[1] David Scheidemeyer and Daniel J. McCarty, "Altruism, Professional Decorum and Greed: Perspective on Physician Compensation," *Perspectives in Biology and Medicine* 38(2): 239-253, 242, 1995.
[2] *Ibid*., 243.
[3] Paul Starr, "Medical Care and Pursuit of Equality," in *Securing Access to Health Care, Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, Vol. 2 (Washington, D.C.: U.S. Government Printing Office. March 1983), 4.
[4] Charles E. Rosenberg, "The Origins of the American Hospital System," *Bulletin of the NY Academy of Medicine* 55(1): 10-21, 1979.
[5] Starr, 1983, 8.
[6] Raymond Pearl, "Distribution of Physicians in the US," *JAMA,* 1024-1027, 1925.
[7] Rosenberg, 15.
[8] Wisc. Stat. 49.141 (1999).
[9] Gert H. Brieger, "The Use and Abuse of Medical Charities in Late Nineteenth Century America," *American Journal of Public Health*, 67(3) 264-267, 1977.
[10] Starr, 1983, 9.
[11] I. S. Falk, The *Incidence of Illness and the Receipt and Costs for Medical Care Among Representative Families* (Chicago: The University of Chicago Press. 1932).
[12] Randall S. Krakauer, "Survey of Health Planning Proposals," American Journal of Surgery (1994) 167(2): 232-235.
[13] Starr, 1983 ,14, 16.
[14] *Volume of Physician Visits, by Place of Visit and Type of Service, July 1963-June 1964, U.S*. Dept. of Health Education and Welfare, National Center for Health Statistics, (Washington D.C.: Government Printing Office, 1964), Series 10(18).
[15] Medicare regulations are codified at 42 USC 1395 (subchpt. XVIII)(1965). Medicaid regulations are codified at 42 USC 1396-1396v (subchpt. XIX)(1965).
[16] Starr, 1983,19.
[17] Paul Starr, The *Social Transformation of Medicine* (Basic Books. 1982), 22.
[18] Brieger, 264.
[19] Nancy C. Dunham, David A. Kindig, *et al*., "Uncompensated and Discounted Medical Care Provided by Physician Group Practices in Wisconsin," *JAMA* 265(22): 2982, 1991.
[20] *Ibid*.

[21] "Compensation Monitor," *Managed Care* (June 1998): 23. The data provided by the AMA for this report represent the average income for all physicians regardless of specialty and location. Residents and active Federal Civil Service physicians who provide patient care were excluded.

[22] Dunham, 2985.

[23] Milwaukee Academy of Medicine, "Survey: Milwaukee Academy of Medicine," (Milwaukee, WI, Dec. 1998, photocopied). The results of this informal survey are not the product of rigorous experimental design nor are they intended to report statistically significant conclusions, but rather to discern general attitudes of local physicians regarding their personal opinion and practices of charitable medical care. Of the physicians surveyed in undisclosed specialties, there were 291 responses. Not all responding physicians answered every question on the survey.

[24] *Ibid.*

CHAPTER THREE

The Physician as a Fiduciary

Abstract: *The physician-patient relationship is both sacrosanct and fiduciary. Special duties of loyalty from the physician (fiduciary) to the patient (principal) arise because patients are dependent on physicians for their expertise. Unlike business relationships, patients are not expected to be able to protect their own interests. Competing obligations within Managed Care systems require conformity to a business model respecting the notion that investors in health care delivery are entitled to a return on their investments. True professionalism requires that despite legitimate concerns of stakeholders in health care delivery, doctors' primary allegiance is first to their patient, but then to the health of the public.*

From the time of the Hippocrates, the relationship between a physician and a patient has been sacrosanct and, generally, considered as fiduciary**.** In a fiduciary relationship, special duties of trust and loyalty stem from the fiduciary (here the physician) to the principal (patient). The fiduciary is charged to act in the best interest of his or her patient. Although the doctor is usually personally gratified and financially rewarded, the relationship is one of professional altruism. However, the friction between medicine as a healing art that is limited to the relationship between individual doctors and patients as opposed to medicine as a business is long-standing. In the Fifth century BC, Greek dramatists Aristophanes and Sophocles argued whether medicine was a craft or profession. Aristophanes contended that medicine was an art, not a simple *techne*. Sophocles, on the other hand, asserted that a physician is merely a craftsman or a tradesman.[1] Medicine, until quite recently, has rarely been considered a "business" in a traditional sense.

A. Profession v. Business. A profession differs from a business. Professions such as medicine, law and the clergy are self-regulating. They develop and maintain their own standards. The theory is that lay people lack sufficient knowledge to assess the qualifications of a profession, and therefore must rely on the profession to establish

its own credentials and rules of conduct. If there is public trust, the standards a profession sets for itself are more likely to be accepted. A profession guards that public trust by meeting or exceeding external expectations concerning its special skills and the individual and collective integrity of its membership.

"Business" also differs from "profession" in that professionals must recognize the dependence of the client or patient, while a businessperson presumes parity, mutuality and equality. Business is usually defined as buying and selling of commodities or services, and has profit as its driving force. Very often business relationships are adversarial. With the phrase *caveat emptor*, or "let the buyer beware", the consumer is admonished to look after his or her own interests, and the seller is excused from being responsible for the buyer's best interests.

Table 1: Comparative Characteristics of Profession vs. Business

Profession	Business
Self-Regulating	Market Regulated
Special Skills/Trust	Standard Skills
"Care" Motive	Profit Motive
Power Differential	Parity between parties
"Best Interest" of Principal	"Self-interest"

The institution of professional licensure justifies the consumer in forgoing responsibility for raising certain questions of competence. Licensure bestows status and status implies trustworthiness. The licensed professional has an ethical responsibility to serve rather than an empty ideology perpetuated to retain a privileged position. As the status of the medical profession is declining, the fundamental basis of both the business and the practice of medicine requires recognition. Physicians need to express their commitment to established professional

standards, which standards the public has come to trust.[2] Managed Care concepts increasingly require conformity to business models. Nonetheless, the problems inherent in that system require public evaluation of the impact of health care priorities on physicians' ability to maintain their professionalism.

B. Stakeholder Analysis. While the "stakeholders" within a third-party payer medical system include patients and physicians, additional parties emerge to whom duties are legitimately owed. Within the insurance context, both the healing mission and economic interests of physicians become constrained by the payer's justifiable interest in the balance sheet.

Stakeholder analysis is a common form of business ethics that was developed as a theoretical framework to extend the concept of responsibility beyond the boardroom, and by reference the examining room, so that it encompassed communities, employees and customers as well as shareholders.[3]

> *When applied in the context of managing medical care, stakeholder analysis inadvertently, but inescapably, demotes patients from the position of primacy they enjoy in traditional medical ethics. In a stakeholder analysis, patient's interests become just one more among many that must be balanced against those of (1) the managed care organization, which must retain its competitiveness in the market, (2) employers and other third-party payers, who have an interest in containing their costs, and (3) society at large, which seeks to minimize the number of uninsured by containing the cost of employer-financed health insurance. Additionally, in for-profit managed care organizations, (4) shareholders are stockholders with a right to a reasonable return on their investment*.[4]

As divisive as these competing stakes are, the most complex and ill-defined relationship may be that which is implied between physicians and society. In light of the history and traditions of medical professionalism, one must consider the duty physicians have to the health of the community.

With professional codes providing guidelines, a physician's obligations have expanded from individual patients to society. Society, in turn, has conferred respect, authority and certain kinds of autonomy upon physicians. Further, taxpayers have long supported medical education and research within its public and private institutions. In the context of the physician-society relationship, that fiduciary responsibility includes participation in informed advocacy for the public health.[5]

Notes

[1] David Schiedemeyer and Daniel J. McCarty, "Altruism, Professional Decorum, and Greed: Perspective on Physician Compensation," *Perspectives in Biology and Medicine,* 38(2): 242, 1995.

[2] Alan R. Nelson, "Medicine: Business or Profession, Art or Science?" Transactions of the Sixteenth Annual Meeting of the American Gynecological and Obstetrical Society (1996).

[3] K.E. Goodpaster and L.L. Nash, *Policies and Persons: A Casebook in Business Ethics,* 3rd ed. (Hightstown, NJ: McGraw-Hill, 1997).

[4] Baker, Robert, "American Independence and the Right to Emergency Care," *MSJAMA* 281: 860, 1999.

[5] Michael McCally, Andrew Haines, Oliver Fein, *et al.,* "Poverty and Ill Health: Physicians Can and Should, Make a Difference," *Annals of Internal Medicine,* 129 (9): 726-33, 1998.

CHAPTER FOUR

Professions and Professionalism

***Abstract*:** *True professionalism requires both competence and respectful relationships. Regarding physicians, the nature of their unique expertise within those relationships requires that they extend their sphere of responsibility beyond the individual patient to society at large. Personal motivations driving a commitment to medicine as a career, such as professional autonomy and control, may be less attainable under "gatekeeping" and utilization review prescribed by Managed Care models. Altruism may be superceded by the expectation of economic gains. Milwaukee County research confirms that the greater control a care plan exerts over a medical practice, the less satisfaction physicians experience with their profession, and the less likely they were to provide charity care.*

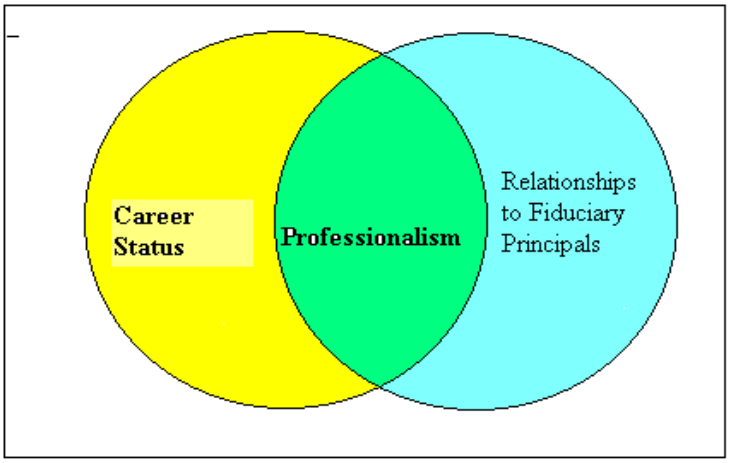
In general, the laws and regulations of the United States delineate only the lowest acceptable standards for professional behavior in fiduciary relationships. Professional codes expand these requirements, often using prescriptive language as guidance for expected, but not necessarily mandatory conduct. However, genuine professionalism requires an understanding and acceptance of the unquantifiable components of the relationships among professionals and those with a stake in their services. As will be expanded upon later in this chapter and in Chapter Five, the public at large has a legitimate stake in how medicine is delivered.

A. The Nature of a Profession. In characterizing medicine as a profession, there may be no clear syllogism that all physicians are professionals simply by virtue of their education and employment status. "What" we do for a living suggest that the concept of work is bound to and defines our sense of self. In general, society imputes the elements of professionalism to job categories.[1]

Work by itself has no moral status. No particular occupation has inherent moral superiority to another. Such characterization would imply that someone is morally superior to another merely because of membership in a group, training or specific expertise, which is absurd.[2] However, "how" work is done can acquire a moral status.

Professionalism consists of a both a skill (or quality) component and a relational component. Both can be traced to a commitment to following through on obligations.[3] In medicine, the skill component requires that professional physicians are competent in performing the tasks of the work, while the relational component requires that the work he or she does be in the best interest of the patient and society.[4]

Figure 7: Venn Diagram Establishing the Dependence of Professionalism on Status and Relationships.



In addition to the status and relational components of professionalism, physicians may be subject to obligations that are even more comprehensive. As are other professionals entitled to that status, doctors must be competent. Physicians must be competent and must establish respectful relationships with their principals (patients). To act within this more complete construct will require that physicians should not limit conduct in pursuit of their career to the patient fortunate enough to be able to pay to be on the examining table. This is intrinsic to the nature of being a doctor. Even if denying medical treatment because of inability to pay is rational in a capitalist culture, it is nevertheless harmful to society.

Physicians provide a service available only through their calling, and which all human beings need at some time in their lives. Unlike any other commodity, as will be further addressed in Chapter Five, health is the asset without which few other opportunities can be accessed. Throughout modern history, the public has supported medical research and education. Further, society has traditionally bestowed upon physicians a lofty position of respect and professional autonomy. Our culture has done so with the expectation that by belonging to society, each member will personally benefit. Even physician assistants and nurse practitioners must work under the supervision of licensed physicians. As the sole proprietors of the expertise necessary to deliver comprehensive and competent health care services, the skills of physicians belong, at some level, to the public.

B. Motives and Medicine. The work of doctors often puts them in situations where they must bracket their personal life in order to uphold the commitments they have made to their work or profession.[5] It is in that context that we consider the "why" of professionalism. Considering physicians' compound obligations, why do doctors go into medicine?

The "why" here refers to the manner in which the practice of medicine will affect physicians' lifestyle and require them to consider how they want to live. Under the dominion of Managed Care, does the occupation as originally contemplated by physicians have a place? These new administrative systems may not foster the career for which physicians bargained. The fiduciary obligations created by new insurance regimes may lead to professional isolation, resulting in a "we" and a "them" mentality. For instance, "gatekeeping" and stringent utilization review of treatments prescribed by Managed Care will generally diminish physicians' perceived level of autonomy and professional freedom. These very characteristics may have been significant among those which made medicine an attractive choice among the many

careers for which they were qualified to train. As professional control deteriorates, lines are drawn and it may appear that doctors must "choose sides."

The response to these dilemmas reflects only descriptions, without moral judgment of "good" or "bad." The descriptions are nonetheless important, as the answer to "why practice medicine?" is closely tied to physicians' notion of "self." It is the notion of "self" that guides us to choose the kind of life we believe will satisfy us when choosing a particular career. As for medicine, Galen believed that there are four types of physicians: those who practice because they love humanity, those who practice because they love honor, those who practice because they love glory, and those who practice because they love money. However, Galen did not consider those who practiced medicine for love of money to be inferior physicians, but rather inferior philosophers.[6] Depending on his or her motives within the career, under this analysis, one could technically be a capable doctor, without being a professional. As the latter term is more inclusive, the converse, of course, is false. Throughout history, scholars have considered the "why" of becoming physicians. Managed care and its commensurate tensions may cause those considering a career as a doctor to respond to the question differently than those in prior centuries.

