HEALTH CARE REFORM IN U.S: A STUDY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT 2010

Dissertation submitted to Jawaharlal Nehru University

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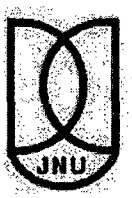
ALLEN V. L PUNDIR



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School of International Studies

JAWAHARLAL NEHRU UNIVERSITY

New Delhi – 110067

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SCHOOL OF INTERNATIONAL STUDIES
JAWAHARLAL NEHRU UNIVERSITY
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DECLARATION

I declare that the dissertation entitled **"HEALTH CARE REFORM IN U.S: A STUDY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT 2010"** submitted by me in partial fulfilment of the requirements for the award of the degree of **MASTER OF PHILOSOPHY** of Jawaharlal Nehru University is my own work. The dissertation has not been submitted for any other degree of this University or any other university.

ALLEN V. L. PUNDIR

CERTIFICATE

We recommend that this dissertation be placed before the examiners for evaluation.

PROF. K.P.VIJAYALAKSHMI
Chairperson, CCUS&LAS

PROF. CHRISTOPHER S RAJ
Supervisor

Tel : 26704334, 26704333 • Fax : 091-11-26741586

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Preface

Public health is a bond—a trust—between government and its people. The society at large entrusts its government to oversee and protect the collective good health. And in return individuals agree to cooperate by providing tax monies, accepting vaccines, and abiding by the rules and guidelines laid out by government public health leaders. If either side betrays that trust the system collapses like a house of cards.

The health care system in the United States today has come to the brink of collapse with its unsustainable rise in health care costs and millions of American citizens can no longer afford to buy health insurance because of high premiums as well as not meeting insurance companies' stringent and biased checking of pre-existing health condition. This is despite the fact that health care system gets the highest budget allocation from the Federal budget. Whereas the U.S government allocates roughly five percent of its Federal budget for the military, the health care system gets roughly fifteen to sixteen percent of the annual Federal budget.

The dilemma the health care system in the United States face becomes interesting when it is compared to other developed countries with roughly the same standard of living. The annual expenditure on health care by the United States is roughly $2.3 trillion dollars. This is ridiculously high and approximately, only five or six countries in the world have a GDP higher than two trillion. India's GDP is not even two trillion with a population of more than a billion.

These statistics gives a largely fair idea of how the U.S health care system is under-performing and is in a mess. The interesting point is that the health care system has gradually been under-performing for decades before but nothing concrete had been done about it since the 1965 Social Security Act which created Medicare. It becomes an area of interest for research after analysing and bearing in mind all the statistics and data available.

Though the United States has seen moments in history that could have changed the health care industry, change has still eluded them. The major reform agenda came only during Clinton's Presidency lead by Hillary Clinton, but the movement was quashed by interest groups. The failure of the Clinton health care reform effort was largely a demonstration of how powerful private interests can triumph over the public interest by manipulating public opinion to defeat reform desired by a majority of people.

Barack Obama's health care reform proposal becomes a subject of active interest for the very reason that he has vowed to tackle the opposition parties and interest groups head on to reform the system. The sweeping margin and the wave of support Obama came in to power with becomes a strong platform for him to advocate major changes in the economy as well as the administration.

The Patient Protection and Affordable Care Act becomes an important subject matter to study as it will throw light on the process of making the bill, creating awareness about the bill, getting support for the bill in and outside the Congress and most of all handling powerful special interest groups who would strongly support a status quo. The ways and means the Obama administration employs to garner support or would lose their support becomes a very interesting subject to study.

This dissertation has tried to objectively analyse and critically study the patient Protection and Affordable Care Act, the health care bill that was eventually passed, and also study and analyse the journey Barack Obama made from his Presidential campaign right up to his campaign of getting the health care bill passed.

CHAPTER 1

INTRODUCTION

The current dissertation examines and analyses President Barack Obama's health care reform plan, which was eventually signed into law as the Patient Protection and Affordable Act, and the process by which the plan was finally passed into law. The health care reform debate in the United States has been a political issue for many years, focusing upon increasing coverage, decreasing the cost and social burden of healthcare, insurance reform, and the philosophy of its provision, funding, and government involvement. The opposition to the proposed reforms was fierce and many, from the Republican Party members, representatives of the insurance companies, pharmaceutical companies, various doctors association including the American Medical Association (AMA), conservatives and even some from the democrats themselves. The dissertation has attempted to construct and analyze the making of the bill and the process in which the bill was drafted into law after much opposition.

The health care field is complex, perhaps the most complex of any area of the economy. It is a behemoth comprising many separate legal entities. Thus far, the ownership of the health care system has mainly been in private hands, though federal, state, county and city governments also own certain facilities. This means that there is no nationwide system of government-owned medical facilities that is open to the general public providing coverage to all. Current estimates put U.S health care spending at approximately 15.2% of the country's G.D.P, second only to the tiny Marshall Islands among all the member nations of the United Nations. In 2007, the U.S spent $2.26 trillion on health care or $7439 per person which is the highest compared to the rest of the nations in the world. Further, growth in spending is projected to average 6.7% annually over the period 2007 through 2017 (Banthin 2008).

A study of international health care spending levels published in the health policy journal Health Affairs in the year 2000, found that while the U.S spends more on health care than other countries in the Organization for Economic Cooperation and Development (OECD), the use of healthcare services in the U.S. is below the OECD median by most measures. The authors of the study conclude that the prices paid for healthcare services are much higher in the U.S.A. A 2008 report by the Commonwealth Funds ranked the country last in the quality of healthcare among 19 countries (Anderson 2003). Notwithstanding very high health spending (about 15% of GDP) and the use of cutting edge technology, the health status of the US population does not appear to fare well by international comparison. A particular source of concern is the large number of people who lack adequate health insurance. It is estimated that 46 million persons were not insured at all in 2007 (16% of the population) (OECD 2008), with a further large share of the population underinsured. With Mexico and Turkey, the United States is the only OECD country that does not get close to universal health care insurance.

Although there are several public insurance schemes (such as Medicare for the elderly and disabled, Medicaid for the poor, and SCHIP for poor children), the number of uninsured is widely considered to be a problem that needs to be rectified and making progress towards health insurance coverage for all given a high priority on the policy agenda. This is exactly what President Obama promised in his campaign during the presidential elections and a public health plan was floated for the millions uninsured and to cut the mounting deficit and to give competition to the private insurers to create more efficiency among the players and to lower the mounting cost of health insurance.

The current problem in healthcare did not emerge overnight. It is the direct result of the accumulated policy decisions and market choices made over the last 60 years. Though the country has seen moments in history that might have changed the healthcare industry for the better somehow change has eluded it. Now, with the election of a new president, the United States once again stood to witness a similar kind of moment wherein change might actually be possible. The challenges are many but the rewards, if successful, could be worth the pursuit.

The Patient Protection and Affordable Care Act will ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs. The Congressional Budget Office (CBO) has determined that the Patient Protection and Affordable Act is fully paid for, will provide coverage to more than 94% of Americans while staying under the $900 billion limit that President Obama established, bending the health care cost curve, and reducing the deficit over the next ten years and beyond.

The Patient Protection and Affordable Care Act contain nine titles, each addressing an essential component of reform:

- Quality, affordable health care for all Americans
- The role of public programs
- Improving the quality and efficiency of health care
- Prevention of chronic disease and improving public health
- Health care workforce
- Transparency and program integrity
- Improving access to innovative medical therapies
- Community living assistance services and support
- Revenue provisions

DEFINITION, RATIONALE AND SCOPE OF STUDY

The scope of this study more or less begins with an essential feature of the public plan: its role as a strong player in the market keeping in mind key concepts like access, quality, efficiency, cost control and financing. An interest on this subject is prompted by general observations like the U.S., despite being one of the wealthiest and politically the most powerful nation on earth is not able to successfully implement a plan that is beneficial for both, the health care industry in terms of promoting efficiency and excellence, and its citizens. In light of this observation we go on to study the benefits of the new public plan and analyze the disadvantages of the existing conditions in the health care industry as well as the opposition against the bill and the drawbacks of the bill.

The bill passed into law as the Patient Protection and Affordable Care Act on March 23, 2010 met with opposition from political parties to special interest groups to opposition within the Democratic Party itself has been analyzed thoroughly. This opposition was broadly based on objections to rises in taxation, especially of the so-called "Cadillac insurance plans" and the corollary increase in government spending on affordability subsidies. The GOP also objected to a new Health Insurance Rate Authority that would determine whether rate increases were "unreasonable" and to enforced rebates or premium reductions, and to any proposal that might have allowed government funds to subsidize abortion (Latest White House health... 2010). The opposition declared the law to be a "government takeover of health care", although the government did not propose taking over either the management of the health care system, which largely remains in private hands, nor was there ultimately legislation for a public insurer competitor.

Obama had said that fixing health care would be one of his four priorities if he won the presidency (Goodman 2008), during the general elections and after his inauguration he announced to a joint session of congress in February 2009 that he would begin working with Congress to construct a plan for health care reform (Remarks of President.. 2009). From June 17, 2009, extending through September 14, 2009, three Democratic and three Republican Senate Finance Committee Members met for a series of 31 meetings to discuss the development of a health care reform bill. Over the course of the next three months, this group, Senators Max Baucus (D-Montana), Chuck Grassley (R-Iowa), Kent Conrad (D-North Dakota), Olympia Snowe (R-Maine), Jeff Bingaman (D-New Mexico), and Mike Enzi (R-Wyoming), met and the principles that they discussed became the foundation of the Senate's health care reform bill (USSCF 2007). During the August 2009 congressional recess, many members went back to their districts and entertained town hall meetings to solicit public opinion on the proposals. During the summer recess, the Tea Party movement organized protests and many conservative groups and individuals targeted congressional town hall meetings to voice their opposition to the proposed reform bills.

The health care bill which originated in the House was amended and proposals of the Senate Health and Finance committees were heavily incorporated by the time it came to the Senate to be passed. The filibuster threat by Nebraska Senator Ben Nelson was

overcome with a compromise known as the "Cornhusker Kickback" (Fox News 2010) but was later repealed in the reconciliation bill. The compromise offered a higher rate of Medicaid reimbursement for Nebraska (Dunham 2010). The Senate voted 60-39 to pass the bill on December 24, 2009, with Senator Jim Bunning (R-Kentucky) not voting. As Republican Scott Brown won the Senate seat from the erstwhile Democrat stronghold of Massachusetts, the fate of the health reform bill became uncertain with the Republican minority having enough votes to sustain a filibuster. This left Obama solely in-charge of saving the bill and he came up with a health care plan of his own, drawing largely from the Senate bill. On February 25, 2010 he held a meeting with leaders of both parties urging for the passage of the reformed bill (Dunham 2010). At this stage, the fate of the bill was still uncertain as many Representatives from the Democrats themselves were against the bill and none of the Republicans supporting. A negotiation with the group of pro-life Democrats led by Bart Stupak took place, where the group objected to the possibility of federal funding for abortion and hence their opposition. President Obama issued Executive Order 13535, reaffirming the Principles in the Hyde amendment and this concession won the support of Bart Stupak and his group. The House passed the bill with a vote of 219 to 212 on March 21, 2010 with 34 Democrats and all 178 Republicans voting against it.[1]

According to Obama, America's health insurance industry has spent hundreds of millions of dollars to block the introduction of public medical insurance and stall other proposed legislation (HuffPost 2007). There are six registered health care lobbyists for every member of Congress (Salant 2009). The campaign against health care reform has been waged in part through substantial donations to key politicians. The single largest recipient of health industry political donations and chairman of the Senate Committee on Finance that drafted Senate health care legislation is Senator Max Baucus (D-MT) (McGreal 2009). A single health insurance company, Aetna, has contributed more than $110,000 to one legislator, Senator Joe Lieberman (ID-CT), in 2009.

As the role of lobby groups in American politics is very influential in framing policies, their role and influence will be dealt with critical detail and in-depth analysis. The final draft of the bill passed which became law will be dealt with in an

[1] Roll call vote 167. http://clerk.house.gov/evs/2010/roll167.xml

exclusive chapter going into details of the draft. The clauses will be studied and analyzed highlighting the ones dealing with cost control, public insurance plan, tax cuts and subsidies affecting the uninsured and the lower income group families.

The dissertation throws light on the intricacies and politics which goes into making and passing legislative bills which has wide spread ramifications on the American people. The number of failed attempts by a number of presidents bears testimony to the fact how the health care system has been a bone of contention between the two rival parties and the recent passage of Obama's health care bill into an act is a historical achievement, no matter the bill has the desired effect of overhauling the health care system. This dissertation provides an objective and critical analysis of the making of the bill, the opposition to the bill and process of the final draft of the bill and its plausible short term and long term effects.

REVIEW OF THE LITERATURE

As Holahan and Blumberg provide a detail analysis of Obama's health care act in their essay (Holahan, 2008), Obama's new National Health Insurance Exchange would require that all approved private plans are at least as generous at the new public plan which would have benefits similar to a standard plan offered through federal employees' health benefit plan (FEHBP). The authors observe that the purpose of insurance is to pool risks so that people in good health subsidize others who are experiencing poor health; the young support the higher costs of the old; able-bodied individuals support accident victims, and so forth across the life span. Life is notoriously uncertain and insurance coverage, whether for material items or health, protects against financial ruin in the event of a catastrophe, accident, or illness. The broader and more diverse the risk pool, the less likely it is that one event will cause financial ruin for an individual, a group, or an insurance carrier. In addition, with a broad and diverse risk pool, the individual cost of the premiums will be lower.

According to Holahan and Blumberg, part of the Obama plan is the public plan that would compete with insurers within the health insurance exchange. The authors point out that a public plan could be a strong player in the market and have strong

negotiating power with providers; the public plan would compete actively with other insurance arrangements. To the extent that the public plan that was offered was an attractive product and could contain costs because of its bargaining power with providers, other insurers would have to compete more aggressively than they do today. The authors believe this is an essential part of the plan because of the lack of true competition in a large number of U.S. health care markets as a result of extensive provider consolidation (Cueller 2003). This consolidation, particularly among hospitals, has resulted in serious constraints on the ability to contain costs as concluded in the findings of A.E Cueller and P.J Gertler. However, Holahan and Blumberg caution that it would be erroneous to suppose that the public plan will dominate the market and drive out private competition, because the public plan is unlikely to use all of its market power because of political pressures and caution regarding the ability to maintain access to a high-quality health care system. In fact, it could have a positive influence on this market as the competition it would engender could certainly lead to savings relative to the current system (Blumberg 2006). The public plan would provide the countervailing power the market needs. However, many of these initiatives will take several years to be fully effective according to the authors.

In general, the Obama plan approaches cost containment on multiple fronts because most individual initiatives by themselves have only small effects. By and large, the proposal contains the basic components necessary for effectively addressing some of the most important shortcomings of the current health care system. However, Holahan and Blumberg in their findings raise a number of significant concerns with the health reform bill: first, the approach cannot achieve universal health insurance coverage without an individual mandate for adults; consequently, while this plan would increase coverage significantly, it would still leave about 6 percent of US residents uninsured (compared to 17 percent at present) (Burman 2008). Because there would be uninsured remaining, including the undocumented noncitizens that are not covered by the approach, the plan will not be able to fully tap into existing safety net funds to help with financing.

Secondly, the approach relies on an employer mandate, which will increase costs to some businesses and engender the same political opposition that has contributed in the past to the defeat of other reform efforts. The Obama plan has the potential to

increase the regulation of insurance markets. Hadley et al. agree that insurance regulation is intended to increase the pooling of risks and minimize risk segmentation[2]. Attempts to broaden risk pooling bring their own complications; for example, when healthy individuals faced with premiums that exceed their expected costs decide to go without insurance. This is turn increases premiums for those with coverage.

Third, the bill leaves several key details unspecified, like the new eligibility levels for Medicaid and SCHIP coverage, the subsidy schedule, out-of-pocket payment limitations among others, and these choices can greatly affect coverage, equity, and costs. And finally, the cost estimates are likely a bit low according to the authors, and much would depend on how the details are resolved. The plan could benefit from considering caps on, but not the elimination of, the exclusion of employer health insurance contributions from taxation as a source of revenues.

In *The Cure for the American Healthcare Malady* (2009), Dr. James H. DeGerome details the fatal flaws of a government-controlled healthcare system, comparing such a system to Canada and European countries' socialized healthcare in his book. DeGerome spells out the myths of these existing socialized systems and gives the reader a comprehensive and complete understanding of the essence of the healthcare reform debate, its terminology and what needs to happen in order for the healthcare system to deliver in a budget neutral manner, universal coverage, affordable to all without massive increases in personal and corporate taxation. DeGerome's solution, The Cure, carefully analyzes how simple reforms of private marketplace healthcare delivery systems and tax deductibility can accomplish this goal.

In *Eliminating Healthcare Disparities in America* (2007), Dr. Richard Allen Williams assembles the very best scholars on healthcare disparities to raise the public consciousness of this issue. These experts provide the benefits of their experience and

[2] Risk segmentation can be achieved by separating individuals of differing risks into different health insurance products, denying coverage outright or limiting the benefits offered to higher-risk populations, or allowing price discrimination within the same products according to health status. Greater segmentation will tend to make medical care less accessible for many with serious health care needs, either because coverage is denied or the financial costs are too great.

expertise as a resource for helping others to make judicious determinations about how to proceed in efforts to improve the disparities in American healthcare. Arranged into discrete categories, this volume contains comprehensive coverage, both historical and current, of the healthcare disparity crisis currently plaguing the country. The volume includes chapters of examples that are currently working and concludes with recommendations on how to move forward.

In *Protecting American health care consumers* (2002), Eleanor D. Kinney first analyzes the procedures by which consumer concerns in health care have been discerned and resolved and then explains why these systems are unsatisfactory. She also discusses problematic procedures for making coverage policy and quality standards and proposes reforms in a variety of processes that would enable all consumers, including the uninsured, to influence key policies and standards and also to raise concerns and obtain appropriate remedies. This book is one of the first comprehensive treatments of administrative procedures in American health plans.

Finally in Bob Laszewski's review of the latest developments in federal health policy (Laszewski 2008), notes that the final draft of the bill is full of compromises, political and otherwise, and the Democratic health care bill doesn't even come close to be deserving it to be called a "health reform bill". He objects to how the Democrats have termed the bill, as a moral imperative to push through an agenda that will fall way short in meeting the challenges and problems the health care system faces today. He points out four areas where the bill would be a failure, they are

- It is unsustainable, and promises are being made that cannot be fulfilled. As the president had pointed out that a fundamental change is required in the health care system otherwise the Medicare and Medicaid entitlements would bankrupt the health care system, the final draft of the bill contains such a watered down version of the cost containment policies that it would not sustain itself
- The final version of the bill still pays off the people who are profiting the most from the status quo. The drug deal, the hospital deal, promises not to cut or change the ways the physicians are paid would add up to more guaranteeing the status quo rather than changing the system.

- Nothing in the bill would fundamentally change the current fiscal course, as the experts as well as the CBO are saying. The CBO says the plan would reduce costs during the next ten years by about $100 billion, but that would be miniscule compared to the $32 trillion that would have been spent anyway.
- The bill would not stop unaffordable health insurance rate increases as there is little in the bill that would mitigate or control any such increases because so little would be done to impact the underlying health care costs.

In summing up the various articles on the health care bill, it would be safe to say that, although the bill would be passed more because of the moral imperative and the definite need to do something about the health care system, the bill would most probably fall short on meeting the current and future problems the health system faces. The system itself seems to be in need of reforms rather than particular departments or areas of the health system.

RESEARCH PROBLEM

The Obama plan seeks to control the spiralling cost of health insurance premiums as well as the health insurance itself. In order to do this a public option of health insurance will be floated where people would be able to buy insurance according to their needs with no prior screening nor denies patient coverage due to pre existing health conditions. But everyone would have to buy health insurance to offset the risk and the cost of the project, and the government would offer subsidies for low income groups and small businesses. The goal of this bill is to make health insurance universal as well as check the rapid rising rate of health insurance. Several problematic questions arise from this proposition, ones that this dissertation has addressed are as follows:

- Is the bill sustainable in the long run with no systemic changes proposed in the health system?
- The bill might be paying off people already profiting from the status quo with a significantly watered down version passed.

- Can this bill fundamentally change the course of the current fiscal deficit that is spiralling out of control?
- How will the bill help in mitigating unaffordable insurance rate increases?
- Will it substantially increase access to affordable and adequate coverage for those with the highest health care needs, including those with chronic illnesses, by spreading health care risk broadly?
- Will it significantly increase the affordability of care for low-income individuals?
- With six public options already available in the form of Medicare, Medicaid, Military Medicine, Department of Veterans Affairs, Tricare and Federal Employees Health Benefits Program already running huge deficits, how would adding another public option on health insurance guarantee success?