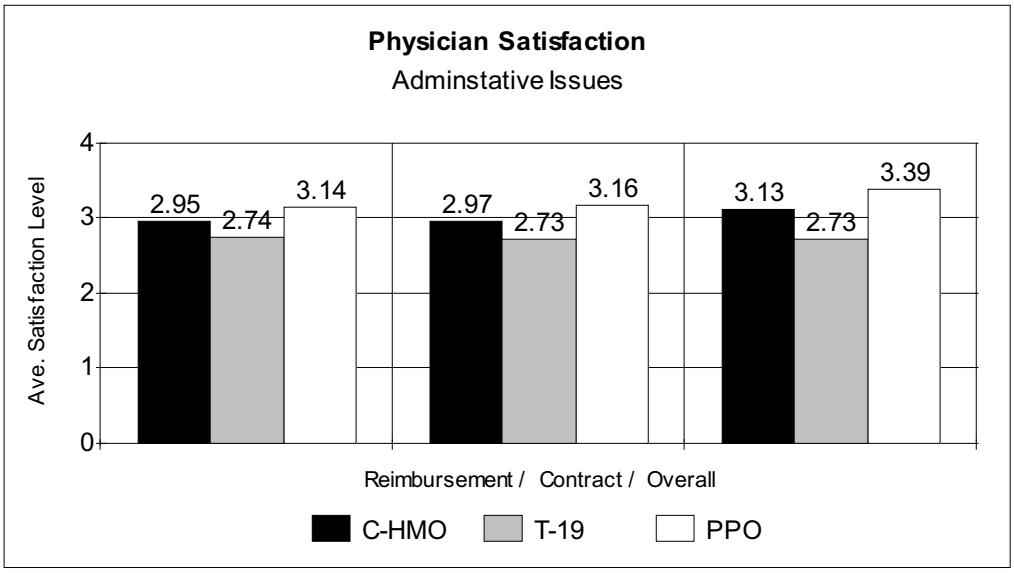
In 1992, Steve Miles, physician and medical ethicist, opined that there is a "cynical redefinition of medical professionalism." He proposes that in the last decade, "medical students have become much less inclined to be primarily motivated to seek a meaningful philosophy of life and are correspondingly more motivated to become financially very well off."[7] A self-evaluation of individual career expectations in the evolving world of medicine may assist physicians and future physicians in determining whether those expectations are realistic. Considering the encompassing requirements of professionalism (described above), an honest evaluation of the potential for career satisfaction may lead fewer good candidates to become physicians. The level of satisfaction doctors experience with their careers

under Managed Care is not encouraging. As satisfaction diminishes, so may the willingness to accept implied obligations to provide uncompensated care.

B. Physician Satisfaction: Milwaukee County. In 1995, the Medical Society of Milwaukee County conducted a survey concerning changing physician opinion and satisfaction with the business aspects of medicine under these new compensation schemes.[8] A copy of the survey instrument survey is included at Appendix II.

Among other things, that survey collected data regarding physician satisfaction under contracts with three prevalent models of managed care plans: Commercial HMO plans (C-HMO), Title-19 only plans (T-19) and Preferred Provider Organizations (PPO). Figures Eight and Nine represent the data collected, collated by mean response and type of plan with which the majority of Milwaukee County physicians have contracted. Therein (5)=Very satisfied; (4)=Somewhat satisfied; (3)=Neither satisfied nor dissatisfied; (2)=Somewhat dissatisfied and (1)=Very dissatisfied.

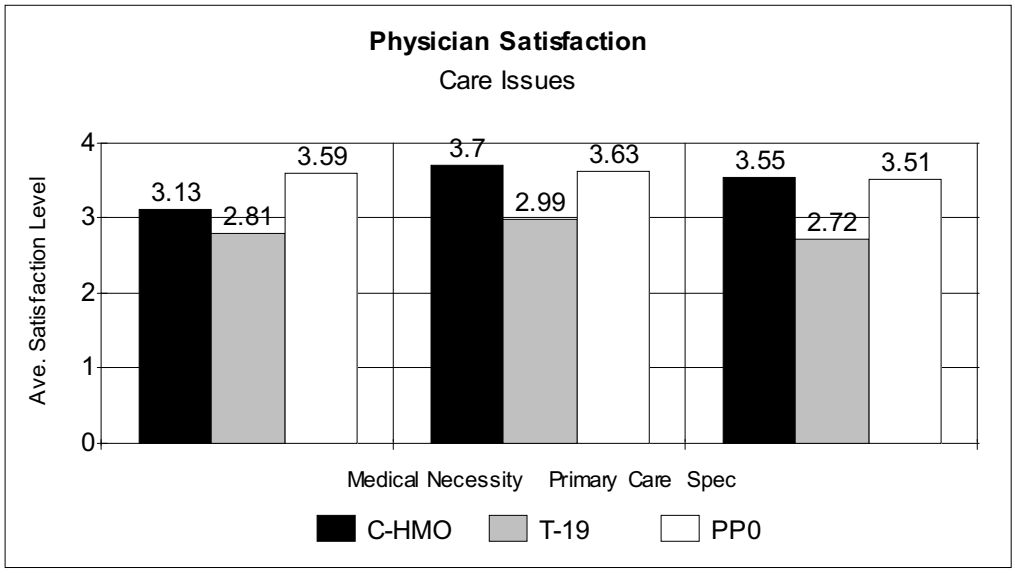
Figure 8*: *Physician Satisfaction with Administrative Requirements of Medical Practice in Milwaukee County[9]



While the data is fairly consistent across C-HMOs, T-19 HMOs and PPOs, no managed care plan ranked over 3.39 (neither satisfied nor dissatisfied) regarding the administrative requirements of Managed Care Organizations. Specifically, the first section of Figure Eight represents the level of surveyed physicians' satisfaction with the reimbursement level of the managed care system depicted (question 17c). The center graph depicts physicians' level of satisfaction with the contract provisions between the HMO and the doctor (question 19f). The third graph depicts the surveyed physicians' overall satisfaction with the organization (question 20). Note that in all categories, T-19 HMOs ranked a half point below PPOs with C-HMOs ranking squarely between them. With particular attention to utilization review and excluded services, traditionally, PPOs provide the most autonomy for practitioners and T-19 the least.

The variation among the plans is more remarkable in the area of mean values of physician satisfaction with their perceptions of patients' access to care and prescribed treatments. Figure Nine depicts those differences.

Figure 9*: *Physician Satisfaction with the Quality of Care in Managed Care Organizations in Milwaukee County.[10]



The first question (17h) asked the treating physicians' opinion of the willingness of their MCO to authorize exceptional services prescribed as "medically necessary." The second and third questions (18a, 18b) reference physicians' evaluation of patient access to primary and specialty care, respectively. Again, T-19 physicians are the least satisfied with patient care provisions. Even so, no plan group reaches even the "somewhat satisfied" category.

Managed care concepts continue to pervade third-party payer health networks. Patients may erroneously assume that their doctors are the sole arbiters of what treatment they are given. They may unknowingly be subject to ethical norms that until recently were not customary in the clinical practice of medicine.

Physicians are increasingly aware of their obligations to multiple stakeholders whose interests may be opposed to each other. It is expected that without organized intervention, physicians' unencumbered medical decisions will diminish as the scope of managed care increases.

> *However, Managed Care and the profit motivated utilization review methods it employs have assaulted the professionalism of the medical community. The very concept of managed care makes the historical role of the physician as a member of a learned profession obsolete. The idea that medical care should be managed by someone other than a physician is antiethical to the every essence of the profession.* [11]

This perceived lack of control and autonomy may alter the "why" of becoming a doctor described historically by Galen and contemporaneously by Stephen Miles.

The tension created by opposing but well established responsibilities to stakeholders creates ethical and even legal dilemmas for physicians. Those obligations were acknowledged mainly at the patient care level. Currently, we are presented with the more complex systemic dilemmas inherent in designing an equitable national health care policy that would insure adequate health care for all

citizens, regardless of ability to pay. As such, concepts of justice and efficiency require clarification of the specific rights of the current stakeholders before tackling the daunting responsibility of advocacy for systemic changes. Doctors under contract to Managed Care plans, while enjoying no lesser standard of professional responsibility, may already be pulled in so many directions as to be unavailable to engage in activities such as lobbying efforts or individual charity where there is no immediate economic gain.

A recent issue of *JAMA* addresses concerns for the uninsured. That article confirms that physicians who derive at least 85 percent of their practice revenue from managed care plans are considerably less likely to provide charity care and tend to spend fewer hours providing charity care than physicians with little involvement in managed care plans.[12] Therein, Peter Cunningham proposes that:

> *It is possible that physicians in larger group practices provide less charity care because the larger and more formal structures of these settings intentionally or unintentionally result in greater organizational barriers. In addition, 'employed' physicians may have less autonomy and discretion in treating medically indigent patients.* [13]

As the culture of commercialism invades the practice of medicine formerly governed by autonomous professionalism, both the quality and the scope of care available to every member of the national community is threatened, especially for those unable to pay.

Professionalism, with particular consideration of its relational element, illuminates the duty of physicians to society. However, it is well settled in law and recognized in some philosophical theories that the language of obligations is translated into the language of rights. Called the *Doctrine of the Logical Correlativity of Rights and Duties,* a right entails a prima facia obligation and all prima facia obligations entail rights.[14] Chapter Five analyzes that issue.

[1] Cynthia Brincat and Victoria S. Wike, *Morality and the Professional Life: Values at Work* (Englewood Cliffs, NJ: Prentice Hall, 1999) Chapter 1.
[2] *Ibid.*
[3] *Ibid.*
[4] *Ibid.*
[5] *Ibid.*
[6] David Schiedemeyer and Daniel J. McCarty, "Altruism, Professional Decorum, and Greed: Perspective on Physician Compensation," *Perspectives in Biology and Medicine* 38(2): 239-253, 245, 1995.
[7] Stephen D. Miles, "What Are We Teaching About Indigent Patients?" *JAMA,* 268 (18): 2561, 1992. In J.M Colwill, "Where Have All the Primary Care Applicants Gone?" *New England Journal of Medicine* 326:387-393, 1992.
[8] *The Managed Care Check-Up Program: The Physician's Perspective in Milwaukee County,* Milwaukee County Medical Society (Milwaukee WI, 1995). Of the 6,616 surveys mailed to physician members of MCMS, 1849 surveys were returned for an overall response rate of 33%.
[9] *Ibid.*
[10] *Ibid.*
[11] Robert Nordgren, "The Case Against Managed Care and for a Single-Payer System," JAMA, 273(1): 79, 82, 1995.
[12] Peter Cunningham, "Reduced Charity Care and Research Funding Reflect Pressures of Managed Care and Competitive Markets," *JAMA* 281(12): 1091, 1999.
[13] *Ibid.*
[14] Joel Feinberg, "The Nature and Value of Rights," *Journal of Value Inquiry*, 4:243-57.1971. In Tom Beauchamp, *Philosophical Ethics: An Introduction to Moral Philosophy* (McGraw Hill, 1991): 308-339.

CHAPTER FIVE

Heath Care as a Responsibility or Health Care as Right

Abstract: *The high cost of health insurance alone does not account for the excessive numbers of uninsured Americans. There is considerable tension between characterizing health care as a responsibility or rather a right. The "responsibility" model assumes that individuals are accountable for themselves to make prudent decisions regarding their health, and health care financing. Proponents hold that due process equalizes the opportunity to pursue life goals. However, once opportunities are equalized, unequal outcomes are morally acceptable. Further, the opposing "rights" model would be a burden to some citizens by the consequences of the individual choices of others. The alternative "rights" advocates support universal access to health care by legislative mandate. Under a theory that health care is special and different from other necessary commodities, a right to health care flows from the overriding importance of health to the life of every person. Without health, no other rights can be accessed. Further, because medical education has been supported by public funds, the public should have access to its resources. The difficulty in this model arises in discerning some consensus in defining "adequate" health. However, if health care was characterized as a protected right, it should not be diminished by the inability to pay for it.*

As many as 13% or 125,000 Milwaukee County residents may currently be uninsured.[1] In the United States, the number of uninsured persons exceeds 15.2% or 39.7 million.[2] In addition to the chronically uninsured, 15 to 20 million Americans are without coverage at some point in any one year. Millions more are underinsured for many of the costs of health care.[3] Most people who are uninsured earn too much to qualify for Medicaid coverage, yet not enough to afford private health insurance.[4]

The health care system in the United States accounts for approximately 13% of the gross domestic product, a figure much higher than that of countries providing universal coverage and access.[5] Cost alone cannot explain the excessive numbers of uninsured Americans. There exists a tension between the concept of health care as "responsibility" and health care as a "right." The former represents a commitment to the free market system. The latter represents a belief that because societal relationships are interdependent, membership in the national community confers entitlements to its assets. Both philosophies have their strengths and weaknesses. However, the Rights Model is more consistent with the societal values American culture places on liberty. "Equality"

rather than "liberty" is usually the watchword for advocates of publicly funded benefits. However, like education and public safety, health is a minimum requirement for the full enjoyment of personal liberty. Although the Responsibility Model recognizes that liberty is essential, the Rights Model expands on that concept by reference to legislative support for the priority we place on the concept of liberty in the United States.

A. Health Care as a Responsibility. The premise that health care is a responsibility assumes that individuals are accountable for themselves. Medicare and Medicaid, which subsidize care for the aged, the disabled and some categories of the extremely poor, violate that premise.[6] However, even these extraordinary programs assume that payment is expected and required for health care goods and services. The exception is that for certain classes, the government will pay the bill. For Medicaid eligibility, the law has codified guidelines for assessing the ability to pay.[7] The motivation for the Medicare legislation, which is an entitlement not based on individual assessments of economic need, included the original assumption that aged Americans may not be able to afford adequate health care when they were likely to need it most.