HYPOTHESIS

The U.S health care system needs health system reform and not health insurance reforms and universal coverage will only make things worse if the system itself does not become more efficient and less costly.

RESEARCH METHOD

The basic research approach has been description and analytical. The dissertation will basically progress from an analysis of the steps taken to achieve universal coverage extrapolated with a study of their advantages and disadvantages as regards the health care industry and the country's citizens. Therefore, it is only natural to start out by answering a few questions regarding the history of health care in the U.S. and the age-old problems of opposition to universal coverage associated with it. It is important to analyze why at every turn in the history of the country's policy-making the promise of universal health care has been met with stiff opposition. Regarding data collection and source materials, this research benefitted greatly from public documents, official government documents and mass media proliferation of this subject. To aid this

dissertation further, books, journals and televised documentation of debates and arguments as well as internet sources have been widely consulted.

STRUCTURE OF THE STUDY

The present dissertation has been divided into six chapters, inclusive of the introduction and conclusion:

INTRODUCTION

The purpose of this chapter is to situate the topic in its context. The chapter briefly discusses the problems faced arising out of the inefficient and flawed structure of the American Public Health System. Various authors' opinions have been analysed and discussed for a deeper understanding of the Health system itself.

HISTORY OF THE PUBLIC HEALTH SYSTEM

The second chapter discusses in detail, the early origins and evolution of the Public Health System from its humble beginnings in the late eighteenth century uptil the end of the twentieth century. The achievement of the public health system as well as its failure has been briefly discussed.

NEW PRESIDENT, NEW PLAN

The third chapter traces and discuss the build up of the health reform bill from the days of Obama's Presidential campaigning right up to his election. This chapter also outline and compare the characteristics of the public plan, viz, access, cost containment and financing, including subsidies and the public plan's market power of the both the Presidential candidates, John McCain and Barack Obama, as well as Hillary Clinton's.

OPPOSITION PARTIES AND LOBBYISTS

The fourth chapter deals with the stand taken on the health care bill by the Republican Party and similar groupings on the right of American politics, such as the Tea party movement as well special interest groups like the drug companies, the doctors associations as well as the private players of the insurance companies as well as other special interest groups.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The fifth chapter deals exclusively with the passage of the bill as well as the pros and cons of it. This chapter tries to critically dissect the bill into different areas and try to analyze the impact and changes it proposes to make and bring about as well as the shortcomings the bill may have in the future.

CONCLUSION

The conclusion summarizes the findings of each chapter and highlights proven propositions.

CHAPTER TWO

HISTORY OF THE PUBLIC HEALTH SYSTEM

INTRODUCTION

The American health care system is built around two complementary yet, unfortunately, often competitive models of health care. The first model -- the curative model-- emphasizes treatment and cure of illness and diseases. It is built around efforts designed to improve diagnostic and treatment/cure capabilities through the discovery of better drugs, surgical techniques, and life sustaining and prolonging technologies. The second model -- the preventive model -- emphasizes prevention of illness, diseases, and promotion of health. It is built around efforts designed to prevent illness and diseases through promotion of a healthy lifestyle at the individual level and to discover and address environmental factors that contribute to ill health at the community level. The activities and services associated with prevention of illness, diseases, and promotion of health are what is generally referred to as public health. Public health has often been defined to include all knowledge and measures designed to foster health or prevent disease. This includes the recognition that "health" means much more than just the absence of disease (Winslow 1997).

These two models have competed for pre eminence in the American health care system. Despite the accomplishments and successes of public health services in the United States, the curative model has dominated the American health care system since the second half of the twentieth century. In contrast, the public health system in the United States has suffered significant damage due to the politics of benign neglect.

ACCOMPLISHMENTS OF THE PUBLIC HEALTH SYSTEM

Public health in the United States has had many successes and accomplishments to its credit. During the twentieth century, public health activities helped significantly improve the quality of life in America. According to an annual report released by the Centers for Disease Control and Prevention (CDC), Americans are healthier today than they were twenty-five years ago because of fewer smokers, less hypertension, lower cholesterol levels, better infant survival, and longer life expectancy ("CDC report finds Americans....." 2001). During the twentieth century, life expectancy increased by almost thirty years. In fact, life expectancy for persons in every age group also increased (U.S Department of Health and Services 2000). Of the thirty year gain in life expectancy, twenty five years of the gain is attributable to advances in public health ("Public health achievements" 1999). Smallpox has been eradicated and polio has not been seen in the United States since 1979. Cardiovascular deaths have also declined significantly (Lee 1994).

According to the CDC, the top ten accomplishments of public health in the United States during the twentieth century include elimination of several infectious diseases due to the widespread use of vaccines, decreases in deaths related to motor vehicular accidents, declines in rate of fatal occupational injuries due to safer workplaces, better control of infectious diseases due to better sanitation, fewer coronary and stroke deaths, safer and more healthy foods, dramatic decreases in maternal and infant mortality, better family planning, significant decline in tooth decay and tooth loss with the addition of fluoridation to drinking water, and prevention of millions of smoking-related deaths due to increased recognition of the hazards of smoking(" Medical triumphs" 1999; "Ten great public health achievements" 1999). The 1980s alone saw a major decline in death rates for three of the leading causes of death among Americans-heart disease, stroke, and unintentional injuries. Some childhood diseases were nearly eliminated, and infant mortality also declined (U.S Department of Health and Human Services 1990).

SHORTCOMINGS OF THE PUBLIC HEALTH SYSTEM

Despite the great strides taken and achieved in the public health system in America, many problems remain. According to the World Health Organization (WHO), the overall life expectancy for babies born in 1999 in the United States is seventy years. The United States ranks only twenty fourth in healthy life expectancy ranking[1] among all member states (WHO Press Release 2000). Despite the fact that the United States ranks first among all WHO member states in health expenditures per capita in international dollars, it ranks fifteenth on the index of overall health system attainment, seventy second on the index of performance on the level of health, and thirty seventh on the index of overall health system performance (World Health Organization 2000).

According to a report of the Institute of Medicine (1988), the role and mission of the public health system is not clearly defined nor fully supported. Many health departments suffer problems of health care delivery, financing, and quality of personal health services. Public health services have fallen into disarray and the ability of the public health system to take effective actions to deal with continuing and emerging public health threats is questionable. According to the report, public health as a vital function is in trouble and many public health issues have become inappropriately politicized. In addition, public health responsibilities have become highly fragmented, and the public health system suffers from a hodgepodge of fractionalized interests, organizational turmoil, and unbalanced appropriations. A recent report by the Institute of Medicine (2002) concludes that not a great deal has changed since its 1988 report. The report argues that public health law at all levels of government is outdated and internally inconsistent creating inefficiency and lack of coordination. It further argues that the public health workforce is not receiving appropriate education and training to perform its current role. The current infrastructure burdens the work of the state and local public health agencies with too many administrative requirements. Furthermore, the report concludes that the Department of Health and Human Services (DHHS) currently lacks the capacity for conducting

[1] Health life expectancy ranking is based on the WHO's Disability Adjusted Life Expectancy (DALE). DALE summarizes the expected number of years to be lived in what might be termed the equivalent of "full health". To calculate DALE, the years of ill health are weighted according to severity and subtracted from the expected overall life expectancy to give the equivalent years of a healthy life.

regular evaluation of the adequacy and ability of the governmental public health infrastructure.

Critics also argue that the American public health system, once the envy of the world, has fallen into disrepair with government laboratories running short on funds and equipment, and emergency preparedness plans that are antiquated (Kluger, Bjerklie, Dorfman and Goldstein 2002). According to a report issued by the Institute for the Future (2002), public health is likely to continue to be underfunded and marginalized; efforts designed to address some of the underlying problems will continue to be incremental rather than dramatic.

The CDC has listed ten public health goals for the twenty-first century. They include eliminating health disparities, establishing a rational system of health care, focusing on children's physical and emotional development, achieving a longer "healthspan", integrating physical activity and promoting a healthy lifestyle, cleaning up and protecting the environment, preparing to respond to emerging infectious diseases, reducing the toll of violence in society, recognizing the contribution of mental health to overall health, and making wise use of scientific knowledge and technology (Koplan and Fleming 2000).

A report by the Institute of Medicine (2002) calls for action and change in six areas to address the present and future challenges faced by the American public health system. The six areas for action include adopting a population-based approach that considers multiple determinants of health, strengthening the government's public health infrastructure, building new intersectional partnerships, developing a system of accountability, decision making based on evidence and enhancing and facilitating communication between health professionals and community members.

The goals and challenges facing the U.S. public health system outlined by the CDC and the Institute of Medicine are daunting challenges, and meeting these challenges will require a strong political will, a significant commitment of monetary resources, and public health leadership.

HISTORY OF PUBLIC HEALTH POLICY IN THE UNITED STATES

"The history of public health in America has not been of constant and steady upward progress. One has only to glance at present public health statistics to realize how much still remains to be done. Yet public health, like politics, is the art of the possible" (Duffy 1990, 315). One of the best and most comprehensive accounts of the history of American public health is provided by John Duffy in *The Sanitarians (1990).* Duffy identifies three themes that run through the history of American public health. The first theme centers around the fact that public and community reactions to periodic public health crises have alternated between apathy and strong collective responses. For example, during the colonial period the public reacted strongly to yellow fever and smallpox by taking collective preventive actions. Yet, the diseases responsible for most of the sickness and death, such as malaria and respiratory infections, did not generate much public and community reaction. Since America is a land of immigrants of different cultures, the second important theme in the history of American public health is the impact of acculturation upon public health, that is, how various groups of immigrants have been integrated into American society with respect to how to live and interact with their environment. The third theme is the constant friction between individual and civil liberties on the one hand and public welfare on the other as the government tries to regulate individual behavior in order to protect community health. This issue is certainly at the heart of a democratic society. The task of public health officials in the United States is made more difficult by the general American distrust of government laws and regulations (Cantril and Cantril 1999; Wills 1999).

Duffy (1990) also argues that American public health policy has been influenced by three key factors. First at any given point in time, public health measures and policies to be used are always influenced by the medical concepts predominant at that point in time. For example, if a sickness or disease is attributed to the gods, then prayers and sacrifices may be considered the most appropriate responses for treatment. A second factor that shapes public health policies is the prevailing social attitude. If the public equates certain sicknesses or diseases with individual failings and sins, as was the case with venereal disease in the past, society may show no inclination to try to cure or prevent it. The slow

response to the AIDS crisis in the United States to some extent reflected such societal attitudes (Shilts 1987).

The third factor that shapes public health policies is role of government in a country's economy. Government regulatory policies are influenced by what the dominant political ideology views to be proper relationship between government and business or industry. For example, in American society, mistrust and suspicion by the citizens of government in general and national government in particular do not allow the national government to play a major role in the national economy except during a period of crisis. The mistrust of government is a reflection of the constant tension between the philosophy of Lockean liberalism, in which government is supposed to play a neutral role to allow individual self-interest to prevail in the market-place, and the philosophy of republicanism, which advocates a more positive role for the government in order to ensure the primacy of the commonwealth. The result is that businesses in the United States are subjected to piecemeal regulations for specific purposes without a clear overall purpose (Ballam 1994).

(Patel and Rushefsky 2004) add a fourth factor- prevailing politics- as another important factor that shapes the formulation of public health policies. Which party is in power and which political ideology is dominant at any given point in time determines how confidently governments wields its authority and deploys its regulatory power to protect public health (Scheiber 1997). The formulation, adoption, and implementation of public health policies are influenced by social and political processes (Nathanson 1996). The political culture of a country is important to the conception of policy solutions because policy innovation is guided by what is culturally imaginable, and policy implementation is guided by structural constraints and opportunities (Dobbin 1994).

THE COLONIAL PERIOD: SEVENTEENTH AND EIGHTEENTH CENTURIES

The first two hundred years of American history were a period of rapid population growth marked by the dramatic appearances of diseases such as diphtheria, measles, smallpox, and yellow fever. They often had devastating effects and wiped out as much as

10 percent of a community's population in a few months. Smallpox and yellow fever were two of the most feared diseases. However, the diseases that were the main killers on a regular basis included malaria, dysentery, typhoid, and smallpox. Death rates were horrendous during the early colonial period. Data compiled from 1778 to 1795 in Rhode Island indicated that 20 percent of deaths occurred in people older than sixty years (Mermann 2000). The first colonists reported unprecedented epidemics among the native people.

During this period, colonists believed that all diseases were an expression of Divine Providence (Jimenez 1997). For example, in 1633 a New England colonist reported that "it pleased God to visit these Indians with great sickness" (Taylor 2001, 41). Health, sickness, recovery, and death, even in children, were considered acts of God that served a divine purpose. For example, a smallpox epidemic in 1689 was considered the work of God. Similarly, following the yellow fever epidemic in 1798, the Common Council of the city of New York declared February 5, 1799, a day of thanksgiving, humiliation, and prayer (Bloch 1974).

Thus, it is not surprising that health guides and medical advice tracts of the time urged readers to avoid behaviors and emotions that could lead to disease. Strong emotions such as anger, fear, grief, and envy were often linked to ill health (Jimenez 1997). The desire to ensure that the welfare of the colony, that is, the community, prevailed over that of the individual led colonial governments not only to direct business activities but also to engage in extensive supervision of personal conduct and behavior (Ballam 1994).

One of the first public health laws in Massachusetts limited the number of passengers on a ship according to the size of the vessel, recognizing that overcrowded conditions posed serious health problems on long ocean voyages. Concern over aesthetics and a vague sense of connection between sickness and purification also led the town of Boston in 1634 to prohibit residents from depositing fish or garbage near common landings (Duffy 1990). This was the beginning of many colonies passing a variety of sanitation laws. Butchers and slaughterhouses were ordered to keep their premises clean. Scavengers were appointed by local authorities to impound stray cows and horses and remove dead

animals from the street. Similarly, as the export of food increased, inspectors were appointed to supervise the packing of barrels of flour and meat (Duffy 1990).

Another strategy used by the colonists to deal with epidemics was the use of quarantine. Colonial quarantine regulations were adopted around the same time as other sanitary measures. The quarantine function during colonial times was left entirely in the hands of state and local authorities. This continued until the nineteenth century (Cumming 1921). Thus, by the end of the seventeenth century, several colonial towns had passed rudimentary but basic sanitation laws, and quarantine regulations were enforced during a health crisis.

THE EIGHTEENTH CENTURY

During the eighteenth century there was an immense growth in the colonial population. This led to the creation of a more complex society as communities grew into towns and towns grew into small cities. Local authorities passed more specific ordinances and regulations governing sanitation, food and water supplies. The need to take care of the poor and sick also led to the development of alms houses. The 1700s also witnessed the establishment of several hospitals. However, they mainly became places where the sick went to die. An expanding population and crowded conditions provided a potent ground for the spread of diseases.

The development of business in colonial America was shaped by a philosophy of mercantilism in which trade was the driving force (Ballam 1994). The growing trade with Europe, Africa, and the West Indies also led to importation of many diseases to the colonies. Two of the diseases that aroused the most attention were smallpox and yellow fever. Diphtheria was another major concern. However, the most important threat to health and life during the colonial period was from malaria. Ironically, the lack of roads or a modern transportation system also made it possible to confine the spread of disease by an effective quarantine at port cities. In many local communities, quarantine laws were strengthened. For example, cities such as Philadelphia and New York adopted strict quarantine regulations. Under such regulations, ships arriving from an infected port or

with sickness aboard were required to get permission from local authorities before they were allowed to land passengers or goods at port.

Sanitation and lack of adequate drainage in communities also became major concerns. Drains and open sewers had become fertile grounds for the spread of diseases. The growth of the population combined with the waste produced by the emergence of slaughterhouses, fish mongering, and butchering added to the problems. Water supply was also an area of major concern. However, the majority of local authorities were reluctant to impose regulations and fines against businesses. Water supply remained primarily a citizen responsibility, although some local authorities had begun to take on responsibilities for public wells and adopt some regulations about water supply. Even though the effectiveness of inoculation in limiting the devastation caused by smallpox was demonstrated as early as the 1721 epidemic, it remained a very controversial procedure. In fact the careless use of inoculation often helped spread the disease and thus many communities opposed such measures. Nonetheless, the practice of inoculation slowly spread throughout the colonies and had become widely accepted by the time of the revolution for independence.

The disruption of civic life caused by the Revolutionary War led to widespread epidemics. Crowded army camps were ideal grounds for the spread of disease. As the fighting moved into the Southern colonies, troops from the North suffered a great deal from malaria (Duffy 1990). The smallpox epidemic also accompanied the American Revolution between 1775 and 1782. George Washington had to decide between variolation or quarantine as the best method to protect American troops. Variolation of the troops could increase the exposure to the rest while inoculation would have made American troops defenseless for weeks against British attacks. Britain had opted for variolation for their troops. In the beginning, George Washington opted for quarantine over variolation, which proved to be ineffective. Given the fact that American troops were more vulnerable to smallpox, Americans suspected that the British practiced a crude form of biological warfare by sending infected civilians and clothing within American lines (Fenn 2001). Ultimately, the general use of inoculation brought smallpox under control.

For a few years after the Revolutionary War, the basic pattern of sanitary regulations that was established during colonial times continued to be enforced with few modifications because the new nation was occupied with establishing a national government and state constitutions. However, the situation changed with the emergence of a potentially catastrophic yellow fever epidemic that afflicted Philadelphia in 1793 (Scutchfield and Keck 1997). Yellow fever attacked several other port cities such as Baltimore, New Haven, and New York in 1794 and 1795, but the one in Philadelphia was the most serious since the city was the capital and cultural center of the newly independent nation, and virtually the entire government was forced to desert the city. More than one-tenth of the city's population died despite sanitation and quarantine measures used by the city (Shonick 1993). The city of Baltimore, in response to yellow fever in 1794, built its first quarantine station under a legislative mandate (Markel 1995). Local health committees established to deal with the crisis in other cities, such as New York, also used quarantine measures to prevent the spread of diseases. The dramatic situation created by the yellow fever epidemic during the 1790s forced local and state governments to assume greater responsibilities in the area of public health activities. It also provided a major impetus to the sanitary reform movement.

The origins of the federal government's involvement in public health can be traced to the provision of medical and hospital care of merchant seamen and sailors. In 1798, Congress passed the Act for the Relief of Sick and Disabled Seamen to finance the construction and operation of public hospitals in port cities. The act created a tax on the salaries of sailors, and the revenue generated through the tax was to be used for the construction of public hospitals and medical care of merchant seamen. This was the first time that the federal, state, or local government had established a program for a specific group of people rather than a general health program (Anderson 1990). This established the Marine Hospital Service. Initially the service was a loosely knit group of hospitals for merchant seamen. In 1870 it was reorganized, and the administration of the hospitals was centralized in Washington, DC. A supervising surgeon was appointed head of the service in 1871, and in 1912 the Marine Hospital Service was renamed the Public Health Service (PHS) (Gist 1998; Parascandola 1995; Lee 1994).

THE NINETEENTH CENTURY

Sanitation reformers stressed the need for clean water and air, and pure food. Cleanliness came to be viewed as necessary for the preservation of life and health. A connection was beginning to be seen between the quality of water, air, food and illnesses. This led to increased support for the strengthening local government structures to prevent or palliate the epidemics. However, this is not to suggest that a sanitary revolution was well under way. The major emphasis to prevent epidemics remained on quarantine measures and isolating disease victims in pest houses. The high cost of sanitary measures also worked against sanitary reforms (Duffy 1990).

In addition, unlike their predecessors, antebellum writers stressed health promotion and disease prevention. Health reformers were especially concerned with growing urbanization, commercialization, full-scale manufacturing, and increased immigration. Interest in public health grew out of health problems connected with urban growth in the early nineteenth century (Rosen 1958). The surge of epidemics led locally appointed health boards to look for causes of diseases. Antebellum urban sanitary reform was the first stage of the public health movement (Jimenez 1997). Early sanitary engineers sought to provide pure water- the urban sanitary infrastructure's triad- water supply, water treatment, and solid waste disposal- as a public good (Melosi 1999). Prior to 1850, local public health activities were largely a reaction to the onset of epidemics, and local authorities were content with passing quarantine and sanitary measures (Shonick 1993).

Smallpox was brought under control with inoculation, and the introduction of a vaccine in 1798 opened the path for prevention. In fact, in 1813 the federal government passed a law to encourage the use of vaccination to prevent smallpox. By 1830, vaccination had become a generally accepted practice.

The first third of the nineteenth century witnessed only limited advances in the functions and responsibilities of municipal government, such as the emergence of garbage collection and street- cleaning, temporary health boards, quarantine systems, public or private water systems, and nuisance inspections. The period from about 1830 to the start of the Civil War witnessed the emergence of vital statistics as an important public health

tool and the increasing role of medical societies. Improvement in the collection of vital statistics was aided by the American Medical Association (AMA), established in 1847, and the rapid growth of insurance companies around the middle of the nineteenth century (Duffy 1990). Between 1857 and 1860, several national sanitary conventions were held that called for sanitary and hygiene reforms.

However, the outbreak of Civil War in the spring of 1861 delayed the establishment of any national health organization. In the bloody Civil War, about six hundred thousand men lost their lives. Sickness killed twice as many people as did battle wounds. Crowded army camps produced widespread outbreaks of mumps, measles, scarlet fever, smallpox and other disorders. Soldiers also suffered from diarrhea, dysentery, typhoid and other illnesses due to poor food and unsanitary conditions. President Lincoln in June 1861 gave his approval for the creation of the United States Sanitary Commission, which provided assistance to soldiers. The commission also helped reform the Army Medical Corps.

The end of the Civil War helped usher in the sanitary revolution in the United States. By the end of the 1860s, several cities had established effective health boards, and the sanitary movement was well under way. The next thirty years witnessed the emergence of state health boards and the rapid expansion of urban health departments.

The American Public Health Association (APHA) was established in 1872, which ultimately led to the professionalization of public health. By the 1870s, public health reformers were pushing for the formation of a national system of quarantine and a national health board. In 1879 the United States Congress created the National Health Board, and it was given the power to enforce interstate quarantine laws that previously were the responsibility of the Marine Hospital Service (Anderson 1990). The board was responsible for formulating quarantine regulations but it soon became embroiled in a political battle over the issue of states' rights because local governments were unwilling to give up their powers to the national governments. Finally, in 1883, the National Health Board was abolished and its quarantine powers were returned to the Marine Hospital Service (Fee 1997).

In 1876 the discovery of the germ theory of disease by Louis Pasteur established the empirical causal link between germs and diseases (Gorham 1921). In his 1878 celebrated lecture to surgeons on the germ theory, Louis Pasteur warned of the dangers caused by the germs of microbes on the surface of every object (Walker 1930). In 1880 he published his germ theory of disease, in which he argued that all contagious diseases were caused by microscopic organisms (Garrett 2000). This provided public health with an empirical foundation.

In 1887, the first research facility, the Hygiene Laboratory, was established at the Staten Island Marine Hospital. In 1891 it was moved to Washington, DC. In 1889 the United States Public Health was commissioned with a regular corps of physicians (Hinman 1990). The sanitary revolution was fully under way during the last twenty years or so of the nineteenth century. City health departments were establishing vaccination programs and testing water, and the sanitation movement was beginning to improve the quality of life in America. Morbidity and mortality rates in large cities were declining.

However, it should be stressed that during the 1880s and 1890s the successful implementation of vaccination programs was often delayed by the anti-vaccination movement led largely by irregular physicians and lay-persons (Garrett 2000; see also Allen 2002). The movement was successful in opposing compulsory vaccination in schools. The anti-vaccination movement was also successful in using courts and legislatures to delay action on vaccination programs. Nonetheless, public health was becoming both institutionalized and professionalized, and public health departments were increasingly involved in educating the public about public health hazards (Duffy 1990).

THE TWENTIETH CENTURY

The rise of bacteriology combined with advances in pathology, physiology, chemistry, and other fields was beginning to enhance the understanding of the causes of various diseases as many pathogenic organisms were identified. Laboratory testing of water, milk and other foods had become an important function of local health departments. The rise of bacteriology and other scientific advances also contributed to the professionalization

of public health (Fee 1997). Advances in bacteriology and pathologic science also created an appreciation of the importance of laboratory facilities to identify agents of communicable diseases. Local public health departments became responsible for maintaining public health laboratories. In fact, by the first quarter of the twentieth century, most of the causes and methods of transmission of leading communicable diseases had been identified, and preventive measures had been developed. In the early 1900s the new public health movement expanded its role from environmental sanitation and concern with infectious disease to control of communicable diseases (Cassedy 1962).

State health boards, which were weak and ineffective agencies staffed by volunteers, were transformed into strong state departments led by public health professionals between 1900 and the 1940s. Several factors contributed to this transformation, including the Progressive movement, which demanded better government and a better quality of life; urbanization, requiring more attention to be focused on sanitation and health; the influence of strong local health leaders, who had moved into state governments; and the efforts of private foundations and the federal government (Duffy 1990).

The bacteriological revolution combined with other developments in medicine also strengthened the position of the medical profession, and physicians came to dominate public health. For example, during the early years of the APHA, a large majority of its membership was made up of physicians. The method of identifying disease through microscopes and the demonstrated diagnostic power of public health laboratories moved the focus away from environmental reform and narrowed the distance between medicine and public health, creating conflict and tension between the two as physicians increasingly became resentful of public health officials' claims to diagnose and treat infectious diseases (Fee 1997). For example, physicians strongly opposed and tried to defeat passage of the Sheppard-Towner Act of 1921, which authorized federal grants to state health departments for maternal and infant hygiene, because they saw this as a threat to their profession and income.

As the demand for public health professionals increased, separate schools of public health were established through financial support from private donations. For example, the Harvard School of Public Health was funded by philanthropists (Garrett 2000). The Johns

Hopkins School of Hygiene and Public Health was established in 1916 by a Rockefeller foundation grant. Soon, several other schools of public health were established following the John Hopkins model. This combined with other developments ultimately helped public health establish an identity separate from that of private medicine (Duffy 1990).

By the beginning of the twentieth century the federal government was also becoming more active. In 1902 a permanent Census Bureau was established by the federal government to collect vital statistics. The Federal Food and Drug Act was passed in 1906 to supplement state control and regulation of food and to encourage cooperative efforts between the federal and state governments. The Hygiene Laboratory established in 1887 became the National Institute of Health (NIH) in 1909. In 1912 the name of the United States Marine Hospital Service was changed by Congress to the United States Public Health Service (USPHS) and it was authorized to study and investigate causes of diseases and provide information for the public. During the same year the Children's Bureau was established in the Department of Commerce and Labor to address concerns raised about child labor laws. The bureau was soon involved in health-related activities such as maternal and child welfare and infant mortality. In 1921, Congress passed the Sheppard-Towner Act to provide federal grants-in-aid to states for maternal and child health programs to reduce maternal and infant mortality.

By 1935, not only had public health become professionalized, it had also become an important government function performed by agencies at the local, state and to some extent, national levels. All major cities had public health departments and laboratories. Most states had established state health boards and were supervising and monitoring local public health activities. The federal government was working closely with state governments in performing quarantine services and providing some federal financial aid to improve sanitary services. The federal government also provided funds to states for public health training, which helped develop programs for controlling specific diseases, expand local health departments, and increase training of personnel, among other improvements (Fee 1997).

The Social Security Act of 1935 was the first broad-based social welfare legislation passed in the United States. It provided old-age benefits, unemployment insurance, and

public health services. Under the law, federal funds were made available to states for maternal and child health services and expansion of other public health services. In 1937 the establishment of the National Cancer Institute (NCI) expanded public health services' involvement in laboratory and field research, but more important, it provided grants-in-aid to nongovernmental institutions for research to improve the general public health (Snyder 1994a).

World War II also provided public health services with an opportunity to play a major role in American health affairs. During the war years the PHS was responsible for medical and sanitary support for the different of the armed forces. The PHS also instituted a training program for nurses. In fact, in 1943, Congress created the Cadet Nurses Corps within the PHS, and between 1943 and 1948, 124065 nurses graduated from the Cadet Nurses Corps (Willever 1994).

Post-World War II, medical research and science had become the hallmark of health care and medicine in the United States as large sums of grants were awarded by the federal government for basic research and medical technology. Public health professionals were confronted with new community health problems such as alcoholism, drug addiction, smoking, exposure to radiation, heart disease, cancer, mental illness and environmental hazards, among others.

Changed societal conditions following World War II necessitated a new definition for the role of public health professionals. This came in the form of two laws passed by Congress. The first law- Public law 78-184 signed in November 1943- reorganized the Commissioned Corps along military lines and integrated PHS functions into four subdivisions: Office of the Surgeon General, the NIH, the Bureau of Medical Services and the Bureau of State Services (Snyder 1994a). Under this law, the PHS turned into a tightly knit bureaucracy managed by public health professionals. The second law- Public law 78-410, the Public Health Service Act, passed in 1944- codified all of PHS's responsibilities and strengthened the hand of the Surgeon General (Snyder 1994a, 1994b).

The 1994 law gave public health its mission and was a significant innovation in national policy. It helped make scientific research a major area of priority by providing funding for biomedical research at private institutions, the training of public health professionals, and the building of new health care facilities. The USPHS became the leader in implementing national policy based on the new consensus that medical science was the main cause of progress in the fight against disease. In 1946, Congress passed the Hill-Burton Act, which led to the expansion of hospital capacity. The same year the Communicable Disease Centre (CDC) was established (Fox 1994). In 1948, Congress established the National Heart Institute (NHI), the National Biological Institute (NBI), and the National Institute of Dental Research (NIDR) as part of the National Institute of Health. The National Institute of Health itself was renamed National Institutes of Health (NIH). The National Institute of Mental Health (NIMH) was added to the NIH in 1949. The budget of the NIH grew from $46.3 million in 1950 to $400 million during the next decade. Americans placed their hope in the belief that the magic of science and money in terms of biomedical research would lead to finding cures for leading killers such as cancer and heart disease. The curative model of health care began to replace the preventive model.

One issue that did gain prominence in the field of public health was that of community or social medicine (Henig 1997). Epidemiology came to be viewed as an essential discipline for dealing with both chronic and infectious diseases. The idea that community health can be quantitatively measured helped broaden the scope of epidemiology to place more emphasis on the social environment, giving rise to medical ecology. However, under the onslaught of biomedical research, the theoretical innovations of social medicine -- the idea that advances in diet, housing and public health nursing were more important than building hospitals -- were not translated into effective public health programs, and public health services suffered from neglect (Fee 1997).

During the 1950s, public health professionals showed political naiveté by not taking credit for controlling infectious diseases and other scientific achievements during World War II. In the public's mind, many of these successes came to be attributed to scientific medicine and not to public health. Public health expenditures also failed to keep pace

with the increase in population because public health professionals failed to assert a strong political presence or even recognize the importance of politics to public health. In recognition to this fact, the annual meeting of the APHA in 1958 was devoted to the discussion of the politics of public health (Fee 1997).

Similarly, many of the new health and social programs created in the 1960s, such as the War on Poverty programs along with Medicaid and Medicare, bypassed the structure of public health agencies and created new agencies to deal with federal-local government relations. The same was the case with environmental issues in the 1970s. For example, a separate Environmental Protection Agency (EPA) was created to deal with environmental problems. Mental health agencies were often separate from public health agencies (Fee 1997). In fact, by the 1960s those medical areas most immediately connected to public health, such as family practice, infectious disease, pediatrics and medical social work had lost prestige and status while medical specialties connected with hospitals such as oncology, surgery, cardiology and the like had risen to the top in terms of money, prestige and status (Garrett 2000).

While during the 1960s and 1970s the focus was on expanding the capacity to deliver health services, during the 1970s and 1980s the focus turned to cost containment, quality control, practice guidelines and peer review (Henig 1997). This was reflected in various government policies such as the establishment of Health Maintenance Organizations (HMOs), Health System Agencies (HSAs) for the planning of health care facilities, Peer Review Organizations (PROs), and the Prospective Payment System (PPS), also known as Diagnostic Related Groupings (DRGs) for Medicare reimbursement to hospitals. During the Reagan administration, funding for public health programs was cut, and state health departments were left with the task of managing the Medicaid program that delivered health care to the uninsured and indigent populations, severely straining state budgets. The Medicare program shifted American health expenditures toward end-of-life care and away from public health's most important activity, that is, prevention. The AIDS epidemic in the 1980s and the failure of the public health system to respond quickly to the crisis revealed significant weaknesses in the public health system. The Institute of

Medicine's report *The Future of Public Health* (1988) highlighted many of the major shortcomings of the U.S public health system.

The euphoria for the overhaul of the American health system and health care reform that gained momentum during the presidential campaign of 1992 and the election of Bill Clinton to the presidency faded when Congress failed to pass any of the competing health care reform proposals during the summer of 1994. During the 1990s, managed care and managed competition became the new buzzwords for health care cost containment, with marketplace medicine taking centre stage. The role public health will play in such a market place is still evolving.

By the late 1980s and 1990s significant criticisms of the public health system had emerged, pointing to many shortcomings. At the beginning of the twenty-first century, the American public health system resembled a hodgepodge of programs and agencies rather than a coherent system. The emphasis on individualism and individual rights had led to the neglect of the crucial role played by public health activities in maintaining and promoting community health. Most of the legal authorities of the public health system had been stripped by the 1950s. The America that had been the role model for designing and implementing the public health program in the 1890s had become a nation that had neglected its public health system by the 1990s. The American public health system, once an envy of the world, was in shambles by the end of the twentieth century (Garrett 2000).

In 2000 the APHA became more active in promoting laws designed to improve public health ("APHA promotes public health legislation" 2001). Congress passed several key laws to benefit public health activities. The Minority Health and Health Disparities Research and Education Act of 2000, also known as the Health Care Fairness Act, established a new centre for research on minority health and health disparities. The Children's Health Act of 2000 was designed to expand research and treatment on childhood issues such as diabetes, asthma and autism, among others.

The Public Health Improvement Act of 2000 passed by Congress contains a comprehensive package of public health laws. One is the Public Health Threats and Emergencies Relief Act. It is designed to strengthen the country's capacity to detect and

respond to serious public health threats such as bioterrorist attacks and bacterial resistance to antimicrobials. Under the twenty-first Century Research Laboratories Act, the NIH will provide grants to improve the infrastructure of United States' research institutions by renovating biomedical and behavioral research facilities throughout the country. Other laws are designed to expand and intensify research and other activities with respect to lupus, prostate cancer, Alzheimer's disease and to develop treatments for sexually transmitted diseases through NIH research ("Public Health Improvement Act of 2000" 2001; "Legislation to Benefit Key Public Health Issues" 2001; Benjamin 2001).

The terrorist attacks of September 11, 2001, on the Twin Towers of the World Trade Center in New York and on the Pentagon in Washington, DC, followed by the anthrax-laced letter mailed to Sen. Tom Daschle (D- South Dakota) and the death of five citizens exposed to anthrax, raised the specter of a bioterrorist attack in the United States and questioned the preparedness of United States' public health agencies to deal with such an attack. The significant amount of media coverage dealing with the anthrax exposure cases and the public health agencies' handling of these cases put the spotlight on the American public health system and helped raise awareness about the role of public health. This was reflected in an interactive poll conducted by the Harris Poll in which 77 percent of the respondents indicated that it was very or extremely important to strengthen the United States' public health system to detect, diagnose, treat and prevent infectious and other diseases ("Health Care Priorities" 2002).

The Bush administration's budget request for the fiscal year (FY) 2003 proposed $5.9 billion to improve the nation's public health system to defend against the deliberate use of disease as a weapon. The bioterrorism budget request included $1.8 billion for federal agencies and $1.6 billion for state and local public health agencies involved in bioterrorism defense. It also proposed to spend $650 million to expand the nation's stockpile of vaccines and antibiotics, to construct containment laboratories, and to conduct basic and applied research in new drugs (Miller 2002). President Bush also requested an increase of $3.7 billion, or 15.7 percent. For the NIH, with a significant amount of that money going to the National Institute of Allergy and Infectious Diseases (NIAID) for basic and applied research (Stolberg 2002). In May 2002 the House and the

Senate reached a compromise on a bioterrorism bill that included funding to expand the government's stockpile of antibiotics and vaccines and to tighten regulations of laboratories that handle deadly microbes. The bill also includes measures to improve food safety and protect water systems. Under the bill, states would get $1.5 billion in federal grants to prepare for a biological attack. Money is also provided to buy hospital equipment and to train medical workers to deal with a bioterrorist attack and to prepare for medical emergencies. Finally, the bill also provided $300 million to CDC to upgrade its laboratories and scientific equipment (Pear 2002).

Federal funding to state and local governments for bioterrorism-related programs and activities has increased significantly. In fact, the largest share of federal funding is dedicated to this cause. On the negative side, this has led to neglect of other needs. According to Georges Benjamin, executive director of the American Public Health Association (APHA), "We are funding preparedness and cutting everything else" ("Public Health: Costs of Complacency" 2004, 26). Public health budgets derived from state general funds have been reduced in states like Oklahoma, Indiana and Massachusetts (ibid).

Thus it appears that at the dawn of the twenty-first century, the U.S public health system is again in the spotlight as it attempts to address many of the shortcomings created by years of neglect. The success or failure of the American public health system will depend on how the politics of public health shapes future public health policies. The ability, capacity and willingness of public health professionals to enter the political arena to influence and shape public health policies will be a determining factor in their success or failure.

The mission of Public Health is to protect the community; however the community may be defined. The functions of public health are many and various. At a minimum they include surveillance, policy development and treatment (Schneider 2000, 6). The successes of public health have enabled people to live longer, healthier lives. But as can be seen in recent years, public health has had a secondary status in the health care system, had a nearly invisible presence, and been placed on a severely restricted diet of resources.

CHAPTER 3

NEW PRESIDENT, NEW PLAN

ANNOUNCEMENT OF CANDIDACY

Barack Obama's campaign for the 2008 Presidency is described by many political analysts as brilliant, remarkable, and almost flawless (Brill 2009). Despite his inexperience in national politics and limited experience in state politics (Obama was first elected to political office in 1994), he assembled a remarkably cohesive and effective "no drama" campaign team (Mendell 2007), which in turn helped him craft and deliver his message of hope and change that ultimately resonated with the majority of American voters on election night, November 4, 2008.

The origins of this "improbable" campaign, to use Obama's words, can be traced to July 27, 2004. Obama was on his way to an easy victory in his campaign for the U.S. Senate from Illinois when he was invited to give the keynote address at the Democratic Convention in Boston. Many pundits refer to this speech as the one which placed Illinois State Senator Obama before the national electorate and where he established himself as a different type of Black American politician (Souza 2008).

Obama described himself as post-civil rights, multi-cultural "Horatio Alger" (Obama 1995). He rejected the divisiveness of the left and the right that had marred American politics for decades and in his rhetoric embraced a singular United States of America while laying claim to the values of hope and change for a better America. That speech before millions of American television viewers generated a resounding outpouring of national support. Consequently, Obama toured the nation to introduce himself to the electorate, wrote a best-selling book, The Audacity of Hope (Obama 2006) to extend that introduction, and in January 2007, organized a presidential campaign committee.

On February 10, 2007, Barack Obama announced his candidacy at the Old State Capitol Building in Springfield, Illinois. Obama gave an initial insight into his presidential campaign philosophy by making his announcement at the same place that Abraham Lincoln, in 1852, gave his "House Divided" speech (Green 2003). Obama's

"Yes We Can" speech called for a house united not divided. However, it took his surprise victory over frontrunner, New York Senator and former First Lady Hillary Clinton, in the Iowa caucuses, on January 3, nearly one year later, to persuade political observers that the junior Senator from Illinois was a serious contender for the Presidency. The Iowa win and later South Carolina primary victory on January 19, galvanized support from what was rapidly becoming his base: youth, Blacks, Hispanics, and the distressed White middle class, both rural and urban (Todd & Gawiser 2009). As the campaign progressed, endorsements came from a diverse group of celebrities such as Oprah Winfrey, Caroline Kennedy, Julie Nixon Eisenhower, Maria Shriver, Senator Robert Byrd, Ted Kennedy, and many others.

PRE-PRIMARY CAMPAIGN DEVELOPMENTS

Senator Obama's campaign was especially energized by thousands of youthful volunteers working hard under the slogan, "Fired up! Ready to Go!" (Ifill 2009). With their support Obama won a string of primary and caucus victories beginning on Super Tuesday (February 5, 2008). By March 15 he had won primaries or caucuses in eleven states including Vermont, Wyoming, Mississippi, North Carolina, and Oregon. With these wins, pledged delegates and super delegates began a slow but decisive move to endorse Senator Obama's candidacy. After the primaries in Montana and South Dakota, Obama had enough delegates to win the nomination of his party (Todd and Gawiser 2009). Senator Clinton, recognizing this fait accompli, ended her candidacy on June 7th and endorsed Senator Obama for President.

CONTROVERSIES AND ALLEGATIONS DURING THE PRIMARY CAMPAIGN

Barack Obama's hard-won nomination after a six-month contest, where he was defeated in important primaries in Pennsylvania, Ohio, and West Virginia, rested on his ability to deflect and moderate political controversies. The controversy over Obama's pastor, the Rev. Jeremiah Wright, which surfaced in March 2008, was potentially the most damaging. Rev. Wright, the pastor of Trinity United Church of Christ in Chicago, was a leading proponent of Black Liberation Theology. In one taped sermon, Wright was seen and heard saying, "God Damn America." While he

meant this as a condemnation of the policies of the United States government, this and other controversial statements by Rev. Wright were offered as evidence of Obama's radical "un-American" beliefs (Ifill 2009).