In the Responsibility Model, each must plan, save and be prudent to protect one's health. One must make responsible employment decisions in order to purchase health care in a free market. Being granted the privileges of freedom, individuals are responsible for their own behavior. We are accountable for our life choices, such as diet, smoking, drug use, seat belts and dangerous recreational endeavors. If others are compelled to pay for our choices, their freedom is abridged.

This Libertarian argument is founded in our nation's tradition of equality, liberty and justice for all.[8] Each person, through safeguards promulgated by a purely procedural notion of due process, deserves an equal opportunity to pursue life goals and happiness without undue interference. Once opportunities are equalized, unequal outcomes are

morally acceptable. Even in a race fair to all participants, there will be winners and losers. It is irrelevant that the prize is a share of important social goods.[9]

As framed by its Constitution, personal freedom from government intervention is the foundation of the U.S. political system. What each does or accomplishes with that freedom is a matter of choice and initiative. Initiative, responsibility and the principle of self-determination are as deeply rooted in this nation's traditions as are liberty, equality and justice. A just society will protect the rights of property, liberty and equality so that individuals are free to choose. Ostensibly, all citizens are possessed of the same basic rights and are subject to the same due process procedures within the free market. Thus, in this model, success or failure is a matter of personal initiative or simply, a consequence of misfortune.

Although the Responsibility Model acknowledges a prerequisite of procedural due process, it emphasizes the concept of ownership. Seventeenth century philosopher John Locke argued that "we each acquire a *natural right* of property over whatever we produce by 'mixing' our own individual labor with the material nature provides to us."[10] Further, proponents of this model advocate that those natural rights in health care belong not to the patient, but to the physician. "Medical care is neither a right nor a privilege. It is a service that is provided by doctors and other people to those who wish to purchase it."[11]

Consistent with Locke, modern personal responsibility philosophers such as Robert Nozick do not discount the existence of misfortune. They simply claim that society is not responsible for its alleviation.[12] Society has yet to agree to affirmatively respond to those who cannot afford reliable transportation, or to adequately address the issue of affordable housing. Similarly, the government has not undertaken to replace private assets lost in natural disasters. While public transportation schemes, the *Department of Housing and Urban Development*, and the *Federal Emergency Management Act* each attempt to address those issues, such programs are not granted "entitlement" status.[13] Simply put, the government helps by apportioning some funds to the respective programs. However,

by no means do those who belong to the group of intended beneficiaries have vested or "inalienable" rights to that assistance. To create such entitlement under Libertarian theory, where fair process is the predominate imperative, would promote an anti-egalitarian notion that individuals or classes of individuals are somehow innately incapable of independence. Compassionate intervention would serve only to further disenfranchise the beneficiary of societal largess and would ultimately minimize one's ability to participate actively in the free market.

Of course, society and its individual members can and often do choose to assist in charitable enterprises. However, this is not to be taken to mean that those burdened, even through no fault of their own, have a right to expect help. Instead, an entitlement theory of justice propounds that government action, such as mandatory public education, or *Aid to Families with Dependent Children* (AFDC), is justified if and only if it protects the rights or entitlements of citizens.[14] The leap that has not been made is to categorize health care as a right or entitlement.

Proponents of a Responsibility Model also argue that recognizing a right to health care would burden all citizens by the consequences of the individual choices of others. Responsibility to care for the imprudent, it is rationalized, is unjust and infringes on the property and liberty rights of more prudent individuals. This expresses itself in the actuarial "risk rating" theory of insurance. The theory is not without some merit. Certain life-style choices clearly contribute to increased morbidity and mortality.[15] Further, insured persons and investors in health care have certain justifiable expectations regarding a return on their investment, representing a legitimate property interest. Those who are privately insured have contributed funds to secure access to health care. Investors reasonably expect profit. These expectations emanate from legitimate protectable interests.

Physicians' interests are twofold. First, as do all other citizens, doctors have a justifiable property right to make economic decisions, within the boundaries of law and

standard medical practices, that are in their own best interests. Further, there may be a liberty interest in the arduously earned right to make autonomous medical decisions that has historically been acknowledged in the United States. To establish health care as a right may abridge those rights and interests. The insured, investors and physicians have achieved their present advantaged status by their own initiative and good fortune. Interference with their life-style choices would be unjust in a free market system.

Finally, advocates of the Responsibility Model maintain that health care delivery within a free market keeps medical costs in check. When people pay for their own health care, they make more prudent choices as to when and how to utilize the system to best suit their needs and goals. For instance, a rational person may choose to avoid spending on non-emergent health care in order to pay for a commodity he or she perceives as more valuable. Under a Rights Model, personal choice is minimized and society will ration and curb individual options despite private preferences.[16]

B. Health Care as a Right. The Rights Model of health care delivery would require universal access to health care by legislative mandate. A right is a justifiable claim against others, such as the rights protected by the First Amendment to the Constitution and the right to due process. As in the Responsibility Model, the Rights Model is deeply rooted in western traditions of fair opportunity, justice and equality. The most compelling argument for this model is the premise that without health, individuals are not free to use their liberty, their property or their equal rights to pursue happiness. Health, as an asset, precedes the opportunity to pursue individual life goals.[17] Without it, no other endeavor has significant meaning. In essence, without health a citizen is not free. However, unlike the procedural notions supported by the Responsibility Model, the Rights Model requires substantive governmental intervention to create a just health care delivery system.

A Rights Theory asserts that health is special and is therefore different even from other necessary commodities such as food and shelter. This extraordinary status flows from the premise that health care crises are often random, uncontrollable and are of overriding importance to our lives.[18] Many health care needs result from undeserved factors such as genetics and chance, in what H. Tristam Engelhardt, Jr. has described as "the natural lottery."[19] Advocates of a right to health care maintain that such innate needs are not simply unfortunate but also unfair. A central concept of justice demands that we attempt to meet those needs.[20]

The Rights Model of health care delivery is inextricably bound to some equitable notion of universal insurance coverage. While the specific terms of an appropriate plan are not yet clear, there is consensus that the ability to pay for medical care or for health insurance should not determine access to an adequate level of care. In fact, four out of five Americans believe the government should provide or ensure the provision of health care for anyone in need.[21] The philosophy of Universal Coverage acknowledges a common self interest in health care. At the same time, it considers that scarcity of health resources is a reality and increases in health care expenditures are uncontrolled. Further, Universal Coverage theories consider that the nature of health care needs is unpredictable and being insured by profit seeking underwriters is precarious.[22] It is argued moreover, that if a right to health care were established, employment mobility would increase and economic hardships regarding access to health care would be minimized.[23]

Once recognized, this right will no doubt raise subordinate issues of content and scope of services in our present health care delivery system. The free-market rations access to health care goods and services based on price and ability to pay.[24] In a Rights Model, rationing generally incorporates one of two theories.

The first of the two theories proposes that allocation of health care services should be to *each person according to his needs* (equal access to all). This conception envisions a two-tiered system wherein the government would assume responsibility for individual

health insurance only when the private resources of individuals are inadequate. The second theory proposes that allocation should be according to a right of a *decent basic minimum* of health care. Advocates for complete parity argue that those with the same need must be given an equally effective opportunity to receive equal quality treatment as long as treatment is available to anyone.[25] The decent minimum model proposes that health care should be available to everyone for clearly identified and urgent needs, but the distribution of other health care services according to ability to pay is not morally inappropriate.[26] Nonetheless, reaching consensus on the definition of "decent minimum" is problematic.

Under either the equal access theory or the decent minimum theory, a health care system should meet if not exceed the needs of citizens which would afford them the usual opportunities for what bioethicist Daniel Callahan refers to as the "keystone in the search of human happiness."[27] Norm Daniels describes this as that state of health required for "normal species functioning."[28] Considering what is required to function normally, it is the duty of the medical system to bring each of its patients to some minimal standard of health that will allow access to his or her property and liberty interests to the greatest degree possible. Health treatments, which have as their goals raising individual function to a degree above that required for access to these other rights, would not be a communal responsibility.

Other disciplines have supported the idea that health care is a special commodity. In economic theory, health care has *de facto* value determined by what people do, or would give up to have "it." Moral philosophers espousing that theory claim that the value of health is decided by determining for what it is rational to trade.[29]

Advocates of the Rights Model respond to the Responsibility Model with three specific counter-arguments. First, regarding risky habits, there is little consensus on what constitutes "voluntary" behavior. For instance, obesity has a determined genetic component and addiction has a biological element. There may be serious ethical

problems in assessing higher health care costs to people who eat meat, smoke or work in a sedentary job. Advocates question how deeply medicine should delve into these issues of individual choice. The connection between unhealthy behavior and disease is often difficult to ascertain and could result in foreseeable intrusions into privacy.[30] Additionally, healthy life-style choices may not result in the cost savings expected by proponents of the Responsibility Model. Longevity results in increased costs in other areas, such as social security, as well as clearly predictable costs in long-term care.[31]

The second counter-argument addresses the property and liberty interests of investors, physicians and insured persons regarding their reliance on the free market. Advocates of a right to health care argue that the property rights of taxpayers who have subsidized medical education, medical research, and hospital development must also be protected.[32] Thus, since the public pays into those programs through tax dollars, the public should have access to that which is yielded by those community contributions. The use of communal funds to subsidize free-market medicine is a modern tradition. Financing mechanisms for the health care delivery system should adapt, while respecting the history of public contributions.

The third rebuttal concedes that illness may be "unfortunate" rather than "unfair," and members of society, not the government, "ought" to help. Voluntary associations and individuals are not technologically or economically equipped to provide care for the millions of our society who lack reasonable access to adequate medical care.[33] The vast resources invested in equipment and trained professionals in modern American medicine require a coordinated effort to deliver care to all who are in need. Recognition of a right to health care expresses a societal wish to be compassionate toward all in need.

Whether the Responsibility approach or the Rights approach is chosen depends on whether we as a society consider health care to be "special." The Constitutional history of the United States evidences that there are services and commodities the body politic

has determined to be deserving of elevated or special treatment. The Commerce Clause and its interpretative cases clearly mandate special treatment to protect the free flow of trade within the United States.[34] Those protections can limit the property rights of individual entrepreneurs and even individual states. Likewise, the fundamental rights to travel, to vote, and to privacy, as well as any right protected by the First Amendment are justifiably abridged under only the most compelling of circumstances.

Granted, in relations among private citizens, the special protections are not as clear. However, it is well settled that where there is state action, as there is in virtually every health care facility, such actions are subject to judicial review for Constitutional compliance. Further, Congress can create laws designed to implement Constitutional values. If it were to recognize access to health care as a protectable right, Congress could mandate that the right could not be abrogated by the inability to purchase it.

In this country, the debate over access to education, which predates arguments regarding health care, has followed the same pattern. Even without Constitutional mandate, federal law requires and supports that each child, regardless of either extraordinary talent or developmental deficit, be given the opportunity for state provided education through grade twelve. Undeniably, children with deficits utilize far more assets devoted to mandatory education than do those who are unimpaired. As a society, we have decided that in order to access the opportunities of a democracy, an educational foundation is imperative and must be publicly funded. If achievement of "normal species functioning" is an appropriate marker to determine whether health is adequate to access democratic opportunities, health care too should be funded.

Under any system of health care delivery, at the micro level, the obligation of care held by physicians does not seem to be substantively modified by the advent of managed care. Physicians' primary responsibility remains where it has always been, to individual patients who have entrusted them with their care. However, a broader more inclusive analysis of obligations is found in the history and guidelines of professional medical

associations. These guidelines extend obligations to care even for those without financial resources and are set out in Chapter Seven.

If physicians have an obligation to poor persons, how should doctors in Milwaukee County, and by reference, the United States, go about honoring this tacit commitment? Stated simplistically, the solution may be to assure that all people have access to doctors' talents and skills through universal health insurance. In the meantime however, physicians can act according to their oaths through individual volunteerism, aligning with professional associations committed to collective support of charitable work, equitable health care policy and legislative activism at the macro level.

Notes

[1] Jerome Heer, "Uninsured Populations, Medicaid Benefits and Uncompensated Care in Milwaukee County: Information for the Milwaukee County GAMP Program," (County Health Related Programs, Feb. 2, 1998 photocopied).
[2] *Statistical Abstract of the United States*, Department of the Census, (Washington, D.C.: Government Printing Office, 1996). www.census.gov/statab/www/part3.html.
[3] James F. Childress, *Practical Reasoning in Bioethics* (Bloomington, Indiana University Press, 1997), 237.
[4] John Arras and Bonnie Steinbock, *Ethical Issues in Modern Medicine,* 4th. ed., (Mountain View, CA: Mayfield Publishing Company, 1995).
[5] Childress, 237.
[6] *Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, *Securing Access to Health Care,* (Washington, D.C.: U.S. Government Printing Office. March 1983), 1(4).
[7] Medicare Statues are codified at 42 USC 1395 (subchpt. XVIII)(1965). Medicaid Statues are codified at 42 USC 1396-1396v. subchpt. XIX)(1965).
[8] David Boaz, *Libertarianism: A Primer* (New York: The Free Press/Simon and Schuster, 1998), 210-235.
[9] Norm Daniels, *Just Health Care* (Cambridge University Press, 1985), 39.
[10] John Locke, *Two Treatises of Government,* (New York: Mentor Books, 1965), In Lawrence McCullough, "Are Physicians Obligated to Treat Indigent Patients?" *Texas Medicine,* 87(2): 81, 1991.

[11] Robert M. Sade, "Medical Care as a Right: A Refutation," *New England Journal of Medicine* 285 (23): 1288-1292, 1971. In McCullough, 1991.
[12] Robert Nozik, *Anarchy, State, and Utopia* (New York: Basic Books, 1974).
[13] *FEMA* regulations are codified at 42 USC 5195 (Chpt. 86, subchpt. IV-B)(1998); Subsidized Housing regulations are codified at 42 USC 1436 (Chapt. 8 *et. seq*.)(1998).
[14] *AFDC* Statutes are codified at 42 USC 601 (Chapt.7 *et. seq*.)(1968).
[15] Howard Leichter, "Public Policy and the British Experience," *The Hastings Center Report* 11(5): 32-39, 1981.
[16] *Ibid.,* 69.
[17] Dan W. Brock and Norm Daniels, "Ethical Foundations of Healthcare Reform," In Arras, and Steinbock, *Ethical Issues in Modern Medicine,* 1995*,* 593.
[18] Gene Outka, "Social Justice and Equal Access to Health Care," In Reiser, Stanley J., Dyck, Arthur J., and Curran, William J., *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* (Cambridge MA: MIT Press, 1977): 586.
[19] Tristam H. Engelhardt, "Health Care Allocations: Responses to the Unjust, the Unfortunate and the Undesirable." In *Justice and Health Care* (Boston: D. Reidel, 1981): 121-137.
[20] Childress, 243.
[21] Humphrey Taylor, and Reinhardt E. Uwe, "Does the System Fit?" *Health Management Quarterly* 13 (1991): 2-10.
[22] Childress, 248.
[23] Brock and Daniels, 594.
[24] Childress, 238.
[25] Amy Gutman, "For and Against Equal Access to Health Care," *Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, *Securing Access to Health Care,* (Washington, D.C.: U.S. Government Printing Office. March 1983), 4.
[26] Childress, 252.
[27] J. Knowles, ed. *Doing Better and Feeling Worse: Health in the United States,* (New York: W.W. Norton and Co. 1977), 26 In Lawrence McCollough, "Rights, Health Care and Public Policy," *Journal of Medicine and Philosophy, 42*(2): 209, 1979.
[28] Norm Daniels, *Just Health Care* (New York: Cambridge University Press, 1985), 42-49.
[29] Richard Posner, 8 *Hofstra Law Review* (1980), 3-4.
[30] Brock and Daniels, 595.
[31] Leichter, 33.
[32] Harry Schwartz, "Access, Equity, and Equality in American Medical Care," in *Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, Vol. 2 Securing *Access to Health Care,* (Washington, D.C.: U.S. Government Printing Office. March 1983), 347.
[33] Paul Starr, "Medical Care and Pursuit of Equality," *Report of the President's Commission*, 1983*,* 22.
[34] *Commerce Clause*, U.S. Constitution at Article I.

CHAPTER SIX

Rights, Responsibilities and Health Care Policy

Abstract: *Adoption of some form of Universal Coverage will depend on whether the public agrees that health care is a right or a responsibility. Under a Universal Coverage plan, the government will provide insurance for Americans who cannot afford coverage individually or through employment. Opponents of Universal Coverage assert nine major problems with such a proposal. The overarching argument centers on a general distrust of big government programs. Further, such a system would create a temporal rationing system that Americans will not accept. Foremost among the ten major advantages to Universal Coverage through a single payer system are its potential simplicity, its avoidance of risk selection and its bolstering of physicians autonomy within a doctor/patient relationship.*

The philosophical underpinnings of this nation's health care policies express themselves in debates on the future of health care delivery infrastructures. Although the terms are often confused, a Single Payer System (SPS) and Universal Health Coverage (UC) initiatives mark the most sweeping proposals for reform.

As a financing mechanism, an SPS provides that a single agent or group of agents finances all health care using universal rules and means. Among industrialized democracies, the United States and South Africa are the only nations that have not implemented this system.[1]

Great Britain and Sweden each have a National Health Service (NHS) under an SPS. In general, British physicians are employees of the NHS. This strategy is close to what people mean by socialized medicine.[2] In the Canadian model however, general practitioners are private contractors, not employees of the state. In the latter approach, government controls both the organization and the practice of medicine.

> *In Canada's system, global budgets are set on a yearly basis by the government. Within these global spending limits, government negotiates with the medical community on a schedule of fees that can be charged for medical care. The provinces are then responsible for allocating the funds to providers and hospitals within their territory. Doctors treat patients and bill the government for established reimbursal fees or receive a*

> *salary. If funds are low toward end of year, fees are decreased or denied. Practice is monitored, but because spending is controlled at the macro level, there is rarely a need to regulate the individual physician patient interaction unless significantly skewed practice patterns are noted* .[3]

While the Canadian system is an SPS run by the provinces, it is the only major country with that strategy. By default, the government is usually the payer but the concept of the SPS does not technically require governmental participation.

Universal "access" to medical care is a feature of the SPS that provides both the right and the ability to receive a comprehensive, uniform and affordable set of health services. Although there is variance among SPS plans in other countries, sources of cost control are much the same.[4]

Universal "coverage" refers not to a financing plan, but to a substantive type of government sponsored health plan that would provide health insurance for all citizens. Through a system of private insurers, a nation could have Universal Coverage without an SPS. For instance, a nation with universal coverage could insure only those not covered through employment or other affordable means. Indeed, one may support universal access to care without supporting an SPS. Consistent with the "needs theory" in Chapter Five, government could mandate a two-tiered health care delivery system. Such a program would distinguish between those who are privately insured and those who are publicly insured.

A. Disadvantages of Universal Health Insurance. In general, opponents of the SPS favor the Responsibility Model summarized in Chapter Five. Their arguments are rooted in a profound distrust of external controls, especially within a governmental hierarchy. In particular, opponents of an SPS argue that: (1) to control goods or services through a

single agency—especially when the driving force is economic—would fly in the face of the American way of doing things. They advance the uniqueness of the United States' pluralistic form of government. Under centralized management and control, checks and balances are lost. (2) Central controls have been less than first rate and should not be entrusted to monoliths. (3) The design of Single Payer systems creates explicit conflict over resource allocation.[5] (4) The government will intrude into private health care relations.[6] These intrusions jeopardize confidentiality and patients' ability to freely choose a medically reasonable course of treatment. (5) Micromanagement of health systems is far worse in federal programs, e.g. welfare and public housing shows that central bureaucracy fails miserably in addressing human need. (6) Americans have become accustomed to care on demand. The temporal rationing inherent in an SPS will ignore patient expectations and doom the system.[7] (7) Utilization and therefore costs will increase with access. "Moral Hazard" is an insurance industry term for a tendency of insurance to increase risk of loss. Studies show that having homeowners insurance increases the risk of fires and having health insurance increases the utilization of health care and medical costs.[8] (8) SPS based reform would cause a considerable amount of economic disruption. Insurance industry employees would lose their jobs and there would be a disruption of investment patterns now controlled by for profit insurance companies.[9] (9) The SPS would solve the access issue, but without micromanagement, which is an undesirable part of the Medicare system, it is unclear how the problem of costs would be addressed.[10]

B. Advantages of Universal Health Insurance. As Rights Model advocates, proponents of universal access through a Single Payer System generally support

Universal Coverage. The benefits of both SPS and UC include that: (1) The system would provide coverage and access to high quality health care for every citizen. (2) UC financed through an SPS avoids unfair risk selection, and spreads risk financing and access broadly across communities.[11] (3) Physicians will retain more power to determine overall spending levels. Negotiation and debate occur in open public hearings. There will be more explicit accountability to taxpayers who are its sole source of funding. (4) Because cost containment limitations are made outside the physician patient relationship, individual physicians are able to make case by case clinical decisions free from financial consideration. (5) Physicians can choose to practice under a fee for service, salaried or HMO arrangement. Even so, standardized forms under an SPS would simplify unduly burdensome record keeping and review.[12] (6) Although the *status quo* is described as the best health care system in the world, the definition of "best" is elusive. The technology is unequalled, but it is more expensive and cares for a smaller percentage of citizens than do those of other post-industrial democracies. Our best system is not a single system but rather a myriad of competing and contentious systems.[13] (7) Contrary to the opposing view, the government has a clear record of success in providing complex services required by the entire population, including national defense, highways, environmental protection and education. In fact, the U.S. government spends 2-4% of its health care budget on administration, while those costs of the health care financing industry exceed 16-20%.[14] (8) Although there will be cost increases under a Single Payer UC approach as coverage is extended to uninsured populations, these increases are short term. An invitation to strategic thinking, the long-term effect would create a system which controls expenses by limiting cost shifting.[15] (9) A plan for UC under an SPS has the potential to

be simple (i.e., a single claims form, single fee schedule, and single plan). (10) Freed from the administrative and economic constraints of Managed Care, patient and physician autonomy and choice would be enhanced.

> *All providers accept the same plan and will be equally economically attractive to prospective patients. Patients and Physicians would have essentially complete choice in establishing care relationships. Because all patients would be covered by the same plan, each would be equally economically attractive to providers. Because all providers accept the same plan, each physician would be equally economically attractive to patients.*[16]

Thus, the only significant variable in choosing a doctor would be the quality of care, as defined by individual patients.

Opponents of Universal Coverage through a Single Payer system point to public complacency about health care issues as support for their position.[17] A recent edition of the *Annals of Internal Medicine* suggested that nothing short of a Constitutional Amendment will uncomplicate the system and serve to make health care fair and consistent, both in quality and access at the national level.[18] However, both camps acknowledge that only a crisis will motivate resolute work toward reforming health care delivery in the United States.[19] The seminal question becomes how many people must sicken or die before the crisis is sufficient to call us to action?

Notes

[1] Johnson B. Lightfoote and Karen D. Ragland, "Single Payer Health Insurance Systems: National Myths and Immovable Mountains," Journal *of the National Medical Association*, 88(4): 217-24, 1996.
[2] The Health Care Study Group, "Understanding the Choices in Health Care Reform," *Journal of Health Politics, Policy and Law,* 9(3): 499-541, 1994.

[3] Robert Nordgren, "The Case Against Managed Care and for a Single Payer System," *JAMA*, 273(1): 79,82, 1995.
[4] *Ibid.*
[5] T. Bodenheimer and K. Grumback, "National Health Insurance and the Problems of American Medicine," *International Journal of Health Sciences*, 23(2):137-40, 1997.
[6] Lightfoote, 223.
[7] James Todd, "Its Time for Universal Access, Not Universal Insurance" *NEJM* 321: 46-47, 1989.
[8] Kathleen M. Haddad, "Insurance Reform in a Voluntary System: Implications for the Sick, the Well, and Universal Health Care". Position paper for the American College of Physicians. *Annals of Internal Medicine*, 124(3):242-249, 1996.
[9] Physicians for a National Health Program, "Advantages and Disadvantages of a Single Payer System," Chicago, 1999.
[10] Randall S. Krakauer, "Survey of Health Planning Proposals," American *Journal of Surgery,* 167(2): 232-235, 1994.
[11] Haddad, 245.
[12] Nordgren, 82.
[13] Lightfoote, 218.
[14] *Ibid.* 220.
[15] Health Care Study Group, 505.
[16] Lightfoote, 223.
[17] Short, 99.
[18] Frank Davidoff and Robert D. Reincke, "The 28th Amendment," *Annals of Internal Medicine*, 130(8), 694, 1999.
[19] Stephen Gorin, "Universal Health Care Coverage in the United States: Barriers, Prospects and Implications, (1997) *Health and Social Work*, 22(3) 223-230, 1997.

CHAPTER SEVEN

Reform Initiatives

Abstract: *National health care reform efforts have, for the most part, failed to gain public and legislative support. Because they can act more quickly and more efficiently, many states have taken the lead in localized initiatives. Most notably, states have attempted market reforms, expansion of voluntary coverage, cost control through market competition and leveraging purchasing power to broaden access and keep costs in control. The varying degrees of success at the state level provide valuable lessons to drafters of legislation for national health care reform.*

The Milwaukee Academy of Medicine joins with other professional medical associations supporting universal access to health care and reforms making health insurance coverage available to the public. Although no specific platform has been selected, state health care reform initiatives may provide some guidance as viable concepts emerge.

A. State Initiatives. Both prior and subsequent to the federal government's foray into the health care debates of the 1990's, states have consistently led the nation's push to make health care more efficient and affordable.[1] As states are less diverse and more numerically manageable than the nation as a whole and were left without national leadership, a large majority of states have attempted to address the problem of cost and access to the health care system. State-level reform has the advantage of ability to be enacted more quickly.[2] Above all, more localized experiences have verified that states serve well as policy laboratories for one another and for the nation as a whole.

State reform initiatives have ranged from modest incremental approaches to more broad based reforms. The incremental strategies pursued by most states include the methods described below.

1. Insurance Market Reforms. Forty-six states have created or adopted models that laid the foundation for what the federal government accomplished with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) a/k/a the *Kassenbaum-Kennedy Act.* [3] These reforms included guaranteed insurability, portability and restricted exclusion periods for preexisting conditions. While HIPPA applies to group health care plans, eleven states have extended these protections to the individual market.

2. Expansion of Voluntary Coverage.

a. *Eligibility for New Groups*. Several states have implemented measures to expand insurance coverage at a reduced cost to low income groups. The most common method of expanding eligibility was by adding optional groups allowed by federal Medicaid law and new groups eligible for a federal Section 1115 Medicaid waiver. Wisconsin's own Badger-Care plan is one such initiative. Forty states have relaxed the income and age restrictions. Tennessee, Rhode Island, Delaware and Vermont have experienced varying degrees of success. However, Oregon, Minnesota and Washington State have already moved most of their Medicaid populations into Managed Care and therefore seek other sources to finance expansion of their state health care programs. Although initially appealing, many argue that moving large populations into under-funded governmental programs will further erode the ability to offer quality health care to all.

b. *Raising Revenue* Where Medicaid expansion is either politically or administratively unworkable, independent coverage primary care programs have been

developed. States adopting this approach include New York, Massachusetts and Florida's school based program. Both Minnesota and Washington State subsidize coverage in significant numbers using state revenues raised through a combination of provider, premium and tobacco taxes. In general, these revenues were raised solely for primary care services.

c. *Premium Subsidies*. In some states, premium subsidies for specific groups were established. Under an independent program achieved by Washington State's Basic Health Plan, subsidies were targeted specifically to increase enrollment and have produced a significant spike.

d. *Tax Credits and Subsidies*. In this initiative, small employers who agree to provide health care insurance for their employees may be eligible for tax credits and subsidies. This has been tried by only a few states. Iowa responded to independent merchants and farmers by making premium payments for self-employed individuals exempt from state taxes. The Oregon employer tax credit program was repealed in 1997 and the employer mandate was sunsetted after years of limited public response. However, New York expanded a program to subsidize employer sponsored coverage. Generally, these programs are too small and new to evaluate for impact on the uninsured rate.