Obama moved quickly to defuse the controversy. In response to Wright's remarks, he gave a speech in Philadelphia where he condemned the minister's words but also argued that the issue of race in the United States is complicated, contradictory, and oftentimes personal. To that point he said,

"I can no more disown [Rev. Wright], than I can disown my White grandmother, a woman who helped raise me. A woman who sacrificed again and again for me. A woman who loves me as much as she loves anything in this world. But a woman who once confessed her fear of Black men who passed her on the street, and who, on more than one occasion, has uttered racial or ethnic stereotypes that made me cringe. These people are a part of me (Ifill 2009)."

Obama talked at length in that speech about the gifts of America--freedom, opportunity, equality, and that even though racism exists, this country, this generation, and he personally, has moved beyond the injustices of the past. Obama's speech was widely embraced and accepted, but Wright's continued harangues forced the Obama family to leave Trinity Church.

Obama's credentials to be President were challenged on numerous other occasions such as with his alleged close association with former Weather Underground member Bill Ayers and the internet rumour that he was a secret Muslim because of his alleged education in a madrassa (religious school) while he lived in Indonesia with his mother and stepfather. Both Senator Clinton and Senator McCain, in their own separate ways, refuted these false charges (Brill 2009).

Other controversies concerning his actual position on the North American Free Trade Agreement (NAFTA), accusations about his patriotism because he stopped wearing an American flag pin in his lapel, his comments about small-town America at a San Francisco fundraiser, and Michelle Obama's verbal miscue about her love of country were all seized by both Democratic opponents in the primary and later Republicans in the general campaign as evidence of Obama's deficiencies as a presidential candidate and presumably as President. Through all of these controversies Obama was able to

use his powerfully persuasive rhetorical and analytical abilities to answer these charges and keep his campaign focused on the prize (Horn 2009).

Obama's remarkable victory, however, was grounded in more than his ability to deflect spurious charges. The genius of the campaign was his ability to inspire. Widely considered the best political speaker of the past four decades, Obama's words and his vision of a different America attracted the support of millions of previously cynical and disillusioned voters. Attracting these new voters proved crucial to his election victory (Souza 2008).

DEMOCRATIC NOMINATION

Barack Obama's presidential campaign raised nearly $750 million dollars, breaking all records for fundraising. The campaign, as importantly, established a new model for presidential fundraising, appealing to enthusiastic supporters including a network of millions of new voters for relatively small donations. It also incorporated the most advanced fundraising technology through the Internet and other electronic communication sources to far outstrip all of its opponents. In fact, the campaign's enormous fundraising abilities allowed Obama, a Democrat, to outspend his Republican opponent for the first time in recent memory (Thomas 2009).

Obama's national popularity became iconic as hundreds of thousands of voters turned out for his stump speeches. These large numbers were duplicated when Obama went overseas to solidify his foreign policy credentials. In July 2008, he travelled to Afghanistan, Iraq, Jordan, Israel, Gaza, Germany, France, and England. In Berlin, Germany, he gave a speech before a quarter of a million people. This was the largest audience for a presidential candidate travelling abroad. A united world without walls to divide was a central idea of this speech. With the tour completed, Obama returned to the United States, a respected citizen of the world who had just met with numerous heads of state and senior commanders of America's armed forces in Iraq and Afghanistan. He also became arguably the most popular American figure around the world (Street 2009).

On August 28, 2008, ironically the 45th anniversary of Dr. Martin Luther King's "I Have a Dream" speech, Illinois Senator Barack Obama accepted the nomination of the National Democratic Party at its convention in Denver. Again breaking precedent,

Obama gave his acceptance speech not in the Pepsi Centre where the party conducted its other business affairs, but at Invesco Field (formerly Mile High Stadium) before an estimated 85,000 supporters (Obama & Olive 2008). Just before the convention, he chose as his running mate Delaware Senator Joe Biden. Despite their contentious battles in a number of primaries in April, May, and June, Senator Hillary Clinton gave a gracious concession speech where she pledged her support for his candidacy and called for a unified Democratic party.

PRESIDENTIAL CAMPAIGN

Although Arizona Senator John McCain, the presumptive Republican nominee, and Barack Obama had been campaigning against each other since June of 2008, the national presidential campaign moved into its last, most intensive stage in early September after both parties had their conventions. Republican "Grand Old Party" (G.O.P.) nominee Senator McCain surprised most observers by selecting conservative, self-professed "hockey mom" Sarah Palin, the Governor of Alaska, as his vice presidential running mate. McCain hoped his selection would solidify his conservative electorate base and pull the "Hillary vote" of White middle-class women to the G.O.P. standard bearers. This strategy worked briefly as the McCain-Palin ticket witnessed a spike in the polls. However, the spike disappeared after several disastrous television interviews given by Governor Palin (Price 2009).

As brilliant as the Obama campaign seems in hindsight, it was also helped by an enormous stroke of political luck. The investment and banking crisis that began on Wall Street months earlier surfaced in mid-September with the request by President George W. Bush for an unprecedented $700 million dollar bailout of major banking, insurance, and investment firms by the federal government. The crisis took centre stage and allowed the American people to contrast the different approaches and proposals offered by the candidates as well as assess their reaction to the situation. Most observers concluded that Obama appeared to be the more deliberate, thoughtful and "presidential" of the two candidates during this period (Price 2009).

That "presidential" demeanour surfaced as well during the three major debates between Obama and McCain in September and October. Most of the polls of voters viewing the debates indicated that Senator Obama won each debate. He was calm,

cool, analytical, informed, and conveyed to the American electorate that he was truly ready to become the 44th President of the United States.

On election night, November 4, 2008, a crowd of nearly 125,000 gathered in Chicago's Grant Park to hear what they anticipated would be a victory speech by the man who was now the city's most famous resident. At approximately 10:00 pm Chicago time, the major networks announced that Barack Obama had won the Presidency. The multiracial crowd wearing Obama paraphernalia became a sea of emotion as thousands of people began crying and waving American flags. At 10:59 p.m. Barack Hussein Obama took centre stage to make his historic victory speech. The Obama era in American history had begun (Smith 2008).

HEALTH CARE PLAN: BARACK OBAMA'S HEALTH CARE PROPOSAL

The election of Democrat Barack Obama ushered in a new administration that was all but certain to include some level of health care reform. Less clear was how extensive that reform would be and when it would come. The Illinois senator had proposed sweeping changes in the health care system designed to provide health coverage to millions of uninsured Americans. Obama spoke often during the campaign about his mother's battle with ovarian cancer to illustrate his commitment to changing the health care system. He told of her final days, spent battling insurance company bureaucrats who did not want to pay for her cancer treatments. "I know what it's like to see a loved one suffer, not just because they are sick, but because of a broken health care system," he said at his campaign commercial (Barack Obama pulls out stops with... 2008) and at countless campaign stops before that.

Barack Obama said that his plan would extend health coverage by expanding existing private and public programs with the help of federal subsidies and mandates (Obama Wins: What It Means for Health Care 2008). An analysis and brief summary of Obama's proposal has been done by John Holahan and Linda J Bloomberg (An Analysis of the Obama Health Care Proposal 2008) which clearly elucidates the finer points of the proposal. They are:

OVERALL ASSESSMENT

Their general assessment of the Obama plan is that it would:

- Greatly increase health insurance coverage but would still leave about 6 percent of the non- elderly population uninsured, compared to 17 percent today.
- substantially increase access to affordable and adequate coverage for those with the highest health care needs, including those with chronic illnesses, by spreading health care risk broadly;
- significantly increase the affordability of care for low-income individuals; and
- reduce the growth in health spending through a broad array of strategies

In short, Obama's proposal contains the basic components necessary for effectively addressing the most important shortcomings of the current health care system, that is, limited coverage, inadequate risk pooling, and high-cost growth.

COVERAGE

Senator Obama suggests a new framework—the National Health Insurance Exchange (NHIE)—by which individuals without access to Medicaid, SCHIP, or employer-sponsored insurance could obtain coverage. Obama's plan would reach almost all children and more than half of uninsured adults (in 2007, there were 8.9 million uninsured children and 36.1 million uninsured adults) by

- extending eligibility for Medicaid and SCHIP,
- providing income-related subsidies for coverage in the NHIE, and
- offering a guaranteed source of purchasing insurance coverage, even to those in poor health.

A significant number of other Americans (about 5 million) would also be added to the ranks of the insured by requiring employers to automatically enroll their workers in employer-based health plans and permitting workers to opt out, as opposed to today's system in which workers must actively choose to participate.

RISK POOLING

The Obama plan would clearly increase risk-sharing, or risk pooling, by

- prohibiting insurance companies from using health status to determine price or deny coverage,
- making comprehensive benefits available to all through the NHIE, and

- using broad-based sources of revenue to finance health insurance subsidies, thus guaranteeing that all taxpayers, not just those voluntarily deciding to purchase coverage, share in the costs of providing medical care.

COST CONTAINMENT

Senator Obama's plan provides a number of cost-containment incentives, including

- spending $50 billion over several years to accelerate the adoption of electronic medical records and other efficient health information technology,
- creating the NHIE framework, which would result in increased insurer competition,
- repealing the ban on direct price negotiation between Medicare and drug companies and ending the overpayment of Medicare Advantage plans, and
- investing in public health and prevention, expanding chronic care management, and supporting an independent institute to conduct comparative effectiveness analyses on technologies and treatment options.

The plan's architects believe that they could save about 8 percent of health spending in these ways. Holahan and Blumberg agree that cost containment must be pursued on multiple fronts, and, if pursued aggressively, they would eventually achieve savings of the magnitude they envision.

OUTSTANDING ISSUES

Despite the positive aspects of the Obama's plan, there are a few significant concerns.

- While this plan would significantly increase coverage, it would still leave about 6 percent of the nonelderly population uninsured. As a consequence, the inefficient and costly safety net system prevalent today will need to remain in place.
- The approach relies on an employer mandate, which could increase costs to some businesses and engender the same political opposition that has contributed to the defeat of past reform efforts.
- The campaign's cost estimates ($65 billion) may be somewhat low, even if the campaign's cost containment initiatives are successful. Much depends on details that are unspecified, including subsidy levels, benefits, reinsurance, and

a phase-in schedule. How these are resolved will have significant implications for program costs.

HEALTH CARE PLAN: HILLARY CLINTON'S HEALTH CARE PROPOSAL

Democratic Senator for New York and US presidential candidate, Hillary Clinton's speech at George Washington University (Hillary Clinton Unveils Plan for Reducing Health Care Costs 2007), unveiled her strategy for health care reform, focusing on a seven point plan to reduce healthcare costs. Speaking to an audience of health professionals and academics, Clinton made light of the previous time she "tangled with the issue", in 1993 as First Lady (Clinton 2003), saying that she had the "scars to show for it" but had learned a lot from the experience. Clinton said there were three parts to her approach on healthcare: lowering costs, improving quality and making sure everyone is insured which she described as a "moral imperative" (Hillary Clinton Unveils Plan... 2007).

Clinton set the scene by describing how US healthcare presently costs 16 per cent of Gross Domestic Product and by 2016 it will be 20 per cent, "That means that within less than 10 years, 20 cents out of every dollar produced in America will be spent on healthcare," she said. This compares with a maximum of 12 per cent in other wealthy countries. "If we spend so much, why does the World Health Organization rank the United States 31st in life expectancy and 40th in child mortality; worse than Cuba and Croatia?" (Hillary Clinton Unveils Plan... 2007).

Clinton used the event to unveil her seven point plan to tackle the spiralling healthcare costs:

Focus on prevention: wellness not sickness. For example the retailer Safeway changed their whole employee healthcare system to incentivise and resource preventive activity and their healthcare costs stayed flat when the rest of the country's went up by 7.7 per cent. Clinton mentioned incentivising insurers by requiring those that deal with federal employee healthcare to bring in preventive strategies.

1. Use more computer technology: to increase security and accessibility of records, reduce costs and errors, and share research. For instance at the moment if you get taken into an emergency department they can't access your medical records to find out your history and current use of medication. After Katrina, many people's medical records were lost because they were on paper and damaged by the floods. "In fact, if all hospitals used a computerized physician order entry system, an estimated 200,000 fewer adverse drug events would occur, saving roughly 1 billion dollars per year (Hillary Clinton Unveils Plan... 2007)", said Clinton as a cost saving example.
2. Co-ordinate and streamline the care of chronically ill patients. The cost of caring for this patient population accounts for 75 per cent of national healthcare spend, said Clinton, something that she found "astonishing". She gave an example of a streamlined co-ordinated system that was already working in Oregon, where an elderly patient with several conditions was having her care managed and co-ordinated centrally to ensure her treatments were compatible and working together.
3. Offer individuals and small businesses market access to larger insurance pools. The purpose of this part of the plan is to "lower costs and end insurance company discrimination against people with pre-existing conditions," said Clinton. She sees this as part of a system of universal coverage, where "insurance companies cannot as easily shift costs through cherry picking and other means". This means that people with pre-existing conditions would be offered insurance on a par with others, "prohibiting insurance companies from carving out benefits or charging higher rates to people with health problems".
4. Improve the quality of care to help drive down costs: for example by establishing an independent public-private Best Practices Institute. Clinton envisages the Institute being "A partnership among the public and the private sector, to finance comparative effectiveness research, so that doctors, nurses and other health professionals, as well as consumers and businesses, would know what drugs, devices, surgeries and treatments work best" (Hillary Clinton Unveils Plan... 2007). She cited a recent study by Dartmouth researchers that found close to one third of the 2 trillion dollars spent in the US goes to care that is "duplicative and fails to improve patient health".
5. Get prescription drug costs under control. Americans pay the highest prices in the world for prescription drugs; and yet in most instances the research and

development of those same drugs was carried out and funded in America. Clinton said studies had shown that branded drugs were up to 55 per cent more expensive in the US, with the top selling brands over 200 per cent more expensive, compared to other industrialized nations. The cost of prescription drugs as a percentage of total healthcare costs is going up faster in America than anywhere else. An important part of the solution would be to allow Medicare to negotiate for lower drug prices, to allow importation of cheaper drugs, and generics.

6. Reform medical malpractice: in a way that works for doctors and patients alike. By way of example, Clinton offers one already in use: "I have offered one solution that has been used successfully at the University of Michigan Hospital system. It's called the National Medical Error Disclosure and Compensation (MEDiC) Act as I have borrowed it from the University of Michigan to put it into law" (Hillary Clinton Unveils Plan... 2007).

When addressing how these changes would be financed, Clinton stressed the self-funding nature of her seven point plan:

"The money we save from the waste we eliminate and the way we change how we care for people should be used to help finance coverage for the 45 million Americans who have no insurance. Also, when you insure everyone, it will maximize the impact of the prevention programs I have recommended -- with earlier care as opposed to emergency care -- as well as cutting administrative costs." (Hillary Clinton Unveils Plan... 2007).

COMPARISON AND CRITIQUE OF OBAMA AND CLINTON HEALTH CARE PLAN

HILLARY CLINTON:

"His plan would leave 15 million Americans out...I have a universal health care plan that covers everyone."

BARACK OBAMA:

"The fact of the matter is that I do provide universal health care."

This was what both candidates had to say about their health care policy (Democratic Debate in Las Vegas November 15, 2007). The health care plans proposed by Senators Clinton and Obama are similar in many ways, but they differ in several

important respects. The Clinton plan "mandates" health insurance for everyone. The Obama plan requires that all children have insurance, and subsidizes health care for other Americans who are presently uninsured. Clinton estimates that her plan will cost in the region of $110 billion a year (2008 Presidential Candidate Health Care Proposals 2008); Obama has put a $50 to $65 billion price tag on his proposals (Barack Obama's Health Care... 2008).

According to FactCheck.org, a public policy think tank, their comparison on the Obama-Clinton health debate findings says (They've got you covered? 2008) :

- Obama is being misleading when he says his proposal would "cover everyone." It would make coverage available to all, but experts consulted estimate that 15 million to 26 million wouldn't take it up unless required doing so.
- Clinton stretches things a bit, too. Even her plan – which, unlike Obama's, includes a mandate for individuals to get insurance – would leave out a million people or perhaps more, depending on how severe the penalties would be for those who don't comply. She won't say how her mandate would be enforced, but has said that she was open to the possibility of garnishing wages.
- Experts also are sceptical of both candidates' claims that their plans will reduce the cost of insurance for the typical family by $2,000 or more. "I know zero credible evidence to support that conclusion," said M.I.T's Jonathan Gruber.

Experts say the health care plans put forth by Democratic presidential candidates Hillary Clinton and Barack Obama are very similar – and Obama himself has said his proposal has 95 percent in common with hers. But that other 5 percent is a source of contention (They've got you covered? 2008).

According to Michael Doobs of The Washington Post (Doobs 2007), neither the Obama plan, nor the Clinton plan, guarantees "universal coverage" for all Americans, although they both aspire to this goal. MIT economics professor Jonathan Gruber, one of Clinton's health care advisers, describes her plan as a "universal coverage" plan, in contrast to the Obama plan, which he terms a "universal access" plan. But he also acknowledges that the Clinton plan will not include everybody. "Any system that does not have a single payer will not have 100 per cent coverage," he told Michael

Doobs when he reached him after the Las Vegas debate. But it could come very close he said.

So from what can be gathered from the debates between Clinton's and Obama's health care plan, the basic difference between the two that can be deduced are:

One, both plans are very similar. Either one would be a significant step in the right direction, moving the US toward a more workable and sustainable health care system. Of course some of the similarities stem from a necessary lack of detail, but both would point in the direction of universal coverage, especially by allowing Americans to opt for public health insurance rather than private. And, both would be funded by rolling back some of the Bush tax cuts for those in the higher tax brackets and by increasing the cost efficiency of health care through modernization and focusing on preventative care.

Two, when it comes down to it, though, the Clinton plan truly is more comprehensive -- for the sole reason that it mandates that all Americans must have health insurance. Obama's plan does not (but it does require that all children have health insurance). The oft-quoted number of 15 million left uninsured under the Obama plan is probably at least roughly correct, although it's very difficult to judge given it's a rough estimate. It's important to emphasize that those left uninsured would be uninsured out their own choice--at least as long as Obama is able to deliver the affordable health care options that his plan promises -- and would supposedly eventually be lured by these new, more affordable options. Still, experience demonstrates as well as experts believe that a sizable population will opt out -- however ill-advisedly -- of purchasing health insurance, unless it is required. On this point, then, Clinton certainly wins.

HEALTH CARE PLAN: JOHN McCAIN'S HEALTH CARE PROPOSAL

Senator John McCain, the Republican Presidential nominee, stayed true to GOP principles when he unveiled a health-care reform proposal that leans heavily on competition rather than government intervention (Arnst 2008). He also wanted to see the states take a far greater role in fostering that competition and in forming risk pools that would insure coverage for the sickest citizens.

The last of the three remaining Presidential candidates to unveil a detailed health proposal, McCain's was also the least radical (Arnst 2008). He is against mandates, instead proposing universal coverage would emerge through the use of tax credits and a more competitive insurance marketplace. McCain wants to do away with the tax exemption on employer-provided insurance. Instead, he would give a $2,500 annual tax credit to individuals, and $5,000 to families, to purchase their own coverage.

McCain's plan is meant to encourage individuals to purchase their insurance and free companies from the heavy cost of providing coverage. His theory is that employees would take their tax credit and flock to the open market, where they could shop around for the plan that best meets their needs. Insurance companies would have to become more competitive to win their business.

Health care in America "should be available to all, and not limited by where you work or how much you make," McCain said in a speech delivered in Tampa at the University of South Florida's H. Lee Moffitt Cancer Center & Research Institute, he said he wants to give control over the health-care system to patients (Arnst 2008). "When families are informed about medical choices, they are more capable of making their own decisions, less likely to choose the most expensive and often unnecessary options, and are more satisfied with their choices (Arnst 2008)." For the sickest Americans who would find it hard to buy affordable coverage in an open market, McCain wants the states to form risk pools, or what he calls Guaranteed Access Plans. He also said there would be "reasonable limits" on premiums, and federal assistance for those below a certain income level (Arnst 2008).

McCain's campaign staff said the proposal would cost about $10 billion a year in reduced federal tax revenues and subsidized coverage for the poor. The plan's costs would be offset, in theory, by reduced government payments through Medicare and Medicaid for emergency room use by the uninsured, increased use of information technology, and adoption of best-care practices for chronic illnesses. McCain also proposed malpractice reform (Arnst 2008).

A comprehensive and detailed analysis of the McCain health policy has been done by Holahan and Blumberg for the research group Health Policy Center (An Analysis of the McCain Health Care Proposal 2008), and the details are given below:

OVERALL ASSESSMENT

The McCain health care plan represents a philosophical advance over many other health care proposals, principally in its commitment to redistributing the current tax exemption for employer-based health insurance. However, the plan raises more concerns than it addresses. The plan would

- provide a refundable tax credit that is more valuable to low-income workers than the current tax exemption for employer-based insurance, though the credit is not adequate to make coverage affordable for many;
- make insurance coverage less accessible and affordable for those with high health care needs;
- increase coverage among the currently uninsured through the non group market but reduce the number already covered by employers, leaving about the same number of people uninsured;
- Have a high budget cost, at least in its early years.

In brief, McCain's proposal would dramatically change how many Americans obtain health insurance coverage, make coverage less accessible for those with health problems, have a high budget cost, but have little effect on the number uninsured.

COVERAGE

The proposed McCain tax credit would represent substantially greater subsidies for low-income people than have been available to date. However, the credit would not lead to significant net increases in insurance coverage:

- Tax credits would be the same size for all purchasers regardless of income. As a result, they would leave many low-income individuals with insufficient funds to afford adequate health insurance coverage.
- Affordability and accessibility of coverage would vary considerably by health status, age, and geographic area of residence.

Health insurance policies would become less affordable over time because the value of the credit would increase with inflation, while the cost of health care has historically grown substantially faster.

RISK POOLING

By deregulating the health insurance market, the McCain plan would clearly decrease the sharing of health care risk. This would result in lower insurance costs for the young and healthy but would increase costs and decrease access for older individuals and those with health care problems.

- The new tax incentives would decrease employer-based coverage while increasing coverage in the non group market. Health insurance options in the non group market are often very limited for those with health problems.
- The provision to allow insurers to sell coverage to those residing anywhere in the country would undermine regulations that states have implemented to pool health care risk.
- These two provisions necessitate the reliance upon high risk pools as a fall-back mechanism to provide coverage to high-cost patients; however, McCain's proposed funding for these high risk pools falls far below what would be needed to make adequate coverage affordable to those patients.

COST CONTAINMENT

McCain's plan includes several features intended to contain costs.

- The proposal depends heavily upon tax incentives and an increased use of health savings accounts to contain rising health care costs. While these measures may create incentives to decrease spending, they will not have much effect on spending by sicker, high-cost people who account for a high percentage of the nation's spending.
- The plan proposes other strategies, such as the increased use of health information technology, chronic care management, and malpractice reform, but it is not clear if enough would be spent to successfully implement those strategies.

OUTSTANDING ISSUES

To address the problems with the proposal, the plan would need to

- provide a guaranteed source of adequate, affordable coverage for all individuals, regardless of health status;
- phase out the employer exclusion over a period of years to avoid severe disruptions in health insurance markets;
- provide larger subsidies at the low end of the income distribution;
- develop a better strategy for spreading the costs of older and sick individuals broadly across the population; and
- make a significant commitment to cost-containment mechanisms to adopt efficient health information technology, strengthen prevention, evaluate the effectiveness of new technologies, and manage the costs of the chronically ill.

COMPARISON AND CRITIQUE OF OBAMA AND McCAIN HEALTH CARE PLAN

Senators John McCain and Barack Obama would have placed the nation's health system on very different paths, with profound implications for the American people. Obama's proposal for mixed private–public group insurance with a shared responsibility for financing has greater potential to move the health care system toward high performance than does McCain's proposal to encourage individual market coverage through the use of tax incentives and deregulation (Collins et al. 2008). According to an estimate discussed in the report, in 10 years McCain's proposal would reduce the number of people who are uninsured by 2 million out of a projected 67 million, while Obama's plan would reduce the number of uninsured people by 34 million (Collins et al. 2008).

DISTINCT APPROACHES TO HEALTH CARE REFORM

The presidential candidates' health care reform proposals offer fundamentally different visions of the future of health insurance in the United States. Both candidates propose reforms in which the health system would continue to be structured around private insurance markets, with a supporting role played by public insurance programs. But their plans diverge significantly on the way a reformed system should operate. McCain would change the tax code to encourage people to buy coverage through the individual insurance market and effectively loosen state rules governing

the sale of insurance by allowing people to buy policies across state lines. Obama would encourage the continuing participation of employers in the health insurance system, expand eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP), and create a new insurance market "exchange"—with consumer protections, choice of public and private health plans, and income-based premium subsidies—that would largely replace the individual market. According to one estimate (Burman et al. 2008), in 10 years McCain's proposal would reduce the number of people who are uninsured by 2 million out of a projected 67 million. Obama's plan would reduce the number of uninsured people by 34 million in 10 years.

McCAIN'S APPROACH: TAX CREDITS FOR INDIVIDUAL MARKET INSURANCE

According to Sara R. Collins (Collins et al. 2008), McCain proposes to expand coverage through the individual insurance market by replacing the current tax exemption for employer-provided health benefits with tax credits of $2,500 for individuals and $5,000 for families. Currently, premium contributions from employers are not treated as taxable income to employees. Under McCain's proposal, these contributions would be subject to income taxes. People could use their tax credits to offset the costs of employer coverage or coverage purchased on the individual market, and could deposit any remaining funds in health savings account (HSAs). He also would effectively deregulate individual insurance markets by allowing people to buy coverage across state lines. He has proposed federal funding to expand existing state high-risk pools for people who cannot gain coverage through the individual market because of their health conditions, with premium assistance for those with lower incomes.

OBAMA'S APPROACH: PRIVATE AND PUBLIC GROUP INSURANCE WITH CONSUMER PROTECTIONS AND INCOME BASED SUBSIDIES

According to Sara R. Collins (Collins et al. 2008), Obama has proposed a plan for universal coverage that would build on the current system of mixed private and public group insurance. Some of its features are similar to the universal coverage law now being implemented in Massachusetts. All employers, other than small businesses, would be required to offer health insurance to their employees or contribute to the

cost. Eligibility for Medicaid and SCHIP would be expanded. Small businesses, self-employed individuals, and people who do not have coverage through their employers, Medicaid, or SCHIP would be able to purchase a plan through a new insurance market called the National Health Insurance Exchange. Through this exchange, people could choose a private plan or a new public plan similar to that offered to federal employees and members of Congress. All insurance carriers would be required to offer plans to all applicants and could not charge premiums based on health status. Small businesses would be eligible for tax credits to offset their premium costs and individuals would be eligible for income-based premium subsidies. Obama has not yet defined the size of eligible small businesses and those not subject to the requirement to offer coverage.

KEY DIFFERENCES BETWEEN THE CANDIDATES' PROPOSAL

There are several differences between McCain and Obama's proposals to reform the health insurance system, a detailed analysis by the Common Wealth Fund; a private think-tank foundation on the health system in America is given below (Collins et al. 2008):

- **Aiming to cover everyone.** While McCain proposes to expand access to health insurance coverage, he has not said that covering everyone is a goal. Obama supports the goal of universal coverage.
- **Minimum state rules vs. uniform national rules for the individual insurance market.** Policies in the individual market are individually underwritten in all but a few states, making it difficult for older people or those with health problems to find coverage at affordable rates. Consequently, only about 7 percent of the under-65 population buys coverage in the individual market. This has changed little over time, despite the growing number of people who have lost access to employer-based health insurance. Individually underwritten policies increase administrative costs and reduce the potential for economies of scale. McCain would change the tax code to encourage more people to enroll in the individual market and allow people to buy policies across state lines. This would help people who currently buy coverage on the individual market by giving them a tax benefit. But allowing health insurance to be sold across state lines would effectively remove

consumer protections now in place in some states, such as community rating and guaranteed issue. This would reduce access to insurance for older people and those with health problems and increase access for young and healthy people. McCain proposes to cover people with pre-existing health conditions by using federal funds to expand high-risk pools, which now cover fewer than 200,000 people in 34 states. Obama, in contrast, would largely replace the individual market with an insurance exchange, in which small businesses and people without access to employer or public coverage could purchase a private health plan or a public plan with premium subsidies and tax credits. Insurers, including those selling policies outside the exchange, would be prevented from rejecting applicants or charging higher premiums because of pre existing conditions.

- **Reducing vs. expanding the role of employers in providing health benefits.** About 160 million people, more than 60 percent of the population under age 65, have insurance coverage through an employer. As stated above, McCain proposes to treat employers' contributions to employees' health insurance premiums as taxable income and provide tax credits for people to apply to their employer plans or to individual market plans. This change has the potential to reduce the incentive for many employers, particularly small employers, to continue providing health coverage to their employees. Obama's proposal would require all employers, other than small businesses, to offer coverage to their employees or pay part of the costs to cover them. This would allow most people to keep the coverage they have and maintain the more than $400 billion in employer contributions to health insurance currently in the system. He would provide tax credits to small businesses to buy coverage through the insurance exchange and would offer federal reinsurance for employers that experience catastrophic claims.
- **Reducing vs. expanding Medicaid and SCHIP.** McCain has said he would allow states to use Medicaid funds to enable purchase of private insurance by eligible families. To the extent that healthier Medicaid enrolees opted for private coverage, this option could fragment the program's risk pools into healthy and less healthy groups. Obama would raise income eligibility levels for Medicaid and SCHIP, allowing more people to join the programs. This would expand the large risk pools of Medicaid and SCHIP.

- **More vs. less exposure to health care costs.** McCain does not specify a standard floor for benefits and cost-sharing, which means that people buying coverage on the individual market with his new tax credits could face wide variations in their premiums, benefits covered, and out-of-pocket costs. He has said he would provide subsidies to help people with pre existing health conditions buy coverage in high-risk pools, though he has not specified the size of the subsidies or what household income levels would qualify. Obama would provide premium subsidies, on a sliding-scale based on income, for people to buy private or public plans through the insurance exchange; he has not specified the size of the subsidies or the eligible income levels. Obama would require that the public and private plans sold through the exchange have benefits and cost-sharing similar to that available to federal employees and members of Congress.
- **No requirement vs. requirement to have coverage.** McCain would not require that people have health insurance. Obama would require that children have health insurance and has said he would consider a similar requirement for adults if substantial numbers of people do not buy coverage that is deemed affordable.
- **The same vs. more leverage to stimulate improvement in quality and efficiency.** Both candidates have proposed conceptual approaches to improving the quality and efficiency of care. The candidates agree that: the U.S. should change the way providers are paid; care, especially chronic disease care, should be better coordinated and managed; and preventive services should be covered and easily accessed. However, their proposals for health insurance reform could significantly affect their ability to achieve improvements in quality and efficiency throughout the system. Both candidates point to public programs such as Medicare, Medicaid, and SCHIP as places to implement quality and efficiency initiatives, such as paying doctors and hospitals on the basis of quality. But because McCain's reforms would entail even less oversight of private insurance markets than already existing, he would be limited to implementing such initiatives in public programs. In contrast, Obama's proposed creation of a new public plan and an insurance exchange would provide new and larger arenas in which to experiment with quality and efficiency innovations. He has also identified the

Federal Employees Health Benefits Program (FEHBP) as an insurance program in which innovations in quality and efficiency might be pursued. For example, providers and health plans participating in public programs and the exchange could be required to develop chronic disease management programs. The more organized insurance markets are and the more standardized the system is, the more leverage points there will be to make improvements in quality and efficiency.

CONCLUSION

Obama's proposal for mixed private–public group insurance with a shared responsibility for financing has greater potential to move the health care system toward high performance than does McCain's proposal to encourage individual market coverage through the use of tax incentives and deregulation (Collins 2007). Compared with McCain's approach, Obama's approach could provide more people with affordable health insurance that covers essential services, achieve greater equity in access to care, realize efficiencies and cost savings in the provision of coverage and delivery of care, and redirect incentives to improve quality. In the absence of a requirement that everyone has affordable coverage, however, the proposal is likely to fall short of achieving universal coverage.

McCain's proposal to reform the health insurance system by relying on tax incentives and voluntary purchase of coverage in the individual insurance market with few ground rules is, by itself, unlikely to achieve universal coverage (Collins 2007). Buying coverage in the individual market will continue to be challenging if tax incentives are not coupled with benefit standards, regulations against risk selection by carriers, and premium and out-of-pocket spending limits as a share of income. Insurers would still write individual policies rather than policies for a broad group of people. Moreover, because of the substantially higher administrative costs in the individual market, covering more people in this market would increase spending on insurance administration. Reliance on state high-risk pools to cover those denied policies in the individual market is also likely to be expensive.

CHAPTER 4

OPPOSITION PARTIES AND LOBBYISTS

CAMPAIGN PROMISE

Barack Obama's announcement of his candidacy for the President of the United States on February 10, 2007 was a historic moment in itself. It was at the Old State Capitol building in Springfield Illinois, where Abraham Lincoln delivered the historic "House Divided" speech in 1858. In a campaign that projected themes of "hope" and "change" (Leading Article 2008), Obama's campaign emphasised on the ending of Iraq war as soon as possible, providing universal health care as well as increasing energy independence of the country (Falcone 2007).

Obama's foreign policy priority as he outlined during his Presidential campaign was, first to end the war in Iraq and "bring the boys home" as soon as possible (Gibson 2011), to invest more in the war in Afghanistan and capture Osama Bin Laden dead or alive. He wanted to "reset" ties with the Muslim world and sought for a "new beginning" with Russia. Obama's national popularity became iconic as hundreds of thousands of voters turned out for his stump speeches. These large numbers were duplicated when Obama went overseas to solidify his foreign policy credentials. In July 2008, he travelled to Afghanistan, Iraq, Jordan, Israel, Gaza, Germany, France, and England. In Berlin, Germany, he gave a speech before a quarter of a million people. This was the largest audience for a presidential candidate travelling abroad.

Overhauling the troubled $2.5 trillion U.S. healthcare system, by cutting costs and expanding coverage to the estimated 46 million Americans without health insurance, was Obama's top domestic initiative (Lynn 2009). Closing down the Guantanamo Bay prison was also a high priority Domestic policy. Obama spoke often during the campaign about his mother's battle with ovarian cancer to illustrate his commitment to changing the health care system. He told of her final days, spent battling insurance company bureaucrats who did not want to pay for her cancer treatments. "I know what it's like to see a loved one suffer, not just because they are sick, but because of a

broken health care system," he said at his campaign commercial (Barack Obama pulls out stops with... 2008) and at countless campaign stops before that. Overhauling the health insurance system was his key campaign promise and top goal.

OPPOSITION TO HEALTH CARE REFORM BILL

The United States health care system has serious problems. Costs are rising at three times the inflation rate (Lynn 2009). Many Americans are uninsured. Millions more fear losing their insurance in a weak economy or because of pre-existing conditions. Doctors are ready to close their doors because of high malpractice insurance costs and low government reimbursement rates. Everyone agrees that something has to be done. The disagreement is over what is to be done and how it should be done.

The opposition to Obama's health care reform was widespread and fierce, to say the least. Different factions and groups of physicians, insurance companies, businesses, workers, and others, as well as the interest groups and lobbyists were fiercely opposed to his proposal apart from the political opposition of the Republican party as well as some from the Democratic party themselves. Different factions and groups have different reasons and understanding in opposing the health bill. In general, the main reasons for opposing the bill were, one, because it would mean the "government takeover" of the public health system or as they call it "socialized medicine". Two, "Obamacare" would result in the government spending more money and with the recession going on, fiscal deficit would reach stratospheric heights. Three, the "individual mandate" would mean it would become compulsory to buy health insurance, either from the private insurers or from the public option the government would provide. A penalty can be imposed if an individual does not buy health insurance from either the private party or from the public option. This means the government is coercing its citizen to do something irrespective of the citizen's choice. This is clearly felt to be a government overreach of its power and influence over its citizen which many argue to be contrary to the American culture of individual freedom and even being unconstitutional.

The opposition to the proposed and eventually passed health care bill was cohesive and spread across political, social and cultural spectrum. There were differences

within the doctor's association itself, some supporting the bill -- American Medical Association (AMA) -- being the more prominent one, while groups like the Association of American Physicians and Surgeons (AAPS), Docs4PatientCare and Physicians Against Obamacare, vociferously opposing the health care bill. There were opposition within the ranks of the Democratic Party itself and 34 democrats eventually voting against the bill when it was brought on the floor. The various factions and groups opposing the bill are discussed and analysed as follows:

REPUBLICAN PARTY OPPOSITION

On March 21, 2010 The House of Representatives voted 219 to 212 to approve the Health Care Reform Bill. 178 Republicans along with 34 Democrats voted No. Some of their concerns are listed here (Herwood 2010).

- Doctors are ready to close their doors because of high malpractice insurance costs and low government reimbursement rates.
- Health care reform will increase government spending by nearly $2 trillion once it is fully implemented.
- The bill will create dozens of bureaucracies, which increases the federal government's role in health care.
- The system will impose a staggering tax burden on U. S. taxpayers for generations to come.
- Although people have been promised lower costs for their health insurance, they will instead end up paying much higher premiums.
- New fees and taxes will be pushed onto the consumer through premium increases which will occur as early as 2010.
- The legislation will necessarily inflict higher prescription-drug coverage on seniors and the disabled.
- Health care reform is intended to lower premium costs and reduce the deficit. Instead, it will have the opposite effect.

The Republicans feel that the Patient Protection and Affordable Care Act would make a bad situation worse (Grassley 2009). According to Senator Grassley (R-Iowa), the bill would "cause us to slide rapidly down the slippery slope toward increasing government control of health care". He claims the bill contains the biggest expansion of Medicaid since the program's creation; that the bill imposes an unprecedented federal mandate for coverage backed by the enforcement authority of the Internal Revenue Service and would increase government spending by nearly $2 trillion when fully implemented. The bill would give the secretary of health and human services the power to define benefits for all private plans and to redefine those benefits annually. From a new health-choices commissioner to a centre for comparative-effectiveness research, these bills create dozens of new bureaucracies, increasing the federal role in health care. All of this amounts to a lot of power over people's lives (Grassley 2009).

The Republican Party feels the bills fail to solve the fundamental problems in health care. They take no serious steps to reduce costs, either for the health care system or for individuals. The bills will cause insurance premiums for scores of people, especially those who are relatively young and healthy, to go up, not down. It tightens the allowable price variation for insurance rates, so that millions of people who are expecting lower costs as a result of reform will end up paying higher premiums. The bills also impose new fees and taxes that will be pushed directly onto the consumer. Totalling about a half-trillion dollars over the next few years, these fees and taxes will cause premium increases as early as 2010, even before most reforms take effect. Then, after forcing premiums to go up, the legislation makes it mandatory to buy health insurance (Grassley 2009). According to senator Grassley, the bills also make problematic changes in Medicare. According to the Congressional Budget Office (CBO), the legislation imposes higher premiums for prescription- drug coverage on seniors and the disabled. The Senate Finance Committee bill creates a new, permanent Medicare commission with broad authority to make further cuts in Medicare. The damage that this group of unelected people could do to Medicare is unknown, although the top actuary at the Department of Health and Human Services recently concluded that cuts of this magnitude will limit benefits and decrease access to care for Medicare beneficiaries (Grassley 2009).

These points are good examples of the philosophical difference between the two sides. According to Republican Senator Chuck Grassley (Rep- Iowa), the Republican Party wants to reduce the overall cost of the legislation, try to reduce the government's role, make it harder for illegal immigrants to get benefits, allow alternatives to the individual mandate and harsh penalties, and reward states with extra Medicaid dollars if they pass medical malpractice reform. Instead, the prevailing plan is to move millions of people from private coverage into public coverage and create new taxpayer funded subsidies for families making close to $100,000 a year. Yet even with all the changes, after raising billions of dollars in new taxes, cutting a half-trillion dollars from Medicare, imposing stiff new penalties on people who don't buy insurance, and increasing costs for those who do, 25 million people will still not have health insurance under the Senate Finance Committee bill, and 18 million people will not have it under the House bill, according to the CBO. "I don't think this is what the American people had in mind when the President and Congress promised to fix health care" (Grassley 2009).

These were largely the areas and concerns the Republican Party raised in the build up to the passage of the health reform bill. The party itself claimed it was not against reform in the health care field, but were opposed to the clauses and specifics the Democratic Party raised in the health care bill, particularly the "Government takeover" of the health care system, which was the creation of a government insurance plan, also known as the public option, to compete with the private insurers. The Republican Party's answer to the health care bill is clearly stated by Senator Grassley's article in the New England journal of Medicine, where he says
"It's not too late for bipartisan legislation that builds on common ground to improve coverage and affordability, increase quality, and decrease costs. I've worked for years on bipartisan legislation that would change Medicare so that it paid not for the volume of services provided but for the quality of the care delivered" (Grassley 2009).