Tax incentives for assuming personal responsibility for health insurance demonstrates state action consistent with the personal responsibility model.

e. *Employment Based Insurance*. The Employer Retirement Insurance Security Act of 1974 (ERISA) states that absent a waiver, only the federal government—not

the states—can pass laws that regulate health insurance plans for all people in the state.[4] This would include defining minimum benefits or requiring employers to provide or even continue insurance coverage.[5] Hawaii acquired that waiver which accomplished their universal coverage initiative by 1974. This was largely because its employer mandates predated ERISA. No other state, excepting a small exclusion allowed by the United States Supreme Court for a New York State program, has met with similar success.[6]

In the area of employment based insurance, there is concern that reform states could be victimized by neighboring states that might entice their employers away (if reforms include an employer mandate) while exporting the uninsured poor. It is suggested that Hawaii's phenomenal success in the area of universal care is largely due to the fact that it has no neighbor states. Similarly, one reason reform states tend to border on Canada is that it reduces the number of potentially predatory neighbor states.[7]

3. Cost Control via Market Competition. By promoting managed care, some states persuaded plans and providers to control cost increases.[8] Tennessee was able to create a new managed care market through the now troubled TennCare. Similar efforts in Vermont failed because Medicaid capitation rates were too low. However, Minnesota found that their market incentives were already strong enough and did not need a new delivery system.

Despite multiple state initiatives, little has been decided on how to regulate physician and other provider-based groups that seek financial returns by assuming greater financial risks. In general, these physicians groups pursue increased leverage

in the market, maintain autonomy in clinical practice and increase their portion of the health care dollar. States have yet to consider if these groups are subject to the same regulations as third party payers. No state wants to be so overzealous as to prevent innovation by these groups who are trying to protect the interests of the consumers and the purchasers of health care.[9]

4. Leveraging Purchasing Power. The emergence of states in health care reform efforts proves that, as purchasers, they have a larger policy impact than they have as regulators.[10] Almost universally, states have converted some or most of their coverage for women and children into managed care and are working toward similar responses for the less numerous but more expensive aged and disabled populations.

Many states are becoming aggressive purchasers for their own employees, combining this group with others to increase negotiating leverage. For most states, this has resulted in price discounts. The Wisconsin Department of Employee Trust Funds reports significant prices reductions through a "managed competition" approach.[11] Additionally

> *A few states have attempted to organize public purchasing alliances for small employers and individuals…The best known are Florida's Community Health Purchasing Alliances (CHPAs) and the Health Insurance Plan of California (HIPC). However, at least 12 states have sponsored or promoted purchasing pools for groups of employers and individuals. Kentucky's Health Purchasing Alliance of 1994 was boosted when state employees were folded in at the beginning of 1996. However, before the other mandatory groups (municipalities, schools, and universities) could be added, the legislature made their participation voluntary. Iowa encouraged the development of private purchasing cooperatives through enabling legislation but the initiative was short lived. Colorado and Nebraska took a similar tack but both failed.*[12]

5. Information Sharing. Lack of standardized data clearly makes analysis across health plans in and among states more difficult. A number of states such as Minnesota, New York, Vermont, Missouri and Maryland have established systems to track state health expenditures modeled somewhat after the Health Care Financing Administration national health expenditure accounts. Further, state investment in collecting information to track the number of uninsured or to monitor health expenditures and utilization patterns has lead to more informed policy decision making.

B. The Policy Process. Although most states have reacted to the need for health care reform, they are realistically reluctant to pay for any activity they think the federal government may be induced to subsidize.[13] Regardless of the magnitude of the initiative, states must contend with political issues and policy processes that differ from those at the federal level and that vary from state to state. In general, reform states build on their individual health care infrastructures, whatever they are, and configure change in a manner that is reasonably comfortable for their citizens.

> *Reforms based on managed care are a comfortable fit in Hawaii, Minnesota, and Washington, and would be in California; but there are no health maintenance organizations in Alaska or Wyoming, and fewer than 1% of the residents of Mississippi and North Dakota belong to one. Managed competition, with its multiple plans, is feasible in large metropolitan markets; but less than half the population lives in markets that can support three nonoverlapping plans.* [14]

Vermont and Tennessee were successful in no small part due to special extensions of their legislative sessions. Less dramatic endeavors, as those in Maine, New Mexico, North Carolina, North Dakota and Oklahoma established task forces with small professional staffs. Those states, which had insufficient legislative support,

floundered. Even so, as in Washington State and Oregon, task forces can be successful in developing background data and appropriately framing the issues for public debate.

Regional initiatives have provided important data for national plan advocates. The Federal government has exclusive Constitutional authority to regulate insurance as interstate commerce. However, the US deferred authority to regulate insurance to the states 50 years ago. Inherently, state programs are limited to their own borders. However, congressional involvement could ease the ability of interstate corporations to comply with insurance regulations. It could make coverage more easily portable across state lines and facilitate the collection of useful data with which to study the effect of policy change on health coverage. A Federal role like that taken by *Kennedy-Kassenbaum*, expands the protected community of uninsured people across state borders, enforcing the charge that private health insurance be socially responsible.[15]

State initiatives are useful laboratories for potential health care reforms. However, considering the magnitude of problems with health care delivery, on an interim basis, more localized initiatives may be necessary. However, we must recognize the relationship between incremental change and fundamental reform.[16] Continued state experiments may lead to a rational consensus on meaningful health care reform. Nevertheless, while incremental changes may be necessary, efficient and fundamental reform must occur at the national level.

Notes

[1] "State Health Care Reform: Looking Back Toward the Future," Special report of the Robert Wood Johnson Foundation, September 1, 1997.
[2] Friedman, Emily, "Getting a Head Start: The States and Health Care Reform," *JAMA*, 271(11), 1994, 875.
[3] 42 USC 6A, subchpt. XXV, 1996.
[4] *Employer Retirement Insurance and Security Act*, 29 USC 18 (1974).
[5] Crittenden, Robert "The Limits of State Action? The Myths and Realities of ERISA," *Journal of the American Board of Family Practice,* 9(3), 1996, 208. The ERISA statute is codified at 29 USC 18, 1974.
[6] Travelers Insurance v. NY. 115 S. Ct. 1671 (1995), where the U.S. Supreme Court found that pooling funds by the state through its hospital rate-setting system (ie requiring health plans and HMO's to pay a surcharge on inpatient hospital bills to help subsidize the uninsured) was not prohibited under ERISA through that states regulatory powers. In Crittenden, 210.
[7] Friedman, 880.
[8] State Health Care Reform, 14.
[9] *Ibid.*
[10] *Ibid.*
[11] *Ibid.*
[12] State Health Care Reform, 15.
[13] Friedman, 875.
[14] Friedman, 879.
[15] Kathleen M. Haddad, "Insurance Reform in a Voluntary System: Implications for the Sick, the Well, and Universal Health Care". Position paper for the American College of Physicians, *Annals of Internal Medicine*, 124(3): 242-249, 1996.
[16] Stephen Gorin, "Universal Health Car Coverage in the United States: Barriers, Prospects and Implications," *Health and Social Work,* 22(3):223-230, 1997.

CHAPTER EIGHT

Interim Proposals

Abstract: *Until Universal Coverage is a national reality, an element of professionalism requires physicians' charitable contribution to patient care. As individuals, a majority of doctors report donating some level of time and talent to charity. Only rarely do established medical practice policies address philanthropy in any official or documented manner. Many medical associations promote the practice of medicine to include an element of public service and encourage volunteerism, although without a specific mandate. Additionally, public/private partnerships may be a valuable tool in furthering the notion that health care is a shared responsibility. An organized system should be developed by which physicians will be better able to volunteer services that better meet the needs of the community. However, no amount of volunteerism will solve the problem of access. As experienced physicians, professionalism also requires participation in public debate regarding national health care policy.*

The Milwaukee Academy of Medicine believes that a component of professional responsibility requires physicians to be active in political debate concerning health care policy. In time, with due attention, Universal Coverage can become a reality. However, patients and prospective patients have immediate needs. Regardless of the level of public or private support, physicians are obligated to share some responsibility for the health of individual patients, regardless of their ability to pay. There are several approaches to organized, charitable patient care.

A. Individual volunteerism. George Lundberg, who was until recently the editor of *JAMA*, encouraged physicians to volunteer care to the medically indigent by stating:

> *Since the federal government has been unable to assure universal coverage, it falls by default to the private sector to do so…The JOURNAL calls on all players in the entire health industry—for profit and not-for profit—to give away their fair share of free care to those in need…Those who deign to enter the arena of caring for the sick should expect to play by medicine's age-old ethics of altruism and professionalism* [1]

In the legal profession, the concept of free services to the indigent is called *pro bono publico*. In medicine, it is called charity. In everyday society, says Lundberg, it is called fairness.[2] In a seminal work on physician volunteerism, Laurence B. McCullough dissects donating medical care as an element of charity. He justifies prescriptive giving in the same

manner as those advocating the Rights Model in Chapter 5. Charity is mandatory, says McCollough, because it

> *follows directly from the realization that society has some legitimate claim on the knowledge and services of every physician. [P]hysicians have been given much by society: the opportunity and financial support to become physicians; handsome remuneration; and (still) high social status. The minimal response to this is for physicians to recognize and incorporate into their individual practice, obligations in charity to serve the sick poor. [T]he entire point of "obligations" is to deny our freedom to act on our mere self-interest when the latter conflicts with what we ought to do.*[3]

Milwaukee County physicians responding to a survey averaged 3.30 hours of charity care per week.[4] Employing a more sound experimental design, the Cunningham study of charity care (described in Chapter 4) found that 77.3% of responding physicians provided an average of 10.3 hours of charity care per week. In 1994, physician uncompensated care costs nationwide were estimated to be as high as eleven billion dollars.[5] These contributions are invaluable and positively impact access to medical care by indigent persons.

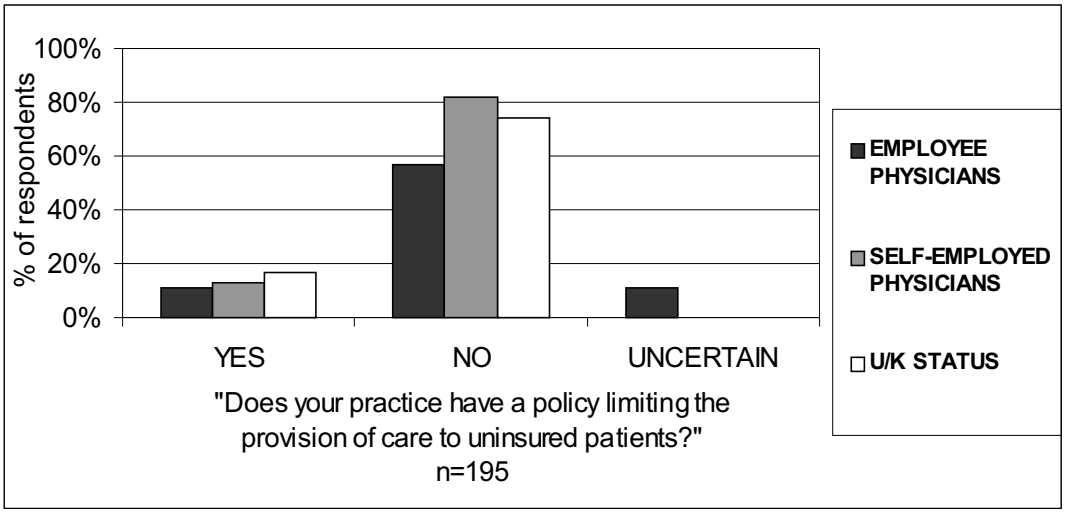
However, most charity care is *ad hoc* and insecure. Rare is the medical practice with a stated policy regarding treatment of the poor. The 1988 study of charitable medicine in Wisconsin, (described in Chapter Two), found that practices establishing guidelines for charity or discounted care fell into six categories.[6]

Table 2: Policies on Charity Care Reported by Responding Physician Groups

Type of Policy	Practice with Policy by Percentage
Catastrophic consideration only.	
If patient's bills are large, fees can be reduced	15.8
Established income and/or asset guidelines	
Patients can receive care at no charge	13.9
Patients can receive a percentage discount	22.8
Insurance accepted as payment in full	31.7
Other policies	
Services could be "down-coded"	26.7
Indigent patients can be referred to alternate source	25.7

In the Milwaukee Academy of Medicine's informal survey, physicians were grouped by employment category (Employed, Self-Employed, Uncertain). They were asked if their respective practices had policies limiting charity care. Figure Ten depicts these local responses.

Figure 10: Milwaukee County Physicians with Practice Policies Limiting Care to Uninsured Patients.



The results of this inquiry may indicate that employment status has no significant effect on charitable care policies.

An organized and more systematic approach to volunteerism could ameliorate some of the hardships incurred by doctors willing to treat uninsured populations, thereby spreading the economic and time losses incurred in treating the uninsured across a larger field of willing physicians. Indigent patients will benefit in the security of increased availability of volunteer doctors. Until Universal Coverage is a reality, physicians may address the problem of the uninsured at the three levels described below.