The Republican Party's stand, as elucidated by Senator Grassley reveals, the Party is aware that there's widespread support for health insurance exchanges and for ending discrimination based on pre-existing conditions to make coverage more affordable and accessible and that the party would work for that. Allowing individuals to purchase insurance across state lines and enabling small businesses to band together

when shopping for insurance are also proven methods for reducing costs and should be included as part of comprehensive reform (Grassley 2009).

Tort reform was another area the Party laid stress on as the Party maintained it would reduce abusive lawsuits that drive up costs and limit access to doctors. The CBO estimated that comprehensive medical liability reform would reduce federal budget deficits by roughly $54 billion over the next 10 years. The Republican Party charged the Democratic Congressional leaders showed little interest in creating an environment in which doctors don't have to engage in defensive medicine just to keep their practices open. They exhorted the medical community to continue arguing for reasonable reforms that would cut down on unnecessary medical tests that serve no purpose other than to reduce malpractice premiums (Grassley 2009).

Apart from giving suggestions and coming up with their own agenda on framing the health care bill, the Republican Party charged the Democratic Party with consistently rebuffing or killing their legislative bills and concerns. According to Senator Grassley (Rep-Iowa), "On several occasions, Republicans tried to take the legislative substance in a different direction. We tried to ensure that the President's pledge not to tax middle income families, seniors, or veterans would be carried out. We were rebuffed every step of the way" (Grassley 2009). He further argues that the amendments offered by Republicans on the Senate Health, Education, Labour, and Pensions (HELP) panel and the Finance Committee to provide consumers with a lower-cost coverage alternative, similar to the high-deductible health plans and health savings accounts sold today, were consistently defeated. Those alternatives would have allowed more people to keep their existing coverage. The defeat of these amendments and the forthcoming pressures on employers and individuals mean that despite the President's promises, a lot of people aren't actually going to be able to "keep what they have." In fact, given the long list of new benefit mandates and strict new actuarial- value requirements, a lot of people are going to end up paying more to meet the government's new definition of health insurance (Grassley 2009).

The Republican Party's final charge is that the Congressional Democratic leaders are advancing their extremist health care reforms with the bare minimum of votes and they disagree with that approach. Health care is one sixth of the economy — as large

as the entire British economy. The legislation Congress is considering will affect every American, at every level of health and at every stage of employment. When the debate began, interested legislators of both parties set forth benchmarks that were no-brainers: Health care reform should lower premium costs, reduce the deficit, and bend the cost curve the right way. The bills before Congress don't do any of these things (Grassley 2009).

INTEREST GROUPS AND LOBBYISTS

Of all the problems with the current U.S health care system, perhaps the most insidious is that the system is fuelled by special interest groups, whose chief concern is their own bottom line. There are a lot of hands in the pot: insurance companies, drug makers, hospitals, device and equipment manufacturers, and yes, doctors. They all pay lobbyists huge sums of money to convince legislators to maintain the status quo, or to draft legislation in their favour. But unless these groups agree on a solution that will overhaul our system, costs will continue to rise and the quality of care will fall.

As has already been seen earlier, special interest groups are willing to play nice because they all want to be included in health care reform discussions. But it has to be kept in mind that special interests ended up killing Hillary Clinton's efforts at health care reform in the 1990s (Turk 2009). More importantly, the companies and groups profiting from the current system have a lot at stake.

In the parlance of Washington, the organizations on both sides are special interests — the insurance industry and business groups strongly opposed to the direction health care legislation is taking in Congress, as well as the groups of doctors, nurses, drug makers and labour unions working to pass an overhaul despite any misgivings they may have.

Part of the permanent landscape in the capital, they all lobby Congress and federal agencies on the issues they care most about. Many purchase political ads in campaign season or try to turn out their own memberships to vote for preferred candidates. They have enormous sums at stakes in the outcome of the struggle over Obama's proposed remaking of the health care system.

America's healthcare industry has spent hundreds of millions of dollars to block the introduction of public medical insurance and stall other reforms promised by Barack Obama. The campaign against the president was waged in part through substantial donations to key politicians. Supporters of radical reform of healthcare say legislation emerging from the US Senate reflects the financial power of vested interests - principally insurance companies, pharmaceutical firms and hospitals - that have worked to stop far-reaching changes threatening their profits (McGreal 2009). The industry and interest groups spent $380m in recent months before the bill was passed, influencing healthcare legislation through lobbying, advertising and in direct political contributions to members of Congress. The largest contribution, totalling close to $1.5m, has gone to the chairman of the senate committee drafting the new law (McGreal 2009).

Drug and insurance companies say they are merely seeking to educate politicians and the public. But with industry lobbyists swarming over Capitol Hill - there are six registered healthcare lobbyists for every member of Congress - a partner in the most powerful lobbying firm in Washington acknowledged that healthcare firms' money "has had a lot of influence" and that it is "morally suspect" (McGreal, 2009).

INSURANCE COMPANIES

It's no surprise that profits at ten of the country's largest health insurance companies increased 428 percent from 2000 to 2007, according to Health Care for America Now (HCAN 2009), a grassroots lobbying group. HCAN also reports that the CEOs of these companies earned on average, $11.9 million each - a combined total compensation of $118.6 million.

They've done this by using practices that are both, well-documented and despicable: refusing insurance to people with pre-existing conditions, denying care based on technicalities, and raising premiums for employer-based health insurance 120 percent since 1999, according to the National Coalition on Healthcare. From a doctor's perspective, the insurers also create arbitrary coding and credentialing guidelines contrary to those proposed as fair by large physician organizations, which serve to reduce compensation.

The Health Insurance companies opposing the health care legislation have first tried to discredit the proposals legislated by the Congress and then create fear mongering by ad campaigns, distorting the bill to create panic and opposition, pouring millions of dollars into these campaigns. A study backed by health insurance companies, meant to attack health care reform as a last ditch effort, was released on October 11, 2009 (Decker 2009). The study, or analysis, was completed by PricewaterhouseCoopers, writes Associated Press.

According to health insurance provider's top lobbyist in Washington, Karen Ignani, who is also the president of America's Health Insurance Plans, the PricewaterhouseCoopers has a good reputation as a world class firm. The study completed by this firm, backed by America's Health Insurance Plans, states specific numbers of how the health insurance reform will affect Americans. For example, the study states that in the future, the legislation would add at least $1700 a year to family coverage expenses. The premium costs for a single person would increase by $600 if the legislation did not go through (Decker 2009).

The nation's largest health insurance carrier urged its employees to lobby the Senate against reform proposals that would hurt the firm's bottom line, according to copies of e-mails released on 12 November 2009 by a liberal advocacy group (Eggen 2009). UnitedHealth Group, which is based in Minnesota, sent an e-mail message (PDF) to its 75,000 employees asking them to write their senators and local newspapers in opposition to a public insurance option, alleging that "government-run health care" will force "millions of Americans" to drop their current coverage.

Proposed form letters from the company also lay out opposition to cuts in the costly Medicare Advantage program and advocate higher financial penalties for individuals who do not buy health insurance. The e-mail was sent by United for Health Reform, which is the name of the company's lobbying arm; the subject line read: "Write Your Senators!" "Government-run health care will result in millions of Americans not being able to keep their current coverage and will lead to unintended consequences of higher premiums and less choice," one proposed letter reads. "In addition, I am disturbed by proposed legislation that will lead to increased taxes, less affordable coverage, and reduced benefits" (Eggen 2009).

The health insurance industry has become a major foe of the White House and congressional Democrats, who frequently single out insurers as a key cause of rising health-care costs and the growing ranks of uninsured Americans. The industry is strongly opposed to the public insurance option contained in the House bill, which would create a government-run plan to compete with private insurers, and hopes to quash the idea in the more conservative Senate.

The insurance industry has spent more than $120 million on direct lobbying in Washington through September of 2009, according to data from the Center for Responsive Politics. United Health Group alone has spent $3.5 million so far, disclosure reports show (Eggen 2009).

PHARMACEUTICAL COMPANIES

Pharmaceutical companies led by Eli Lilly tried to eliminate a government panel aimed at controlling Medicare spending seven months after they supported the health care overhaul that created it. The presidentially appointed board have the ability to control drug prices by reducing the amount the federal Medicare program will pay for medicines, Bart Peterson, senior vice president of corporate affairs at Indianapolis-based Eli Lilly, said in a telephone interview (Newshound 2010).

The drug industry's endorsement of the health law included a promise to contribute $80 billion toward the overhaul, helping Democrats offset new spending in the bill and clearing the way for passage in March. The drug industry endorsed the law even though manufacturers considered the cost-cutting board to be harmful, said Richard Smith, senior vice president for the Pharmaceutical Research and Manufacturers of America in Washington (Newshound 2010). The lobbying group had said it would take aim at the panel later, he said. The trade group represents name-brand manufacturers, such as Pfizer Inc., Merck & Co. and Bristol-Myers Squibb Co.

According to press reports (Martin 2009), the drug industry lobby PhRMA would launch a $150 million advertising blitz in support of Obama's healthcare reform drive, after the White House reaffirms its promise that it will limit the industry's "contribution" to the cost of healthcare restructuring to the $80 billion agreed on in

closed-door talks between Obama aides and Pharmaceutical Research and Manufacturers of America (PhRMA) chief Billy Tauzin.

The Obama White House has acknowledged it made a deal with drug makers to block moves in Congress to obtain any cost savings beyond the $80 billion already agreed to by the pharmaceutical lobby. The *New York Times* reported that (Randall 2009), in return for the $80 billion agreement, the Obama administration pledged that it would work to block any health care legislation that would allow the government to negotiate price-setting on drugs.

Details of the White House pledge were revealed when the pharmaceutical lobby reacted to a House health care measure that would have allowed the government to negotiate drug prices, or demand additional rebates from the drug companies. The lobbyists immediately insisted that the Obama administration publicly acknowledge its commitment to protect the pharmaceuticals from bearing any further costs. The White House quickly obliged (Randall 2009).

Billy Tauzin, a former Republican congressman and head of the Pharmaceutical Research and Manufacturers of America (PhRMA) trade group, described how the deal went down. "We were assured: 'We need somebody to come in first. If you come in first, you will have a rock-solid deal,'" he said (Randall 2009).

Tauzin added, "They wanted a big player to come in and set the bar for everybody else." He also said that the White House urged him to negotiate with Democratic Senator Max Baucus, who heads the Senate Finance Committee, which has yet to present its version of health care legislation. Baucus is beholden to the health care industry, having raked in nearly $1.5 million in 2007-2008 from lobbies representing hospitals, insurers, pharmaceuticals and other health care interests (Randall 2009).

Tauzin's negotiations with Baucus went well for the drug companies, with the committee reportedly moving away from measures that would have allowed the government to negotiate drug prices, or allowed the importing of cheaper drugs from Canada or Europe. Tauzin said that the White House monitored the negotiations with Baucus throughout (Martin 2009).

During his presidential campaign, Obama derided the drug companies for charging extortionate prices, and pledged he would let Medicare negotiate for lower prices and would allow importation of cheaper drugs from Canada. His selection of Billy Tauzin

to broker a deal with the pharmaceuticals is not accidental. He knows who he's dealing with, and the interests Tauzin brings to the table (Randall 2009).

Obama's public affirmation that no further "cost savings" are to be extracted from the drug companies is confirmation the health care plan Obama signs is a result of a compromise, considering the pharmaceutical companies, who in cutting a deal with the White House got pretty much all the concessions they wanted.

DOCTOR'S ASSOCIATION/ LOBBY

As President Obama pushed for passage of his first major domestic policy change, some physicians waged an all-out war against a health care reform bill that, they said amounted to nothing more than socialized medicine. America's Affordable Health Choices Act of 2009[1] would create a public health insurance alternative and require coverage for most Americans and from most employers (FOXNews 2009).

The American Medical Association (AMA) - the nation's largest physician organization with nearly 250,000 members - initially opposed the president's plan, but backed the House Democrats' version of the bill later. That had led to an internal dispute that has resulted in some physicians leaving the nation's largest doctors' Association. Some doctors charged the bill would lead to inferior patient care as physician offices around the country triple their patient lists and become forced to ration care.

"This is war," Dr. George Watson, a Kansas physician and president-elect of the American Association of Physicians and Surgeons, told FOXNews.com. "This is a bureaucratic boondoggle to grab control of health care. Everything that has been proposed in the 1,018 page bill will contribute to the ruination of medicine." Watson said the president's reform bill is loaded with rules and regulations that will ultimately result in shoddy patient care and long waiting lines. He blasted the bill as "insidious" by forcing doctors contracted with Medicare into the nationalized plan - a "trap" he described as "involuntary servitude" (FOXNews 2009).

[1] The proposed America's Affordable Health Choices Act of 2009 (or HR 3200) was an unsuccessful bill introduced in the U.S. House of Representatives on July 14, 2009.

But the AMA - which has long opposed government health care intervention, including the Clinton's administration's attempt to revamp the system in 1994 - issued a statement calling the House version of the bill "a solid start to achieving health reform this year that makes a positive difference for patients and physicians" (FOXNews 2009). James Rohack, president of the American Medical Association, said that the pending bill wasn't perfect, but it's the next step toward real reform of the nation's health care system, "This is certainly not the bill we would have written, but we cannot let the perfect be the enemy of the good," (Johnson 2010) he said. Still, Rohack said the debate was far from over, adding that the AMA will have a hand in drafting the final legislation, including a push for medical liability reform.

While most doctors support some form of health care reform, there was a growing number blasting the president's proposal and calling for a dramatically different approach - one that called for a system that pays for quality rather than quantity of medical procedures available to patients. Some physicians charged the AMA was putting its business interests above the most critical issue at stake: patient care.

When, in 2009, the American Medical Association (AMA) endorsed President Barack Obama's healthcare reform bill, many Americans probably assumed that most physicians therefore backed the legislation. In fact, this was not the case at all.

There were a host of Doctor's group that joined the fight against the health care bill, and some were explicitly formed to oppose the health care bill the Democratic Party was pushing for. There was three main Doctor's organisation that led the campaign against the proposed health care bill; they were the Association of American Physicians and Surgeons (AAPS), Docs4PatientCare and Physicians Against Obamacare, apart from other fringe associations as well as individuals fighting against the passage of the bill.

The AAPS is by far the oldest of these organizations. Founded in 1943 to oppose the federal government's first attempt to nationalize healthcare, the Wagner-Murray-Dingell bill (named after its sponsors, Sen. Robert Wagner of New York, Sen. James Murray of Montana, and Rep. John Dingell, Sr. of Michigan, all Democrats), the AAPS has been a consistent, principled opponent of government intrusions into medicine ever since. It opposed Medicare and Medicaid from the outset and, in 1993,

sued then-First Lady Hillary Clinton and other federal officials for their secrecy surrounding the healthcare task force that came up with Clinton's legislation to create a single-payer national health-insurance scheme. (A federal judge found in favour of the plaintiffs, only to be overturned on appeal.) The group later participated in lawsuits against various provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and on May 25, 2010, became the first organization of healthcare providers to file suit against ObamaCare (Tennant 2010).

Dr. Jane Orient, an internist in solo private practice in Tucson, Arizona, and clinical lecturer at the University of Arizona College Of Medicine, has been the executive director of AAPS since 1989. She explained that AAPS "take[s] a stand on principle, and it's been that same principle since we were founded. We believe in the U.S. Constitution and limited government and the Oath of Hippocrates and that physicians shouldn't be compromising themselves by getting into conflicts of interest with their patients." (Tennant 2010).To that end, AAPS encourages doctors to deal directly with their patients for payment, avoiding both public and private third-party payments; patients, however, are free to file claims with third parties.

Atlanta paediatric urologist Hal Scherz founded Docs4PatientCare in the spring of 2009 to, in his words, "represent doctors in this country who lost their representation when the AMA bailed out and when their specialty societies and state medical societies failed to do the job of stopping the onslaught against American medicine" that is ObamaCare (Tennant 2010). Witnessing the Obama administration's attacks against doctors go unchallenged by medical societies, Scherz, as he recounted it, "got 40 doctors to go into a room, to agree to pony up some money, and that we were going to try to go ahead and put together an organization to get the word out" in hopes of preventing the passage of ObamaCare (Tennant 2010). Thus was born Docs4PatientCare, whose membership has since grown to 3,500 doctors and, according to Scherz, "thousands more in our alliance, people who support what we are doing" (Tennant 2010).

Scherz said he believes that the group's efforts were successful in getting the public to express to Congress its opposition to the ObamaCare legislation. Unfortunately, he said, "the problem was that Congress wasn't listening, and they did what they wanted" (Tennant 2010). Having recognized early in the organization's existence that

they had "an opportunity to be more than just a one-issue advocacy group to stop ObamaCare," Scherz said Docs4PatientCare's main objective now is "to grow our membership so that we become a strong force in Washington so that we can go ahead and represent doctors and help people understand issues that affect our patients every day because nobody has ever done that before" (Tennant 2010).

Two of every three practicing physicians oppose the medical overhaul plan under consideration in Washington, and hundreds of thousands would think about shutting down their practices or retiring early if it were adopted, an IBD/TIPP Poll has found (Jones 2009). The IBD/TIPP Poll was conducted by mail, with 1,376 practicing physicians chosen randomly throughout the country taking part. Major findings included:

• Two-thirds, or 65%, of doctors say they oppose the proposed government expansion plan. This contradicts the administration's claims that doctors are part of an "unprecedented coalition" supporting a medical overhaul.

So how could physicians be so pessimistic about a bill that clearly has so many positives? The answer maybe because, the bill addresses none of the issues most consistently ranked by physicians as the most critical for lowering costs and improving access. Tort reform, streamlining billing and payment, and fixing the flawed government formula for calculating physician reimbursement are given little, if any, serious attention (Palestrant 2010). These were some of the reasons the physicians association were quite polarized on the issue of the health care bill passed by the Obama administration.

THE TEA PARTY AND THE DEMOCRATS

The Tea Party movement is an American populist political movement that is generally recognized as conservative and libertarian, and has sponsored protests and supported political candidates since 2009 (Servatius 2009). It endorses reduced government spending, opposition to taxation in varying degrees, reduction of the national debt and federal budget deficit, and adherence to an originalist interpretation of the United States Constitution (Liptak 2010).

The Tea Party movement has no central leadership but is composed of a loose affiliation of national and local groups that determine their own platforms and agendas. The Tea Party movement has been cited as an example of grassroots political activity, although it has also been cited as an example of astroturfing (Rasmussen 2010). The Tea Party's most noted national figures include Republican politicians such as Sarah Palin, Dick Armey, and Ron Paul, with Paul described as the "intellectual grandfather" of the movement (Smith 2007).

Tea Party activists from across the country rallied in protest against the $875 billion health care bill and demanded meetings with their respective members of Congress. The Tea party lacks coherent and coordinated leaders like other mainstream parties; the Tea Party movement is led mostly by members of the Republican Party and staging protests in the Capitol against the health care bill. The Tea Party elucidated its stand in its email two days before the passage of the bill. The main reasons for opposing the bill were given as follows (Tea Party Boise 2010):

• The entire bill is built upon lies, baseless assumptions that are not supported by historical fact, and are absolutely counter to the will of the people, who you are sworn to represent.

• The use of this parliamentary trick called "Deeming" is a violation of the U.S. Constitution, Article 1, Section 7. A vote to use this underhanded method to pass the bill is viewed by us to be a criminal act

• Nowhere in the Constitution is the federal government given the power to run healthcare, yet this bill does that.

• Nowhere in the Constitution is the federal government given the power to make any American purchase a product (health insurance) as a condition of citizenship, yet this bill does that.

• This bill spends a trillion dollars and establishes well over 100 new federal agencies, boards and bureaucracy designed to control the healthcare system.

• This bill cuts Medicare by half a trillion dollars, and uses that money to build yet another enormous entitlement program.

• The CBO estimate of the cost is built upon tricks, lies and mindless "conjuring" by the Congress and the President.

These were some of the accusations and challenges put forth by the movement. During the Tea Party protests on Capitol Hill, Tea Party activists warned that if Congress manages to pass health care legislation, their movement would become more formidable than ever. Mark Meckler, a national coordinator for the Tea Party Patriots—one of the larger and better-organized national groups—predicted that if the bill passes, "the tea party movement will double in size almost instantaneously" (Mencimer 2010).

But, far from fuelling the tea partiers' cause, the sweeping new health care law could suck the air right out of their movement. Many tea party activists have a lot to gain from reform—because their ranks are dominated by aging baby boomers. It's no coincidence that the movement's unofficial leader is the 69-year-old former congressman Dick Armey. A poll by CNN's (Opinion Research 2010) found that more than 40 percent of self-identified Tea Partiers were over 50. This makes the movement's opposition to the health care bill one of its most enduring paradoxes.

Obama's health care bill did not have the full support of his own party as many would have believed. The Democratic Party was itself divided on some of the issues in the bill. The fiscally conservative "blue dog" Democrats in an angry letter to Democratic congressional leaders, had argued that the bill being put forward failed to make substantive changes. "We must be much more aggressive in bending the cost curve," they wrote. "We cannot simply 'add' new consumers to a broken system" (Garber 2009).

Two things are driving discussion. There are cost issues—how to pay for the roughly $1 trillion price tag—and content issues—what the bill must include in order to make healthcare cheaper for patients. The debate over a government-run insurance plan has swallowed up the lion's share of attention on the second point, but another major headache was figuring out how to encourage doctors and hospitals to provide high-quality care rather than just a lot of it.

Rep. Allyson Schwartz (Pa.), the No. 2 Democrat on the House Budget Committee and a respected voice on healthcare policy issues testified against a major provision of

the healthcare reform law that was intended to help control Medicare costs. She told The Hill that President Obama's stated desire to beef up the Independent Payment Advisory Board (IPAB) in order to pare down Medicare costs "was one of the reasons I spoke out" (Garber 2009). She further said that there were other Democrats who also had concerns about the IPAB, and on behalf of all of them she felt it would be better to repeal that part of the law.

Some of the moderates began to consider taking more time as the legislation appeared to pick up speed. Some were freshmen from Western states, like Jared Polis of Colorado and Dina Titus of Nevada; their victories in 2008, part of a possible regional shift in favour of the Democrats, could have been erased the year later if polls continued to turn against new taxes and mammoth spending plans.

The others were veteran members of the so-called Blue Dog Coalition, which consists of Democrats from less-than-liberal districts. Seven of the eight Blue Dogs on the crucial House Energy and Commerce Committee had threatened to block health-care legislation unless it put a lid on costs. Resistance strengthened after the head of the nonpartisan Congressional Budget Office testified that the current House proposal would push costs up, not down, and would add some $240 billion to the federal deficit by 2019 (Drehle 2009).

THE CONGRESSIONAL VOTING

The Patient Protection and Affordable Care Act is a federal statute that was signed into law by President Barack Obama on March 23, 2010. The law (along with the Health Care and Education Reconciliation Act of 2010) is a product of the health care reform agenda of the 111th United States Congress and the Obama administration. The primary aspects of the law are reform of the private health insurance industry and public health insurance programs, to improve coverage for those with pre-existing conditions, expand access to care for over 30 million Americans, and reduce costs of the United States health care system.

The Patient Protection and Affordable Care Act passed the Senate on December 24, 2009, by a filibuster-proof vote of 60-39 with all democrats and one independent voting for, and all Republicans voting against it, one senator did not vote. It passed

the House of Representatives on March 21, 2010, by a vote of 219-212, with 178 Republicans and 34 Democrats voting against the Bill.

The Health Care and Education Reconciliation Act of 2010 is a law that was also enacted by the 111th United States Congress, by means of the reconciliation process, in order to amend the Patient Protection and Affordable Care Act. It was signed into law by President Barack Obama on March 30, 2010. The Health Care and Education Reconciliation Act of 2010 was passed by the House of Representatives on March 21, 2010, by a vote of 222-211, and on March 25, passed the Senate by a vote of 56-43 albeit after having two minor provisions stricken from the House bill. A few hours later, the amended bill was passed by the House 220-207. President Obama signed the health care reconciliation bill into law on March 30, 2011.

Some of the changes the Health Care and Education Reconciliation Act of 2010 brings are

- Increasing the tax credits to buy insurance.
- Lowers the penalty for not buying insurance from $750 to $695.
- Closes the Medicare Part D "donut hole" by 2020 and gives seniors a rebate of $250.
- Delays the implementation on taxing "Cadillac health-care plans" until 2018.
- Requires doctors who treat Medicare patients be reimbursed at the full rate.
- Sets up a Medicare tax on the unearned incomes of families that earn more than $250,000 annually.
- Offer more generous subsidies to lower income groups. Households below 150% of the federal poverty level would pay 2% to 4% of their income on premiums. Health plans would cover 94% of the cost of benefits. Households with incomes from 150% to 400% of the federal poverty level ($88,200 for a family of four) would pay on a sliding scale from 4% to 9.8% of their income on premiums; rest will be covered by government advanceable, refundable tax credit. Health plans would cover 70% of the cost of the benefits.
- Would increase the penalty to $2,000 for each full time worker in the company, but would exempt the first 30 employees while calculating the penalty. For example, an employer with 53 workers would pay the penalty for 23 workers, or $46,000.

- Would increase Medicaid payment rates to primary care doctors to match Medicare payment rates, which are higher, in 2013 and 2014.
- The federal government would pay all of the costs of expanding Medicaid under the reform until 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter. Some states that already insure childless adults under Medicaid would receive more federal money for covering that group through 2018.
- The Medicare patients will receive 50% discount on brand-name drugs would begin in 2011. By 2020, the government would pay to provide up to 75% discount on brand-name and generic drugs, eventually closing the coverage gap.
- Would extend the ban on lifetime limits and rescission of coverage to all existing health plans within six months after signing into Law.

CHAPTER 5

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

BACKGROUND

On the 23rd of March 2010, President Obama signed into law the Patient Protection and Affordable Care Act. The event has been widely described as "historic." Is it a major step in the right direction, even if not the final chapter of American health reform? Or is it, as their critics have it, a government takeover of health care that deprives Americans of their freedom? Whatever the answer maybe, it is undisputable that this piece of legislation will have widespread ramifications affecting all or most of American citizens either directly or indirectly. A problem with any such legislation is that it is hard to grasp in its entirety. To appreciate what the legislators crafting the bill tried to accomplish, anyone truly interested in this reform bill should start at the beginning, with Senator Max Baucus's "Call to Action: Health Reform 2009" (Reinhardt 2010).

The proposed white paper was composed by the senator's staff of health policy analysts under the leadership of Liz Fowler, Ph.D. The paper drew extensively on a huge array of first-class research papers produced over the years by the health-services research community. It is a well-structured catalog of problems identified in that literature and on the mind of Senator Baucus and his staff members. "Call to Action: Health Reform 2009" became the springboard for the bill that eventually emerged in the Senate (Reinhardt 2010).

The Patient Protection and Affordable Care Act was passed by the U.S. Congress on March 21, 2010, and signed by the President on March 23, 2010. The Health Care and Education Affordability Reconciliation Act of 2010 was passed by the U.S. Congress on March 25, 2010, and signed by the President on March 30, 2010. What is to be understood is that the Health Care and Education Affordability Reconciliation Act of 2010 is a corollary or appendage to. the Patient Protection and Affordable Care Act. This

means that the Health Care and Education Affordability Reconciliation Act does not stand as an Act on its own, it is merely an Act that amends the former Act to bring to effect certain changes sought by the House.

Combined, these two Acts constitute an enormous and complex piece of federal legislation that is over 2,200 pages and imposes hundreds of new requirements on states, businesses, health care providers, non-profit entities, and individuals (Sullivan 2010).

OVERVIEW OF THE ACT

An overview of the Patient Protection and Affordable Care Act is given by Daniel S Sullivan, who is an Attorney General of the state of Alaska and these are his views on the provisions of the Act (Sullivan 2010). The Act contains an "individual mandate" that requires uninsured Americans to purchase health insurance if they do not fall within one of the individual mandate's exceptions. This mandate expressly requires U.S. citizens and legal residents to have federal government-approved "qualifying" health insurance coverage beginning in 2014. Those who refuse to purchase a government-approved health insurance plan will have to pay a tax penalty of $695 per year or 2.5% of their annual income, whichever is higher. The Act imposes numerous new requirements on the terms of health insurance policies and plans under which American citizens will be covered. Most of these requirements involve expanding the terms and conditions of health insurance plans. The Act also significantly expands Medicaid eligibility for low-income individuals.

The Act will assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment (Effective January 1, 2014).

But the Act exempts employers with fewer than 50 employees from any of the above penalties.

The Act also require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% of Federal Poverty Level (FPL) whose share of the premium exceeds 8% but is less than 9.8% of their income and who chooses to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choiee vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)

The Act will expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law and in the House and Senate passed bills undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.

To finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, increase Medicaid payments in fee-for service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric

medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014)

Finally, the Act requires each state to establish an "American Health Benefit Exchange" to facilitate the purchase of federal qualifying health plans, provide for the establishment of a "Small Business Health Options Program," and meet other requirements described in the Act. To qualify to be listed on the exchange, a health benefit plan must abide by numerous federal regulations, which will be promulgated at a future date. If a state fails to establish a health benefit exchange, the Act requires the Secretary of Health and Human Services to establish and operate an exchange within that state.

A. THE INDIVIDUAL AND EMPLOYER MANDATES

The Act contains an "individual mandate" that requires uninsured Americans to purchase health insurance if they do not fall within one of the individual mandate's exceptions. The Act expressly requires U.S. citizens and legal residents to have "qualifying" health coverage beginning in 2014 (The Act provide for subsidies that attempt to make mandatory coverage affordable for all eligible persons, H.R. 3590: 5000A(c)). Individuals without qualifying coverage, i.e., those who refuse to purchase a government-approved health insurance plan, will have to pay a tax penalty of $695 per year or 2.5% of income, whichever is higher, beginning in 2016. Individuals who fail to maintain minimum essential coverage will be subject to a penalty equal to the greater of: (I) 2.5% of household income in excess of the taxpayer's household income (with a maximum of $2,085 for a family); or (II) $695 per uninsured adult in the household. The penalty will be a lower amount in 2014 and 2015 because Congress has phased-in the penalty provisions (H.R. 3590, 5000A(c)(3)(B)) . In 2014, the penalty will be the greater of 1% of household income over the filing threshold or $95. In 2015, it will be the greater 2% of household income over the filing threshold or $325. Beginning in 2016, it will be the greater of 2.5% or $695. (H.R. 3590: 5000A [a][c]-[e]).

Exemptions to the mandate will be granted: (I) for financial hardship, religious objections, American Indians, those without coverage for less than three months,

undocumented immigrants, and incarcerated individuals; (II) if the lowest cost government-approved plan option available exceeds eight percent of an individual's income; and (III) if an individual's income is below the Commerce Department's poverty level . The Act expressly provides that failure to pay the penalty cannot result in criminal liability. The Act states, In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure (H.R. 3590, 5000A[g][2][A]).

Similarly, the Act contains a mandate for employers, which is titled "Shared Responsibility for Employers" (H.R. 3590, 1513). This provision takes effect on January 1, 2014. Under the Act, employers with over 200 full-time employees must automatically enroll new employees in a government approved plan (H.R. 3590, 1511). Additionally, companies with 50 or more employees, at least one of whom is entitled to the federal subsidy for health insurance premium payments, must offer health insurance benefits or face a financial penalty of $2000 per employee. Companies with fewer than 50 workers would be exempt from the per-employee penalty. These employers could be eligible to receive tax incentives and credits for offering health care coverage. The Reconciliation Act lessened the amount of this penalty by subtracting 30 from the number of employees for the purpose of calculating the per-employee penalty (H.R. 4872, 1003[a]).

This mandate will also apply to state and local governments.

B. REQUIRED HEALTH BENEFIT POLICY TERMS

The Act also imposes new requirements on the terms of health insurance policies under which U.S. citizens and businesses will be covered. Under the Act, insurers may not, among other things: (I) establish lifetime limits on the dollar value of benefits or annual limits on the dollar value of benefits (effective 2014) [H.R. 3590, 2711]; (II) rescind a policy, except in the event of fraud or misrepresentation by the insured or (H.R. 3590, 2712) (III) exclude an individual from coverage due to that individual's preexisting condition (H.R. 3590, 2704).

Additionally, insurers must: (I) provide coverage for childhood immunizations, breast cancer screenings, and other preventative health care practices (H.R. 3590, 2713) (II) allow a parent to carry an adult child on his or her policy until the child reaches the age of 26 (H.R. 3590, 2714) and (III) allow the insured to renew his or her policy, if the insurer continues to offer that type of policy (H.R. 3590, 2703).

All insurers must provide individuals a standardized summary of benefits and coverage explanation that complies with regulations to be developed by the Secretary of Health and Human Services (H.R. 3590, 2715). All insurers must also provide a standardized process for coverage determinations and claims that provides certain procedural protections for the insured.

C. EXPANSION OF COVERAGE FOR LOWER-INCOME INDIVIDUALS AND FAMILIES

The Act expands Medicaid eligibility for low-income individuals. Beginning in January 2014, all children, parents, and childless adults who are not presently entitled to Medicaid and whose family incomes are at or below 133% of the federal poverty line will become eligible for Medicaid [H.R. 3590, 2001(a)(1)]. The federal government will fund 100% of the additional cost of providing care for newly covered individuals between January 1, 2014, and December 31, 2016, and it will pay a decreasing percentage of the additional cost in subsequent years [H.R. 3590, 001(a)(3)]. As these federal Medicaid payments decline, states will likely have to pick up these additional expenses.

The Act also provides for a tax credit to those lower-income individuals and families who do not qualify for Medicaid to assist in paying the cost of health insurance premiums. This "premium assistance credit" is calculated on a sliding scale – the lower a person or family's income, the higher the tax credit (H.R. 3590, 1401). Additionally, the Act reduces the maximum out-of-pocket costs that may be paid by lower-income individuals, as compared to the standard ceiling for out-of pocket costs (H.R. 3590, 1402).

D. THE HEALTH BENEFIT EXCHANGE PROVISION

The Act's exchange provision requires each state to establish an "American Health Benefit Exchange" no later than January 1, 2014 (H.R. 3590, 1311(b)(1)). The health benefit exchanges are designed to allow individuals and small businesses to access and compare health insurance policies through a centralized clearinghouse. The exchanges must facilitate the purchase of federal qualifying health plans, provide for the establishment of a "Small Business Health Options Program," and meet other requirements described in the Act [H.R. 3590, 1311(b)(1)].

To qualify for listing on the exchange, a health benefit plan must abide by regulations, to be established by the Secretary of Health and Human Services, governing marketing, enrollment, presentation of benefits in a standard format, and other matters [H.R. 3590, 1311(c)]. The Act authorizes grants of money to the states for activities related to the establishment of the health benefit exchange [H.R. 3590, 1311(a)(1)-(3)].

If a state fails to establish a health benefit exchange, the Act requires the Secretary of Health and Human Services to establish and operate an exchange within that state. The Secretary will do so if: (I) the state does not elect to apply standards that the Secretary adopts by regulation for establishing and operating exchanges, or (II) the Secretary determines by January 1, 2013, that the state will not have an operational exchange by January 1, 2014, or that the state has not (H.R. 3590, 2006).

E. THE DISASTER PROVISION

The Act's disaster provision adjusts the federal medical assistance percentage for Medicaid funding to states suffering major, statewide disasters. The provision applies only if, at any time during the preceding seven fiscal years, the President declared a major disaster in that state and determined that, because of the disaster, every county or parish in the state qualified for public assistance from the federal government (H.R. 3590, 2006). Other conditions also apply (H.R. 3590, 2006).

ANALYSIS OF THE ACT

Any analysis of federal legislation that impacts every aspect of the economy and one that is being implemented over an 8-year period is an "informed guess" at best. There are too many variables and too many unknowns for it to be otherwise. Caution is therefore advised when an analysis is provided by any interested parties that have undertaken the task in the wake of The Patient Protection and Affordable Care Act's enactment.

Nevertheless, the immediate benefits following enactment in March 2010 as given by the Democratic Policy Committee are (DPC 2010):

I. Health Insurance Consumer Information that will provides assistance to states in establishing offices of health insurance consumer assistance or health insurance ombudsman programs to assist individuals with the filing of complaints and appeals, enrollment in a health plan, and, eventually, to assist consumers with resolving problems with tax credit eligibility.

II. Offers tax credits to small businesses beginning in 2010 to make employee coverage more affordable.

III. Closing the Coverage Gap in the Medicare (Part D) Drug Benefit by providing a $250 rebate check for Medicare beneficiaries who do not receive Medicare Extra Help and who hit the 'donut hole' in 2010. Effective calendar year 2010. Beginning in 2011, the same Medicare beneficiaries will receive a 50 percent discount on brand-name drugs and biologics when they reach the donut hole. These are the first steps toward completely filling in the donut hole by 2020

IV. Increasing the Number of Primary Care Providers. It provides new investments in training programs to increase both the number of primary care health professionals and the capacity of the educational pipeline for health professionals.

V. Ensuring Medicaid Flexibility for States. It provides states a new option to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL)

VI. Re-insurance for Retiree Health Benefit Plans creating immediate access to re-insurance for employer health plans providing coverage for early retirees, helping to protect coverage while reducing premiums for employers and retirees.

VII. Access to Affordable Coverage for the Uninsured with Pre-existing Conditions

VIII. Provides $5 billion in immediate federal support for a new program to provide affordable coverage to uninsured Americans with pre-existing conditions until new Exchanges are operational in 2014.

IX. Public Access to Comparable Information on Insurance Options. Enables creation of a new website to provide information on and facilitate informed consumer choice of insurance options

X. No Pre-Existing Condition Coverage Exclusions for Children.

XI. Protects patients' choice of doctors by allowing plan members to pick any participating primary care provider, prohibiting insurers from requiring prior authorization before a woman sees an ob-gyn, and ensuring access to emergency care.

XII. Extension of Coverage for Young Adults. Requires insurers to permit children to stay on family policies until they turn 26.

XIII. Requires coverage of prevention and wellness benefits in all new plans and exempts these benefits from deductibles and other cost-sharing requirements in public and private insurance coverage.

XIV. Prohibits insurers from imposing lifetime limits on benefits.

XV. Tightly regulates plans' use of annual limits to ensure access to needed care in all group plans and all new individual plans.

XVI. Stops insurers from rescinding insurance when claims are filed, except in cases of fraud or intentional misrepresentation of material fact.

XVII. Prohibits new group health plans from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees.

XVIII. Requires all new health plans to implement an effective process for appeals of coverage determinations and claims. In addition, states will provide an external appeals process to ensure an independent review.

XIX. Makes an $11 billion investment over five years in Community Health Centers to expand existing and build new community health centers to increase access to high-quality, affordable health care.

XX. Medicare beneficiaries will receive a free, annual wellness visit and will have all cost-sharing waived for preventive services.

XXI. Ensuring Value for Premium Payments establishing standards for insurance overhead and requires public disclosure to ensure that enrollees get value for their premium dollars, requiring plans in the individual and small group market to spend 80 percent of premium dollars on clinical services and quality activities, and 85 percent for plans in the large group market. Health insurance plans that do not meet these thresholds will provide rebates to their policyholders.

Much of what The Patient Protection and Affordable Care Act will do in the real world depends upon conditions in the broader economy. This legislation's sweeping scope will have its own economic effect, potentially magnifying the impact of other factors.

Any attempt to project the real impact of legislation this massive must take into account both the literal language describing the Act's individual components and the overall trajectory as determined by total content, policy preferences of the party in power, and historical patterns. In law and politics, the whole often does prove to be greater than the sum of its parts, particularly after the implementing regulations are written.

Brady and associates give a summary analysis of this legislation including the Reconciliation Act crafting their analysis from the following economic and systems theory perspectives, in their own words (Brady 2010):

- The Austrian school of economic thought (Rothbard, Von Mises, Hayek) is correct. The Keynesian school is incorrect and its errors lie at the heart of today's economic problems.

- Static analysis of the type employed by the CBO will always understate costs and overstate positive financial impacts. As has been said to illustrate the point, "if you want more of something, subsidize it; if you want less of something, tax it."

- The entropy principle applies. Large centrally controlled organizations are generally less productive than aggregations of smaller enterprises generating the same output because they consume proportionately more resources to maintain their structure. Resources consumed by organizational maintenance are not available to do the actual work of the organization.

Although comprehensive review of the Act's economic impact is beyond the scope of this analysis, the net impact is virtually certain to be profoundly negative, a stark reality that must be taken into account by any decision maker (Brady 2010).

THE ACT'S PRIMARY EFFECT ON HOSPITALS AND PHYSICIANS

There will be an initial increase in demand, particularly for certain outpatient, home health, long-term care and preventive care services. In the short term, Medicare payment protections will be extended for small rural hospitals, including hospital outpatient services, lab services, and facilities that have a low-volume of Medicare patients. However, a net per capita reduction in federally subsidized payment for mandated services will almost certainly occur on an accelerated basis over time (Brady 2010).

The utilization of traditional private hospital and physician office services is gradually and increasingly targeted through a complex system of gradually implemented "financial disincentives" and regulatory changes over the eight-year implementation period. They are given below:

- The Act's financial incentives and regulatory controls promote the transfer of many primary care, dental care, counseling services, women's health, health promotion and education, podiatry, physiotherapy, case management, advocacy and intervention services away from traditional institutions and private practices funded by private insurance to a growing array of alternative delivery systems including the more than 4,000 "federally qualified" Community Health Centers and other subsidized or directly funded government programs. The funding of Community Health Centers, the number of Medicaid recipients, and the number of insured people with federal subsidies persons will all increase exponentially under the Act.
- The Act mandates the provision of grants for up to three years "to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics." The funding period expands to five years beginning in 2011.
- The Act mandates the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. Funds are to be appropriated for five years beginning in fiscal year 2010.