1. Volunteerism Through Primary Clinics. Community primary care clinics in Milwaukee County need and welcome volunteer physicians. Volunteer opportunities at clinics, however, are not without potential bureaucratic barriers. First, under capitated Managed Care contracts by which most Milwaukee County physicians are obligated, time not required to perform those contractual obligations may be minimal. Further

> *because managed care attempts to impose greater price discipline on health care practitioners through discounted fees, capitated payments, selective contracting and other methods, the result is that many physicians are experiencing increased financial pressures, greater competition for paying patients, and less ability to shift the costs of uncompensated care onto other payers. [A]s a result, many physicians may reduce or altogether eliminate charity care to the medically indigent*.[7]

There may be even more practical reasons for physicians' reluctance to donate their skills and talents to an indigent population. Specifically, assurances of compliance by an often-transient patient group can be problematic. There may be diminished availability of aftercare and follow-up necessary to complete and evaluate prescribed treatments. This phenomenon could result in exacerbation of the presenting medical problem. Through no fault of the volunteer physician, he or she may be exposed to a greater risk of malpractice liability.

To address this particular threat, the State of Wisconsin has undertaken to provide malpractice coverage as an "Agent of the State" for physicians or other qualified health care providers if they "plan on providing medical care *without charge* at a qualified facility."[8]

2. Volunteerism Though Local Hospitals. In addition to primary care physicians, medical specialists are essential to the delivery of charitable medical care. Frequently, uninsured patients are admitted to area hospitals on an emergent basis. Although social workers and nursing staff diligently attempt to qualify the patient for Title 19 programs or GAMP, such attempts frequently fail. Nonetheless, the patient may need care ranging from internal medical services to complicated surgical procedures. "House staff" may provide the day to day care for patients. The hospital itself contributes "public" beds, ancillary staff and equipment. Frequently, residents who are supervised by faculty serve indigent patients. It is often difficult to find physicians to donate their time and special talents, knowing there is malpractice exposure but no possibility of compensation for their work. Furthermore, the issue of hospital privileges for volunteer physicians has not been adequately addressed.

3. Prerequisites for Membership in Professional Associations. Within the legal system, many local Bar Associations, although neither the Wisconsin Bar Association nor the Milwaukee County Bar Association, have addressed the needs of indigent persons to be served by the legal profession. To belong to a subscribing association and to reap the benefits of state licensure, the association's policy may require each member attorney to enlist on one of two rosters (civil or criminal). The lawyer is required, absent extreme articulable hardship, to accept *pro bono* cases that for whatever reason cannot be absorbed by the Public Defender or the Legal Aid system as they arise when his or her name is at the top of the list. Arguably, if challenged, the "requirement" could be struck down as coercive under Ninth Amendment Constitutional prohibitions against slavery. However, the obligatory enlistment serves to support the legal profession's recognition of the needs of the poor in the community and its obligation to formalize a commitment to pro bono volunteer attorneys who commit to represent clients, *pro bono*.

The American Bar Association (ABA) premise for the directive is that "it is the lawyer's duty, as a *function of his professional status,* (emphasis added) to provide public interest legal services.[9] As a profession with elevated status often supported by public funds, assertions that access to the legal system is essential to liberty are based on arguments similar to those advanced regarding access to health care. A review of the approaches taken by the legal profession may provide guidance and mutual support for those approaches taken in medicine.

The Model Rules of Professional Conduct provide a framework for each state Bar Association, including Wisconsin, to develop rules of conduct expected from its lawyers. Those rules include that each lawyer should aspire to render at least fifty (50) hours of pro bono legal services per year.[10] However, neither the ABA nor any state bar holds that failure to provide prescribed services violates the rules.[11]

Although it is beyond the scope of this paper to champion a particular system for the practice of charitable medicine, the process could certainly be similar to that practiced by the pro bono bar. Clearly, if an efficient system were in place, with or without the requirement

for membership in their professional associations, physicians could register their willingness to do periodic charitable care through a clearinghouse agency or administrator. As the need arose, a hospital or clinic could contact the clearinghouse to secure a volunteer care provider. Although the State Medical Society of Wisconsin maintains a list of volunteer opportunities for physicians willing to donate their skills and time, there is no inverse list for physicians willing to find opportunities.

Yet, there is a problem with the concept that individual volunteerism is enough to fulfill professional obligations. Obligations of charity are usually understood to be nonspecific in that they do not require the physician to provide free (or reduced cost) care to specified individuals. Which individuals are to be served is a matter of discretion for each physician.[12] Although time and talent donated by individual physicians to indigent patients is valuable, private philanthropy alone can not definitively alleviate the pervasive problem of uninsured populations. A second incremental but more ubiquitous solution presents itself at the institutional and organizational level.

B. Institutional Ethics and Professional Associations. The original Code of Ethics for the American Medical Association, written in 1846, emphasized relief of pain and diseases without regard to danger or personal advantage, stating that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded."[13] Less specific than the ABA policy, in 1987 the AMA House of Delegates urged all physicians "to share in the care of indigent patients." Further, Principle 33-6b of that Health Policy Agenda for American People states that:

> *All health care facilities and health professionals should fulfill their social responsibility for delivering high quality health care to those without the resources to pay.*[14]

In 1987, Lundberg called for the AMA to adopt a policy similar to that of the ABA, suggesting that physicians donate a minimum 50 hours per year caring for indigent patients. While the AMA reaffirmed its commitment to caring for the poor, it has not adopted a

specific guideline regarding the quantity of care suggested. Similarly, the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) has addressed the issue of charitable obligation in only a nebulous way.

> *By history, tradition and professional oath, physicians have a moral obligation to provide care for ill persons. Although this obligation is collective, each individual physician is obliged to do his or her fair share to ensure that all ill persons receive appropriate treatment. Although the physician should be fairly compensated for services rendered, a sense of duty to the patient should take precedence over concern about compensation when a patient's well being is at stake.*[15]

Although the State Medical Society of Wisconsin (SMSW) emphasizes that its membership ought to participate in uncompensated community services, the SMSW manual provides no enumerated policy representing that position. Supporting its unrecorded premise, the SMSW maintains an inclusive listing of clinics, hospitals and medical facilities that welcome physicians wanting to donate their time and talent to the poor people of the community.[16]

Professional charity should not be made mandatory as the expression of a normative value. Mandatory altruism is an oxymoron. Also, edicts without the support of those subordinated by them create natural human resentment. Such resentment could result in less giving rather than more. Although rightfully without mechanisms for enforcement, implied prescriptive policy and encouragement from professional associations are in place for other aspects of professionalism. Nonetheless, charity care should continue to be promoted by professional organizations and associations on a voluntary basis.

C. Public-Private Partnerships. Access to health care as a societal problem cannot be solved by any one professional discipline. As Norm Daniels clarified:

> *Too many social, economic and technological factors about a society affect the distribution of health care needs for it even to be possible for the individual (doctor) or even the profession as a whole to guarantee just health care distribution. The individual cannot know enough nor has the profession power enough to carry out such obligations. Moreover, since society's interests in securing a just distribution and professionals' interests are not likely to coincide, a system dependent on a profession's compliance with principals of justice would likely be unstable*.[17]

The problem of equitable access to health care requires the cooperation of all its individual and association members. The relationships among patients, medical systems and payers are complex and entirely interdependent. In the emerging commercial model, roles played by these interdependent parties are increasingly confused. The diverse elements of distributive justice and respect for the interests of the other parties are paramount considerations in developing an ethical system of health-care delivery.

Frequently, the interests of one of the natural parties to the system will conflict with those of another. Generally, a patient's realistically achievable interests and goals have moral priority over the interests of the payer or the physician. However, like any business, the third party payer system is accountable to its investors. Within limits, its corporate decisions regarding a philosophy of care must be respected and considered.

Although willing to share responsibility, even extensive participation by physicians can not significantly ameliorate the plight of uninsured populations. Even if all physicians donated all of their time, access to medical care would still be an enormous problem. As essential partners in the health-care triad, third-party payers should assume fiduciary obligations to the general welfare of the community that provides the opportunity for profit. Third party payers are business entities that reap the benefits of protections and incentives provided by the state. A business philosophy that provides for the community in which a company sits should extend beyond an obligation to assure that their contracting physicians deliver quality medical care. In partnership with patients and the medical community, the payers should seriously consider contributing financial support to facilities providing care to non-subscribers in the community at large for their own economic good.

In Milwaukee County, there are currently nine predominant Health Maintenance Organizations providing health insurance coverage.[18] The Milwaukee Academy of Medicine constructed a baseline survey instrument to determine if the business interests of these HMOs inexorably conflict with the physician-patient relationship.[19] A copy of the survey is included as Appendix III. Of the nine surveys, only three were returned, even after reminders. Thus, no statistically significant inferences can be legitimately drawn regarding the general

business philosophy of health maintenance organizations of Milwaukee County. However, at item 10, the three respondents each supported the concept that an HMO should consider making "general qualified charitable donations" that effect health care for the uninsured in Milwaukee County

In a letter of support for Dr. Lundberg's call for private sector volunteerism cited above, a respondent reported that in Bloomington Illinois, a "national insurance company," in conjunction with a pharmaceutical company, had provided the resources to open and maintain a free clinic.[20] In Massachusetts, health insurers pay into a pool to support indigent care, but they receive little public credit for their contributions, probably because most of the care subsidized by that fund is delivered at teaching hospitals, with public moneys. Because of the dearth of recognition, payers reap no commercial benefit or good will from their contributions. In these and other ways, current policies discourage Managed Care Organizations from public service.[21]

On April 6, 1999, the *Milwaukee Journal Sentinel* reported that overall, Wisconsin's 25 HMOs earned about 50% as much as they did in 1997, and only 10 profited at all.[22] It cannot be assumed that all these businesses have the economic capability to make significant donations to pubic health. However, even threatened corporations could consider some system of support for physicians who choose to participate in charitable medicine. Mission statements and policy guidelines could specify that should profit margins increase to some predetermined level, a percentage would be contributed to support the provision of care to the uninsured.

Competition for market share among Milwaukee County's managed care organizations is rigorous. Even so, the Milwaukee Academy of Medicine's unanalyzed survey at items 14 and 15 found that each of the three HMO respondents agreed or strongly agreed that it could be commercially beneficial for a managed care organization to make charitable contributions to its community.[23]

There are myriad opportunities for physicians to fulfill their professional obligations to care for indigent patients. Similarly, third party payers should contribute to their contracting

physicians' ability to deliver this care, thereby demonstrating good will and potentially acquiring tax advantages.

D. Other Health Care Partnerships. In the best of all possible worlds, every physician would donate a significant amount of time each year to charity care for patients without sufficient funding. Within that ideal system, quality treatment would be delivered expertly and efficiently. However, without access to a multitude of ancillary services, only relatively minor illness or injuries can be managed by the generosity of individual physicians.

For instance, a surgeon may be willing to perform a lengthy and invasive procedure to repair and reattach musculature in the hand of a medically indigent trauma patient. He or she must first negotiate with his or her hospital for the patient's ancillary care and services. After the surgery, the patient will need significant bracing equipment and other durable and disposable supplies. He or she will also require medications for pain and infection, in addition to potentially protracted physical and occupational therapy. If reconstructive surgery is done without regard to the complex and interdependent aftercare components, the work of the surgeon is invalidated and the patient, ultimately, may be harmed.

Any organized and effective system of physician volunteerism must be supported by similar contributions from ancillary medical disciplines. In all probability, with the consent of their employers, care givers and therapists will be willing to donate reasonable time and skills similar to those given by physicians as a factor of their respective humanitarian callings. However, not philosophically characterized as professionals, retailers of medical supplies, pharmaceutical manufacturers and retailers have profit as their primary motivation. Most likely, merchants will need to conclude that there is economic value for their donations.

Such partnerships are potentially a win-win situation. In the equitable structuring of that partnership, all participants must benefit, whatever the internal motivation of each may be.

> *Recently, Duke University announced a far-reaching code of conduct to insure that products bearing its name are not made in sweatshops. The code bars licensees from using forced or child labor and requires them to maintain a safe-workplace, pay at least minimum wage, and recognize the right to form unions. Then, in a move that makes it the first university to adopt a tough*

> *enforcement mechanism, Duke's code requires licensees to identify all factories making products with Duke's name and to allow unimpeded visits by independent monitors. [A]bout $20 million worth of goods carrying the Duke name is sold every year.*[24]

Although the actual underlying motive for the policy cannot be definitively determined, Duke adopted a code that fostered good media relations and public attention. Certainly, Duke's move brought good publicity. When used as a marketing tool, sales increased. The University may or may not be committed to compassion or concern for abused factory workers. However, the increased profitability of its licensed sportswear line after announcement of the policy demonstrates there is quantifiable value in an *act* of compassion.[25].

A recent article in the Milwaukee Journal Sentinel described the mission of "Business for Sensible Priorities," (BSR) founded by Wisconsin capitalist Harry Quadracci as supporting the concept that strategic giving is profitable. In short, BSR serves as a resource for companies seeking to sustain their commercial success in ways that demonstrate respect for ethical values, people, communities and the environment."[26] Therein, Quadracci stated

> *Socially responsible practices are practices that enhance the community in fulfillment of the responsibility of business to support the community in which it thrives or dies. [T]he buying power of the members of the community will let its members buy the product of the business and the people in the community will build the product.*[27]

Even without charitable motivation, "strategic donations" or "acts" of compassion, could result in positive economic consequences for medically related businesses that participate in initiatives to improve health care for indigent populations.

E. Pervasive Changes in Health Care Policy. Despite the very real benefits and good intentions of a system of physician volunteerism, such initiatives can not alleviate the problem of access to health care. It is beyond the scope of this paper to fully justify the propriety of any particular proposed universal health insurance plan. Nonetheless, the notion of providing care for the poor and uninsured is ultimately bound to a means of universal access where lack of money does not mean lack of care.

Other than those who are themselves denied access to medical care, physicians know more than any group in our society about the nature and consequences in human misery of the systematic denial of health care.[28] However, those in the former group are generally among the most politically powerless in our society. By contrast

> *physicians are among the most politically powerful groups in our society. If physicians speak, there is a good chance that American society may listen and undertake the stressful democratic process of identifying our obligations in justice and of making the inevitable hard choices as to how we should allocate our nation's health care resources*.[29]

At the micro level, physician care of and advocacy for individual patients is laudatory, albeit insufficient to solve the systemic problem of the underinsured. In fact, the Cunningham study specifically concluded:

> *that the relative number of uninsured in a community (as far as a measure of the demand for charity care) is not significantly related to physician charity care, although it is possible that the level of aggregation for the measure (based on entire metropolitan and nonmetropolitan areas) was too large to detect any significant effects. Physician charity care may be more affected by the level of demand closer to their own practice (e.g., the neighborhood).*[30]

As outlined in the previous section, professional codes clarify that physicians' professional responsibility attaches specifically in the examining room but also should be applied to the general community. The physicians' commitment to professionalism, encompassing the traditions of both care and justice, should also express itself in broad legislative advocacy. That course demands that society assist doctors in forcing public debate and participation on the issue of access to health care for those without personal resources. Of course, despite encouragement from professional associations, obligations to provide uncompensated care are not, nor should they be, made mandatory. It would be counterproductive to consider legal or administrative sanctions for failure to participate in charitable medicine. Nonetheless, adherence to established historical obligations of care for the poor should be acknowledged and encouraged.

At no time has it been more important for physicians and their representative associations to collaborate with others to ensure that just, socially responsible health care reforms occur. It is crucial that physicians advise and educate the drafters of public policy and those who make health care decisions in areas where they are uniquely qualified: quality of care and medical ethics.

Notes

[1] George D. Lundberg, "How to Approach Universal Access to Basic Medical Care Without our Government Doing It," *JAMA* 273(3):242, 1995.
[2] George D. Lundberg, "Fifty Hours for the Poor," *JAMA,* 258(21): 3157, 1987.
[3] Lawrence McCullough, "Are Physicians Obligated to Treat Indigent Patients?" *Texas Medicine,* 87(2): 81-85, 82, 1991.
[4] Milwaukee Academy of Medicine, "Survey: Milwaukee Academy of Medicine," (Milwaukee, WI, Dec. 1998, photocopied). The results of this survey are not the result of valid experimental design nor are they intended to report statistically significant conclusions, but rather to discern general attitudes of local physicians regarding their personal opinion and practices of charitable medical care. Of 418 physicians surveyed in undisclosed specialties, there were 291 responses. Not all responding physicians answered every question on the survey.
[5] Peter Cunningham, "Reduced Charity Care and Research Funding Reflect Pressures of Managed Care and Competitive Markets," *JAMA* 281(12) 1087,1999.
[6] Dunham, Nancy, Kindig, David, "Uncompensated and Discounted Medicaid Care Provided by Physician Group Practices in Wisconsin, JAMA 265(22)2983, 1991.
[7] Cunningham, 1092.
[8] Wisc. Stat. 146.89 ss. 895.46. *Volunteer Healthcare Provider Program.* A joint application must be submitted by the free clinic or other non-profit agency. Applications are available through the Bureau of Risk Management, Dept. of Administration.
[9] *Ibid.*
[10] American Bar Association, *Model rules of Professional Conduct*, Rule 6.1 "Voluntary Pro *Bono Publico* Service," (1995).
[11] Wisconsin Supreme Court Rules, Chapter 20, preamble.
[12] McCullough, 82.
[13] American Medical Association Code of Ethics, 1846, In George Lundberg, "Fifty Hours," 3157.
[14] *Ibid.*
[15] American College of Physicians, *Ethics Manual of the ACP-ASIM*, (1997).
[16] For a list of volunteer opportunities, see the Internet site http://www.wismed.com/advocacy/freeclinic.htm.

[17] Norm Daniels, *Just Health Care,* Cambridge University Press, 1985, 117.
[18] Compcare Health Services Insurance Corp., Emphesys Wisconsin Insurance Co., Family Health Plan Cooperative, Humana Wisconsin Health Org. Ins. Corp., Managed Health Services Ins. Corp., Network Health Plan of WI, Inc. Physicians Plus Insurance Corp., PrimeCare Health Plan, Inc. United Health of Wisconsin Insurance Co., Inc., from State of Wisconsin, Office of the Commissioner of Insurance, 1998.
[19] Donna R. Taylor, "Survey of the Business Philosophy of Health Maintenance Organizations in Milwaukee County." Milwaukee Academy of Medicine, 1998. Photocopied.
[20] Robert Reardon, "Letter to the editor", *JAMA*, 273(19):1487,1995.
[21] Robert H. Fletcher, "Who is Responsible for the Common Good in a Competitive Market?" *JAMA* 281(12):1128, 1999.
[22] Joe Manning and James E. Causey*, Milwaukee Journal Sentinel,* April 6, 1999, sec. D, 8.
[23] Taylor.
[24] Steven Greenhouse, "Duke to Adopt a Code to Prevent Apparel From Being Made in Sweatshops, *New York Times*, 18 March 1998, Sec. 1, p13 in Cynthia Brincat and Victoria S. Wike, *Morality and the Professional Life: Values at Work,* Englewood Cliffs, NJ, Prentice Hall, (1999), Chapter 1.
[25] Brincat.
[26] Avrum D. Lank, "Doing Good is Good for Business, Group says," *Milwaukee Journal Sentinel,* (D-1), August 1, 1999.
[27] *Ibid.*
[28] McCullough, 1991, 84.
[29] Brincat.
[30] Cunningham, 1092.

CHAPTER NINE

Protections for Physicians

Abstract: *Society expects a great deal from its physicians. In meeting those expectations, doctors are entitled to certain protections under the laws by which they are governed. Most physicians in Managed Care models are not employees for whom the law has already granted protection, but rather independent contractors who are engaged at the fiat of third-party payers. For example, in pursuit of a payer's financial interests, doctors may be delisted for providing "too much" care. Further, while "gag clauses" have been outlawed by many states, the prohibition is not universal. Although no causal connection is proven, doctors with managed care contracts are less likely to provide charitable medical care. The lack of legal protection may inhibit physicians' advocacy for their patients and must be addressed at a national level.*

Given that physicians share responsibility toward uninsured patients, it is reasonable to expect the State to protect physicians' reasonable professional interests from vitiation by opposing concerns. At one level, the state of Wisconsin has addressed the issue of malpractice insurance for volunteer physicians.[1] Additionally, doctors and other health care workers must be protected from the legal fiat of third party payers when doctors advocate for the best interest of their patients or community in a manner contrary to the immediate financial interests of their contracting managed care plans. Media reports give anecdotal evidence of physicians who are "delisted" as a result of championing a subscriber patient's cause to the financial detriment of the payer. Well-drafted contractual provisions outlining the legal responsibilities between businesses and their employees and contractors can be enforced. However, contractual protections vary from state to state, provider to provider and from contract to contract.

Most states, like Wisconsin, follow the Employment at Will doctrine.[2] Thereunder, absent statutory protection or an employment contract to the contrary, employers can hire or fire employees for any reason, or for no reason at all. The relationship is governed entirely by the agreement (or lack thereof) between the parties.

There is little protection in law for physicians who are not employees, but independent contractors to Managed Care organizations. Public policy has driven statutory exceptions

in the prohibition of "gag clauses" for doctors treating patients insured by Medicaid or Medicare. These decisions evidence some congressional willingness to limit insurers' control of medical decisions. Some private insurers have volunteered to adopt this prohibition contractually. Some have not. Recognizing the primacy of fairness in all business dealings, Federal law will intervene only when contractual provisions run afoul of public policy.

This paper proposes that until a universal right to health care is framed, physicians have expanded duties to contribute to the health care for those without the means to pay. With those far-reaching expectations, government must act to protect physicians from the potentially oppressive requirements of the Managed Care system. Without such protection, restrictions on professional medical judgement may have already contributed to physicians' disillusionment with medicine as well as chilling any willingness to reach beyond the traditional obligation to care for individual patients.

While there is no clear cause and effect proven, a recent analysis suggests that physicians who served a higher number of uninsured persons were more likely to be denied contracts with Managed Care plans.[3] If confirmed, the situation should be investigated by the legislature to prevent the injustice of being wronged for doing right. With appropriate and directed advocacy, public policy exceptions should be carved out for independent contractors similar to those provided within employment relationships.

Job security is a significant issue for physicians under the evolving third-party payer system. It is both unrealistic and inequitable to expect that physicians will undertake a commitment to public health at the possible cost of their own livelihood. There is a clear consensus supporting the need to protect the public and specifically, those insured within Managed Care Organizations from health care denials for reasons of corporate profit. However, the concept of protection must also be applied to the benefit of health care providers as well as to the public they serve.

Notes

[1] See Chapter 8 note 7.

[2] Tatge v. Chambers and Owen, Inc., 219 Wis.2d 99, 579 N.W.2d 217 (1998).

[3] A.B. Bindman, K Grumbach, K Vranizan *et. al*., "Selection and Exclusion of Primary Care Physicians by Managed Care Organizations," *JAMA*, 279(9) 675-679, 1998 in Peter Cunningham, "Reduced Charity Care and Research Funding Reflect Pressures of Managed Care and Competitive Markets," *JAMA* 281(12): 1091, 1999.

CHAPTER TEN

Conclusions

Abstract: *Certain Managed Care theories may be responsible for slowing the growth of health care spending. However, it is unclear whether these reductions result from cost reductions rather than reductions in quality care. The related concepts of professionalism and charity mandate that doctors provide some care for which they do not expect compensation. However, charity will not significantly abate the problem of access to care for the uninsured. As guardians of the public health, physicians must advocate for cooperative and systemic change in the health care delivery system, recognizing universal access to health care as a right.*

Recent profound changes in our health care system have dramatically altered the care that is available to uninsured and underinsured populations. Government has decreased its level of responsibility to poor people, while increasing unfounded mandates for care. The Managed care industry has stressed the economics of care to where decreasing charity services are inevitable. Society has not chosen to address the question of health care, either as a right or an individual responsibility. In the resulting chaos remain uninsured patients who need health care and physicians and hospitals that must decide how to provide it.

It is not the intent of this paper to demonize *managed* care. Health care policy analysts agree that Managed Care is responsible for some essential cost reductions. The new systems have driven hard bargains with providers and limited unnecessary medical treatments. Recent developments in health care delivery have taught us the wisdom of managing and coordinating care among providers and payers in some efficient and equitable way.

However, contemporary successes may represent only a one-time saving.[1] Many of the so called "bargains" made as Managed Care engulfed the health care delivery system may have been made at patients' expense. It has been suggested that much of the savings is the result of work force reduction, and not "harder work." The daring promises of cost reduction and enhanced quality advanced by proponents of

Managed Care have neither decreased the number of uninsured individuals and families, nor improved the quality of health care in Wisconsin or the United States.

Increasingly responsible for the business of medicine within Managed Care systems, physicians are pulled away from the art of medicine. Despite professional charitable dedication to individual patients, barriers to physicians' expert services are multiplying. Considering the cost of hospitalization, ancillary services, technology and pharmaceuticals, no amount of charitable care and medical volunteerism by physicians can significantly abate this troubling course.

To the question, "Have the duties of the physician toward the uninsured changed?" the answer is yes, or rather a broader construction of those duties is acknowledged. Professional medicine has an ancient commitment to the related concepts of professionalism and charity. Nevertheless, the economic reality of twentieth century western medicine is increasingly complex and is evolving to adapt to the unique platforms of societal and commercial interests. These modifications do not represent a paradigm shift in physician responsibility, but rather additions to obligations in an already daunting agenda.

By tradition and within their sacrosanct relationship, physicians have respected their obligation to care for individual patients as they presented themselves. However, in large part due to legitimate market forces, the concept of medicine as a community service has significantly diminished. The enormous barriers imposed by Managed Care mandate that physicians can no longer afford to limit their concerns solely to individual patients. As society becomes more diverse and potentially polarized, the doctors' responsibility enlarges from advocacy for particular patients to participation in organized advocacy for public health and care for the national community. The expanded duty of physician professionalism requires directed, organized effort toward abolishing the barriers to access to their essential and unique skills, for the common good of society and the interests of public health.

The lack of political will to reform the health care system fairly has expanded the ranks of the uninsured, decreased patient's trust in their physicians, complicated the health care delivery system and created mechanisms that increase administrative costs. Physicians are bound to act with professionalism within Managed Care plans that sometimes demand that they subordinate their oaths to priorities of profit.

> *Attempts to manage care treat physicians as suspect persons rather than key figures in improving the quality of American medicine. Reform must respect the professional role of physician. Workable controls must rely upon rather than override professionalism.* [2]

. The lessons of state insurance laboratories illustrate that as homogeneity of a population decreases, so does the degree of success in health care delivery reforms. Likewise, employment based financing is restrictive, regressive and complex.

The Milwaukee Academy of Medicine supports the ultimate goal of Universal Coverage. Single Payer proposals offer the simplest system for improving health care delivery in terms of quality, access, choice and cost effectiveness. That system would simplify administration of the confusing consumer and provider based health care initiatives that have been developed by state and local governments. At the same time, single-payer systems do invite potentially overarching governmental intrusion into private health care delivery. Therefore, some fair, efficient system that offers universal access is the goal of the Academy.

While physicians must have the primary authority regarding treatment decisions, the federal government maintains society's best infrastructure to control the resources to be spent. In the same way that society has supported the value of education and public utilities, taxation represents a clear alternative as a fair and potentially simple mechanism to finance and regulate health care. In addition to patient based concerns,

care providers will be afforded interstate protection from shortsighted sanctions by third party payers.

The physicians of the Milwaukee Academy of Medicine publicly accept their professional obligation to individual patients and to the public. At the same time, we recognize the challenges inherent in the current health care delivery system, as well as those more complex challenges inherent in developing a better one. In the interim, we retain our commitment to sharing the responsibility to care for those in the current system who lack sufficient funding. The Academy calls for the participation of civic leaders, the insurance industry, other professionals, and the public in participating in organized debate and advocacy aimed at developing an equitable plan to improve the public health through universal access to medical care for future generations.

Notes

[1] Donald Light, "Good Managed Care Needs Universal Health Insurance," *Annals of Internal Medicine* 130(8): 686, 1999.
[2] The Health Care Study Group, "Understanding the Choices in Health Care Reform," *Journal of Health Politics, Policy and Law,* 1994, 19(3): 499-541.

BIBLIOGRAPHY

_____. "Advantages and Disadvantages of a Single Payer System," Physicians for a National Health Program, Chicago, 1999.

AFDC Statutes, 42 USC Chapter 7, Sec. 601 *et. seq*. (1968).

American Bar Association. *Model rules of Professional Conduct*, Rule 6.1 "Voluntary Pro Bono Publico Service," 1995.

_____, *Summary of Action,* Report No. 122, August 1975.

American College of Physicians. *Ethics Manual of the ACP-ASIM*, 1997.

Annual Update of the HHS Poverty Guidelines. U.S. Department of Health and Human Services. Washington, D.C.: Government Printing Office, 1999.

Arras, John D and Steinbock, B. Ethical *Issues in Modern Medicine,* 4th ed. Mountain View, California: Mayfield Publishing Company, 1995.

Baker, Robert. "American Independence and the Right to Emergency Care, *MSJAMA,* 281 (March 3, 1999) 860.

Beauchamp, Tom. *Philosophical Ethics: An Introduction to Moral Philosophy.* New York: McGraw Hill, 1991.

Bindman, A.B., Grumbach, K and Vranizan K, *et. al*. "Selection and exclusion of primary care physicians by managed care organizations." *JAMA*, 279 (March 4, 1998): 675-679.

Boaz, David. *Libertarianism: A Primer*. New York: The Free Press/Simon and Schuster, 1998.

Bodenheimer T. and Grumback K. "National Health Insurance and the Problems of American Medicine," *International Journal of Health Services.* 23(2)(Feb. 1991):137-40.

Brock, Dan W., and Daniels, Norm. "Ethical Foundations of Healthcare Reform." Quoted in Arras, and Steinbock. *Ethical Issues in Modern Medicine,* 4th. ed. Mountain View, California: Mayfield Publishing Company, 1995.

Brieger, Gert H. "The Use and Abuse of Medical Charities in Late Nineteenth Century America." *Am. J of Public Health*, 67(3) (1977): 264-267.

Brincat, Cynthia and Wike, Victoria. *Morality and the Professional Life: Values at Work.* Englewood Cliffs, NJ: Prentice Hall, 1999.

Childress, James F. *Practical Reasoning in Bioethics.* Bloomington, Indiana: Indiana University Press, 1997.

Compensation Monitor, "AMA: Doctor's Income Still Rising." *Managed Care* (June 1998): 23.

Cunningham, Peter. "Reduced Charity Care and Research Funding Reflect Pressures of Managed Care and Competitive Markets." *JAMA* 281(12) (March 24/31, 1999): 1087.

Custody of State Offenders Act, U.S. Code. vol. 18. sec. 5003 (1996).

Daniels, Norm. *Just Health Care.* New York: Cambridge University Press, 1995.

Davidoff, Frank and Reincke, Robert D. "The 28th Amendment." *Annals of Internal Medicine* 130(8) (April 20 1999): 694.

Department of Health and Human Services, *Annual Update of the HHS Poverty Guidelines*, 1996.

Dunham, Nancy, Kindig, David, *et. al*. "Uncompensated and Discounted Medicaid Care Provided by Physician Group Practices in Wisconsin." *JAMA* 265(22) (June 12, 1991): 2982.

Eligibility Determination Requirements. Milwaukee County GAMP Policies and Procedures. Policy No.E-4. Jan. 20, 1998.

Emergency Medical Treatment and Active Labor Act. U.S. Code. Vol. 42, sec. 1395, 1988.

Engelhardt, H. Tristam. "Health Care Allocations: Responses to the Unjust, the Unfortunate and the Undesirable." Quoted in *Justice and Health Care.* Boston: D. Reidel, 1981.

Employer Retirement Insurance and Security Act, 29 USC 18 (1974).

Falk, I.S. *The Incidence of Illness and the Receipt and Costs for Medical Care Among Representative Families.* Chicago: The University of Chicago Press, 1932.

Feinberg, Joel. "The Nature and Value of Rights." *Journal of Value Inquiry* 4 (1970): 243-57.

FEMA, 42 USC 5195 (Chpt. 86, subchpt. IV-B)(1998).

Friedman, Emily. “Getting a Head Start: The States and Health Care Reform.” *JAMA* 271(11) (1994): 875.

Goodpaster, K.E., and Nash, LL. *Policies and Persons: A Casebook in Business Ethics.* 3rd. ed. Hightstown, NJ: McGraw-Hill, 1997.

Gorin, Stephen. “Universal Health Care Coverage in the United States: Barriers, Prospects and Implications.” *Health and Social Work*, 22(3)(Aug. 1997): 223-230.

Greenhouse, Steven, “Duke to Adopt a Code to Prevent Apparel From Being Made in Sweatshops,” *New York Times*, 8 March 1998.

Gutman, Amy. "For and Against Equal Access to Health Care.” Quoted in *Securing Access to Health Care, Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, Vol. 2, Washington, D.C.: U.S. Government Printing Office. March 1983, 4.

Haddad, Kathleen M. “Insurance Reform in a Voluntary System: Implications for the Sick, the Well and Universal Health Care. A position paper for the American College of Physicians, *Annals of Internal Medicine.* 124(3)(Aug. 1, 1996):242-249.

Health Insurance Portability and Accountability Act of 1996, 42 USC, 6A (Subchpt. XXV) 1996.

The Health Status of Uninsured Milwaukee Area Residents: Further Analysis of the 1996 Milwaukee Health Status Survey Data. Planning Council for Health and Human Services, April 15, 1997. Photocopied.

Heer, Jerome. “Uninsured Populations, Medicaid Benefits and Uncompensated Care in Milwaukee County: Information for the Milwaukee County GAMP Program.” County Health Related Programs, 2/2/98. Photocopied.

Hislop, Reginald M. III. “Managed Care: Ethical Implications of Balancing Cost v. Quality”. 1998. Photocopied.

Krakauer, Randall S. “Survey of Health Planning Proposals,” American *Journal of Surgery,* 167(2)(Feb. 1994): 232-235.

Knowles, J., ed. *Doing Better and Feeling Worse: Health in the United States.* New York: W.W. Norton and Co., 1977.

Lank, Avrum. “Doing Good is Good for Business.” *Milwaukee Journal Sentinel,* August 1, 1999, D-1.

Larson, Elizabeth and Batemon, Patricia. "An Inventory of the Community-Based Primary Care Clinics." Milwaukee, WI: Planning Council for Health and Human Services, 1997. Photocopied.

Larson, Elizabeth and Tragesser, Susan et. al. "A Description of the GAMP Population and Medical Claims: Comparisons Between 1996 and 1997," Milwaukee, WI: Planning Council for Health and Human Services, September 1998. Photocopied.

Leichter, Howard. "Public policy and the British Experience." *The Hastings Center Report* 11(5) (October 1981): 32-39.

Light, Donald. "Good Managed Care Needs Universal Health Insurance." *Annals of Internal Medicine* 130(8) (April 20, 1999): 686-689.

Lightfoote, Johnson B. and Ragland, Karen D. "Single Payer Health Insurance Systems" National Myths and Immovable Mountains," *Journal of the National Medical Association,* 88(4)(April 1996): 217-24.

Lundberg, George D. "How to Approach Universal Access to Basic Medical Care Without Our Government Doing It." *JAMA,* 273(3) (1995): 242.

Lundberg, George D. "Fifty Hours for the Poor." *JAMA* 258(21)(1987): 3157.

Locke, John. *Two Treatises of Government.* New York: Mentor Books, 1965.

Marmor, Theodore R. and White, Joseph. "Understanding the Choices in Health Care Reform." The Health Care Study Group. *Journal of Health Politics, Policy and Law.* 19(3)(fall, 1994): 500-541.

Mental Health Parity Act of 1966 (PL 104-204)

McCally, Michael, Haines, Andrew, Fein, Oliver, *et. . al.* "Poverty and Ill Health: Physicians Can and Should, Make a Difference." *Annals of Internal Medicine* 129 (9)(Nov. 1998): 726-33.

McCullough, Lawrence. "Are Physicians Obligated to Treat Indigent Patients?" *Texas Medicine* 87(2)(February 1991): 81-85.

_____. Rights, Health Care and Public Policy." *J Med. and Phil. 42*(2)(1979): 209.

Medicaid Statues, 42 USC 1396-1396v subchpt. XIX)(1965).

Medicare Statues, 42 USC 1395(subchpt. XVIII)(1965).

The Managed Care Check-Up Program: The Physician's Perspective in Milwaukee County. Milwaukee County Medical Society. Milwaukee WI, 1995.

Miles, Stephen D. "What Are We Teaching About Indigent Patients?" *JAMA,* 268 (18)(*Nov*. 11, 1992): 2561.

Manning Joe and Causey, James. *Milwaukee Journal Sentinel.* April 6, 1999: D-8.

_____. "Medical Care and Pursuit of Equality"*, Securing Access to Health Care, Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, Vol. 2, Washington, D.C.: U.S. Government Printing Office. March 1983, 4

Milwaukee Academy of Medicine and the Medical Society of Milwaukee County, "Member Survey." December 1998.

Nelson, Alan R. "Medicine: Business or Profession, Art or Science?" *Transactions of the Sixteenth Annual Meeting of the American Gynecological and Obstetrical Society,* 1996.

Nordgren, Robert. "The Case Against Managed Care and for a Single-Payer System." *JAMA*, 273(Jan. 4, 1995)(1) 79,82.

Nozik, Robert. *Anarchy, State, and Utopia.* New York: Basic Books, 1974.

Outka, Gene. "Social Justice and Equal Access to Health Care." Quoted in Stanley, Joel R, Dyck, Arthur J., and Curran, William J. *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*. Cambridge MA: MIT Press, 1977.

Pearl, Raymond. "Distribution of Physicians in the US." *JAMA*. (April 4, 1925): 1024-1027.

Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Securing Access to Health Care. 1(4) Washington DC.: Government Printing Office, March 1983.

Rosenberg, Charles E. "The Origins of the American Hospital System." *Bull. NY. Acad. Med.* 55(1) (Jan. 1979): 10-21.

Rosenberg, Neil. "Outlook Grim for Uninsured Care." *Milwaukee Journal Sentinel,* 14 March 1999, B-1.

Sade, Robert M. "Medical Care as a Right: a Refutation." *N Engl. J. Med.* 285 (23) (1971): 1288-1292.

Schiedemeyer, David and McCarty Daniel. "Altruism, Professional Decorum and Greed: Perspective on Physician Compensation." *Perspectives in Biology and Medicine* 38(2)(Winter 1995): 239-253.

Sneider, Julie. "Hospital's Bad Debt on the Rise," *The Business Journal*, Sept. 16, 1998, Sec. ____ , pg. ____.

Stanley, Joel R, Dyck, Arthur J. and Curran, William J. *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*. Cambridge MA: MIT Press, 1977.

Starr, Paul. *The Social Transformation of Medicine*. Basic Books, 1982.

"State Health Care Reform: Looking Back Toward the Future." Special report of the Robert Wood Johnson Foundation. September 1997.

Statistical Abstract of the United States. Department of the Census. Washington, D.C.: Government Printing Office, 1996.

Short, P.F., and Han, B.A. "The Effect of Universal Coverage on Health Expenditure for the Uninsured." *Medical Care* 35(2)(Feb. 1997): 95-113.

Subsidized Housing regulations 42 USC 1436 (Chapt. 8 et. Seq.) (1998).

Tatge v. Chambers and Owen, Inc., 219 Wis.2d 99, 579 N.W.2d 217 (1998).

Taylor, Donna R. "Survey of the Business Philosophy of Health Maintenance Organizations in Milwaukee County." Milwaukee Academy of Medicine, 1998. Photocopied.

Taylor, Humphrey and Uwe, Reinhardt E. "Does the System Fit?" *Health Management Quarterly* 13 (1991): 2-10.

Todd, James. "Its Time for Universal Access, Not Universal Insurance" *NEJM* 321(1)(July 6, 1989): 46-47.

Travelers Insurance v. N.Y., 115 S. Ct. 1671 (1995)

Trubeck, Louise and Meehan-Strub, Mary. "Medically Uninsured and Underinsured: 1999 Initiatives and Obstacles Forum." Center for Public Representation, Inc., Madison, Wisconsin, Sept. 1999.

"Unreimbursed Care at Milwaukee Area Hospitals, Hospital Fiscal Year 1995-1996" Office of Health Care Information, Office of the Commissioner of Insurance, Wisconsin Legislative Audit Bureau. 1998.

U.S. Constitution, amend. 8.

U.S. Constitution at Article I.

Volume of Physician Visits, by Place of Visit and Type of Service, July 1963-June 1964. U.S. Dept. of Health Education and Welfare, National Center for Health Statistics. Washington D.C.: Government Printing Office, 1964. Series 10(18).

White, Sammis. "The Medically Uninsured of Milwaukee County." Wisconsin Policy Research Institute, March 14, 1999.

Wisc. Stat. 49.141 *The Wisconsin Works Program.*

Wisc. Stat. 938.02 ss. 12 *Juvenile Justice Code.*

Wisc. Stat. 146.89 ss. 895.46. *Volunteer Healthcare Provider Program.*

Young Lawyer Division of the ABA, *"Filling the Gap: Access to Justice for Persons of Modest Means.*" Recommendation 111B. The Affiliate Outreach Project Pamphlet in American Bar Association Young Lawyers Division Report to the House of Delegates. (1994) 1.

APPENDIX I

Survey of Physicians' Attitudes Toward Uninsured
Populations and Charitable Medicine
The Milwaukee Academy Of Medicine and The Medical
Society of Milwaukee County

Milwaukee, WI
December, 1998

APPENDIX II

"The Managed Care Check-Up Program: The Physicians' Perspective in Milwaukee County."
Medical Society of Milwaukee County

Milwaukee WI, 1995

APPENDIX III

Survey of the Business Philosophy of Health
Maintenance Organizations in Milwaukee County
The Milwaukee Academy Of Medicine

Milwaukee, WI
December, 1998