New Medicare regulations directly linked to physician payment will be implemented to "encourage" doctors to form "accountable care organizations" to "improve quality and efficiency" that will facilitate development of centralized mechanisms to control healthcare delivery. The Act mandates that Medicare develop a physician payment program to reward quality of care rather than volume of services. Although the desire to reward "quality" is commendable, the incentives will work to the disadvantage of hard working private-practice physicians who now treat large numbers of Medicare patients and produce queues for service among the elderly ill. A new federally created Patient-Centered Outcomes Research Institute will contract with appropriate federal agencies and private sector groups to conduct "comparative effectiveness research" (CER). Despite current disclaimers to the contrary (easily dispensed with by amendment whenever it becomes useful to do so) CER findings will ultimately define the boundaries of

authorized medical practice which will be used to ration healthcare to the elderly ill by weighing the estimated cost of care against a patient's statistically-determined years of remaining life.

The Act establishes a private, non-profit institute to "identify national priorities and provide for research to compare the effectiveness of health treatments and strategies." It mandates creation of a national commission "to provide comprehensive, nonbiased information and recommendations to Congress and the Administration for aligning federal health care workforce resources with national needs.

It establishes a "Graduate Medical Education" policy to redistribute "unused primary care training slots ... for purposes of increasing primary care training at other sites." It is also to expand the size of the primary care nursing workforce by July 2011. In 2014 the income level for Medicaid eligibility will increase dramatically, creating an estimated 15 million new Medicaid patients and creating significant new financial pressures on the States. What this means for uncompensated care cannot be currently determined. However, it appears likely to increase significant new demand for hospital service by Medicaid patients in all regions which of necessity will produce a parallel increase in the percentage of care compensated at Medicaid rates.

Also starting in 2014, a federal mandate will force all businesses employing more than 50 full-time employees to provide insurance, pay penalties or both. Penalties will be determined by the number of full-time employees (or equivalents) employed, whether or not the business provides health insurance at the "qualified" level of benefit, and whether or not one or more employees qualify for government subsidies toward the purchase of health insurance. This is sound policy only if the intent is to discourage small businesses from providing health insurance as an employee benefit. According to published survey data, the average corporate health benefit expenditure in 2009 was $9,660 per employee. Inasmuch as the cost of providing or continuing the benefit will typically exceed the amount of potential fines by several orders of magnitude, the rational decision for many small businesses will be to continue not offering coverage (if it is not currently provided) or to discontinue existing coverage. This provision will (I) decrease the number of

privately insured individuals; (II) increase the number of people covered by tax supported and/or subsidized programs; (III) decrease premium revenue to insurance companies; and (IV) increase revenue to the federal government from non-compliance fines.

Although the Act's effect on the general economy is beyond the scope of this analysis, the broader impact of this provision on job creation is worth thinking about. Consider the case of a small firm with 50 employees that does not now provide a health insurance benefit. Should the owner decide to hire that 51st employee, an additional hiring cost is now mandated. The owner must pay $2,000 each year for that employee, plus $2,000 per year each for the 31st through 50th employees. Therefore the total additional penalty cost of hiring that new employee is $42,000 per year (Brady 2010).

PRIMARY EFFECT TO INSURANCE COST FOR INDIVIDUALS

The guaranteed issue provision provides increased access to insurance for high-risk people. However, its structure will almost certainly result in some people making the perfectly rational decision to buy insurance only when they perceive a need for it, a decision that will have the effect of increasing prices for everyone. Although participation is made mandatory for the estimated 30% of young adults who are without health insurance (many of them by choice), "undocumented workers" are exempt from the mandatory participation requirement. Because the average "fine" for non-purchase of insurance is $750 per year, the Act's current enforcement measures are unlikely to persuasively change the decision to stay uninsured.

The elimination of health status ratings will inevitably result in younger, healthier individuals subsidizing the premium costs of less healthy and older people. The requirement that all policies meet federally mandated minimum benefit levels guarantees an increase in total program costs. The potential premium cost for a family earning $54,930 per year is $5,218 or 9.5% of their income. This is an out-of-pocket cost. Finally, the Act's provisions will force many people who are currently covered by employer-supplied benefit programs to purchase individual policies as businesses drop health insurance from their benefit packages.

EFFECT ON FEDERAL HEALTH EXPENDITURE

The United States Department of Health and Human Services reported that the bill would increase "total national health expenditures" by more than $366 billion from 2010-2019 (CMS 2009). The Congressional Budget Office (CBO) estimates the new health reform law will provide coverage to an additional 32 million when fully implemented in 2019 through a combination of the newly created Exchanges and the Medicaid expansion. CBO estimates the cost of the coverage components of the new law to be $938 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise $32 billion over ten years. CBO also estimates that the health reform law will reduce the deficit by $124 billion over ten years (CBO 2009).

The Department of Health and Human Services estimate expenditures by a net total of $366 billion during the period – 2010-2019; a combination of $930 billion in net costs associated with coverage provisions, $493 billion in net savings for the Medicare provisions, a net savings of $36 billion for the Medicaid/CHIP provisions (excluding the expansion of eligibility), $2 billion in savings from proposals intended to help reduce the rate of growth in health spending, $38 billion in net savings from the CLASS proposal, and $5 billion in costs for the immediate insurance reforms.

Of the estimated $930 billion net increase in Federal expenditures related to the coverage provisions of the Patient Protection and Affordability Care Act, about two-fifths ($364 billion) can be attributed to expanding Medicaid coverage for all adults who make less than 133 percent of the FPL and all uninsured newborns. The remaining costs of the coverage provisions arise from the refundable tax credits and reduced cost-sharing requirements for low-to-middle-income enrollees purchasing health insurance through the exchanges ($617 billion) and credits for small employers who choose to offer insurance coverage ($12 billion). The increases in Federal expenditures would be partially offset by the penalties paid by individuals who choose to remain uninsured and employers who opt not to offer coverage; such penalties together total $64 billion through fiscal year 2019, reflecting the relatively low penalty amounts specified in the legislation.

FINDINGS

The national health care reform proposals in the Patient Protection and Affordable Care Act would make far-reaching changes to the health sector, including mandated coverage for most people, required payments by most employers not offering insurance, expanded eligibility for Medicaid, Federal premium and cost sharing subsidies for many individuals and families, and a new system of health benefits exchanges for facilitating coverage. Additional provisions would reduce Medicare and Medicaid outlays, add certain benefit enhancements for these programs, and combat fraud and abuse. Federal revenues would be increased through an excise tax on high-cost insurance plans; fees on drugs, devices, health plans and other provisions.

The primary estimates by the Office of the Actuary at CMS for the Patient Protection and Affordable Care Act are as follows (CMS 2009):

- The total Federal cost of the national insurance coverage provisions would be about $930 billion during fiscal years 2013 through 2019.
- By 2019, an additional 33 million U.S citizens and other legal residents would have health insurance coverage meeting the essential-benefit requirements.
- Total net savings in 2010-2019 from Medicare provisions would offset about $493 billion of the Federal costs for the national coverage provisions. The non-coverage Medicaid provisions would reduce costs by about $36 billion.
- Total national health expenditures in the U.S during 2010-2019 would increase by about 0.7 percent.
- The proposed reductions in Medicare payment updates for providers, the Actions of the Independent Medicare Advisory Board, and the excise tax on high-cost employer-sponsored health insurance would have a significant downward impact on future health care cost growth rates. During 2010-2019, however, these effects would be outweighed by the increased costs associated with the expansions of health insurance coverage.

CHAPTER 6

CONCLUSION

We have come to the end of the dissertation and the purpose of this endeavour was to provide an objective and critical analysis of the Patient Protection and Affordable Care Act, 2010. The current dissertation also critically studies the making of the bill, the opposition to the bill and process of the final draft of the bill and its plausible short term and long term effects.

As stated earlier in Chapter One, an interest on this subject is prompted by general observations like the U.S., despite being one of the wealthiest and politically the most powerful nation on earth is not able to successfully implement a plan that is beneficial for both, the health care industry in terms of promoting efficiency and excellence, and its citizens. It is to be noted while the U.S spends more on health care than other countries in the Organization for Economic Cooperation and Development (OECD), the use of healthcare services in the U.S. is below the OECD median by most measures. The authors of the study conclude that the prices paid for healthcare services are much higher in the U.S.A. (*Health Affairs* 2000).

Notwithstanding very high health spending (about 15% of GDP) and the use of cutting edge technology, the health status of the US population does not appear to fare well by international comparison. A particular source of concern is the large number of people who lack adequate health insurance. It is estimated that 46 million persons were not insured at all in 2007 (16% of the population) (OECD 2008), with a further large share of the population underinsured. These and many other factors were the reason the current Obama administration felt health care reform was domestic priority number one, and promptly set the wheels spinning on health reform as soon as he took office.

The Patient Protection and Affordable Care Act became a direct result of the various problems faced in the public health sector. The Act is supposed to be a panacea for

many of the teething problems infesting the American health care system. A number of authors and experts have analysed and studied the Act. A review of some of the writings and literature is done in Chapter One. It would be safe to say that many of the experts and authors are a little cynical and pessimistic of the affect the Act may have in curing and ridding the problems the American health care system faces today. The authors feel the health system needs a system overhaul and not some particular part being targeted and mended. A more detailed analysis of the criticism and shortcomings of the Act will be discussed later.

Chapter Two deals with the history and background of the Public Health system in America. It traces from the origin of the health care system till the end of the twentieth century. From the Act for the Relief of Sick and Disabled Seamen passed in 1798 to the Bio Terrorism bill passed in 2002 under President Bush, a detailed account of the evolution of the Public health system in America is provided. The elusive answer to the real cause of the decline of the American public health system may have been answered in this chapter. One very important reason for both the complacency about public health and its secondary status has to do with what has been explained in chapter two.

To simplify a bit, the health care field is divided between two models, curative and preventive. Modern medicine embodies the curative model; with its elaborate technology, it has developed a preeminent place in the field. It emphasises the treatment and cure of disease and is supported by medical research centres, biotechnology companies (including pharmaceutical companies), and significant amounts of government funding through the National Institutes of Health. Medical journals, almost by definition, are dominated by this field. Further, the curative model operates for the most part outside the public sector, and those involved in medicine have a fair amount of freedom from public scrutiny to engage in their profession.

Public Health embodies the preventive model and focuses on populations and health prevention. There are fewer programs in public health than there are medical schools, fewer people work in the field, funding is much less. And, as have been pointed out (Garrett 2000), the quality of the public health system has deteriorated. The public health system has suffered from neglect.

Part of the reason for neglect is that public health is a government function, with much of it carried out at the state and local level. State and local funding priorities have been in education and criminal justice and health care, meaning Medicaid. Little has been left for public health.

Chapter Three traces the rise of Barack Obama, from the historic keynote address at the Democratic Convention in Boston, in February 2004 to his victory speech on the night of November 4, 2008. As brilliant as the Obama campaign seems in hindsight, it was also helped by an enormous stroke of political luck. The investment and banking crisis that began on Wall Street months earlier surfaced in mid-September with the request by President George W. Bush for an unprecedented $700 million dollar bailout of major banking, insurance, and investment firms by the federal government. The crisis took centre stage and allowed the American people to contrast the different approaches and proposals offered by the candidates as well as assess their reaction to the situation. Obama just had to ride the wave of the peoples demand and desire for change.

A detailed summary and analysis of the health care reform proposals of Hillary Clinton, John McCain and Barack Obama is prepared as well as comparison of their proposals to each other.

Experts say the health care plans put forth by Democratic presidential candidates Hillary Clinton and Barack Obama were very similar – and Obama himself had said his proposal had 95 percent in common with hers. When it comes down to it, though, the Clinton plan truly is more comprehensive--for the sole reason that it mandates that all Americans must have health insurance. Obama's plan does not (but it does require that all children have health insurance). Under the Obama plan, healthy people could choose not to buy insurance, then sign up for it if they developed health problems later. This would lead to higher premiums for everyone else. It would reward the irresponsible, while punishing those who did the right thing and bought insurance while they were healthy.

Experience demonstrates as well as experts believe that a sizable population will opt out--however ill-advisedly--of purchasing health insurance, unless it is required. On this point, then, Clinton certainly wins.

Barack Obama's proposal and John McCain's proposal on health care could be differentiated like water and oil. The presidential candidates' health care reform proposals offered fundamentally different visions of the future of health insurance in the United States. Senators John McCain and Barack Obama had the potential to place the nation's health system on very different paths, with profound implications for the American people. Obama's proposal for mixed private–public group insurance with a shared responsibility for financing had greater potential to move the health care system toward high performance than did McCain's proposal to encourage individual market coverage through the use of tax incentives and deregulation.

McCain's proposal to reform the health insurance system by relying on tax incentives and voluntary purchase of coverage in the individual insurance market with few ground rules was, by itself, unlikely to achieve universal coverage. According to one estimate, in 10 years McCain's proposal would have reduced the number of people who are uninsured by 2 million out of a projected 67 million, while Obama's plan would have reduced the number of uninsured people by 34 million (Collins et al. 2008).

In the end, Obama's health care proposal came out on top when compared to McCain's proposal although many experts believed Hillary Clinton's health care proposal was much better than Obama's. But then Hillary Clinton could not get the Democratic nomination and Barack Obama's Health Care proposal went through because the American people voted for him and his policies.

Chapter four discussed in detail the opposition to the health care reform bill from various quarters, from Republican Party members to representatives of the Insurance companies, pharmaceutical companies and various associations of doctors and physicians. The reason and cause behind such fierce opposition to the health care bill is studied and analysed, and the findings reveal the differing reasons and compulsions of the various groups and associations in opposing the bill.

The Republican Party's opposition to the health care bill has been scrutinized and the idea of requiring every American to have health insurance is one of the most abhorrent provisions of the Democrats' health overhaul bills. "Congress has never crossed the line between regulating what people choose to do and ordering them to do

it," said Sen. Orrin Hatch (R-UT). "The difference between regulating and requiring is liberty" (Tumulty 2010).

But Hatch's opposition is ironic, or some would say, politically motivated. The last time Congress debated a health overhaul, when Bill Clinton was president, Hatch and several other senators who now oppose the so-called individual mandate actually supported a bill that would have required it.

In fact, says Len Nichols of the New America Foundation, the individual mandate was originally a Republican idea. "It was invented by Mark Pauly to give to George Bush Sr. back in the day, as a competition to the employer mandate focus of the Democrats at the time" (Tumulty 2010).

Has the Republican Party suddenly regained their fiscal conservative roots after years of supporting President Bush's profligacy? I would argue that there is a more immediate, more cynical and far more political motive: self-preservation. Passing health care reform that guarantees coverage for the 47 million uninsured Americans would drive a stake through the heart of the party that opposed that reform. The newly covered 47 million voters would, after all, likely have a tendency to vote Democrat. Add to that total the untold millions who would get a warm, fuzzy feeling toward the Democrats after switching to a cheaper, more-efficient public option, and you begin to realise just what a vast problem this could turn out to be for the Republican Party.

Public health care wasn't just the right thing to do from a moral standpoint for the Democrats; it also made the most sense politically. And when it comes to pure politics on a Machiavellian scale, the Republican Party is far from stupid. The movers and shakers would have to know how much damage a public option could do to them, and that's why they fought so vociferously against it; not because of some sense of fiscal discipline, but out of simple self preservation (Sweeney 2009).

Of all the problems with the current U.S health care system, perhaps the most insidious is that the system is fuelled by special interest groups, whose chief concern is their own bottom line. The modus operandi being they all pay lobbyists huge sums of money to convince legislators to maintain the status quo, or to draft legislation in

their favour. But unless these groups agree on a solution that will overhaul the system, nothing will get done and no bill can be passed.

The healthcare reform bill passed by Congress focuses, first and foremost, on insurance companies. And, despite the insurers' opposition to reform, they stand to benefit from it in the long run. The short-term changes that the legislation requires will have a negative impact on insurer profits. Aside from the reduction in government payments to Medicare Advantage plans, insurers will no longer be able to sell policies with lifetime caps on insurance, exclude children from coverage on the basis of pre-existing conditions, or drop adults when they're sick under a policy known as "rescission."

Moreover, as insurance companies get 32 million new customers, they will receive a tremendous infusion of cash that should enable them to reduce their prices. And the $74 billion in other new taxes that will be levied on insurance companies to pay for reform is a rounding error compared to the size of the revenues they'll get in the next decade.

The Obama White House has acknowledged it made a deal with drug makers to block moves in Congress to obtain any cost savings beyond the $80 billion already agreed to by the pharmaceutical lobby. The *New York Times* reported that (Randall 2009), in return for the $80 billion agreement, the Obama administration pledged that it would work to block any health care legislation that would allow the government to negotiate price-setting on drugs.

Obama's public affirmation that no further "cost savings" are to be extracted from the drug companies is confirmation the health care plan Obama signs is a result of a compromise, considering the pharmaceutical companies, who in cutting a deal with the White House got pretty much all the concessions they wanted.

So the real reason for opposing the health care bill by the insurance agencies and pharmaceutical companies I think is because of short-term thinking: Instead of focusing on how the expansion of coverage will provide new business and shore up a rapidly eroding system, insurance executives and investors only see increased government regulation that will restrict the insurers' freedom of action.

The American Medical Association (AMA) - the nation's largest physician organization with nearly 250,000 members – which had initially opposed the president's plant backed the House Democrats' version of the bill later. This had led to an internal dispute that resulted in some physicians leaving the nation's largest doctors' Association. Some doctors charged the bill would lead to inferior patient care as physician offices around the country triple their patient lists and become forced to ration care.

The physician fraternity was quite polarised when it came to the health care bill, while the largest organisation, the AMA, changed its earlier stance and supported the bill, a number of other organisations and associations opposed the bill while some new lobbies and organisations sprung up opposing the bill. The Association of American Physicians and Surgeons (AAPS), Docs4PatientCare, Physicians Against Obamacare and a host of other organisations were fiercely opposed to the bill.

So why were physicians so pessimistic about a bill that clearly had so many positives? The answer maybe because, the bill addresses none of the issues most consistently ranked by physicians as the most critical for lowering costs and improving access. Tort reform, streamlining billing and payment, and fixing the flawed government formula for calculating physician reimbursement are given little, if any, serious attention (Palestrant 2010). These were some of the reasons the physicians association were quite polarized on the issue of the health care bill passed by the Obama administration.

Chapter Five deals exclusively with the Patient Protection and Affordable Care Act, i.e. the provisions of the bill, a detailed summary of the bill; although the bill is too big and vast encompassing many and different areas, one has earnestly tried to be as thorough in covering all the important and controversial aspects of the bill. A critical analysis of the bill backed by various experts and organisation is undertaken to evaluate the effects and causes the bill may have immediately affecting the American citizens. A glimpse of the possible and plausible long term effects of the bill has also been discussed to make the findings more wholesome and comprehensive.

One has tried to answer all questions and problems that could or would have risen with the passage of the bill. The questions posed in the Research Problem have been

largely answered with explanations as clearly and accurately as possible. The hypothesis of this dissertation was that the U.S health care system needed health system reform and not health insurance reforms and universal coverage would only make things worse if the system itself did not become more efficient and less costly. One has sincerely tried to prove the hypothesis and the premise of the dissertation that the bill passed would not meet the requirements to rid the system of its deficiencies and problems.

The first question is if the Act would be sustainable in the long run with no systemic changes proposed in the health system. The cost of the bill according to the Congressional Budget Office (CBO), estimates the bill will reduce the number of uninsured by 31 million in 2019 at a net cost of $871 billion over ten years. The cost of the Act would be financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The Congressional Budget Office estimates the proposal will reduce the deficit by $132 billion over ten years. (CBO, 2009)

So the answer is yes, the Act will reduce the current deficit and would be sustainable, but the deficit reduced would be marginal compared to the total spending on the health care system as a whole.

The second question was if the Act might be paying off people already profiting from the status quo with a significantly watered down version that got passed. The answer is yes, the insurance companies and the pharmaceutical companies will still profit hugely from the system. The interest groups and lobbies of these powerful companies already brokered a deal with the Obama administration and even acknowledged it made a deal with drug makers to block moves in Congress to obtain any cost savings beyond the $80 billion agreed to by the pharmaceutical lobby. In return for the $80 billion agreement, the Obama administration pledged that it would work to block any health care legislation that would allow the government to negotiate price-setting on drugs. The $80 billion dollar pledge is quite insignificant when the companies deal in trillion dollar sales.

The answer to how the Act would help mitigate the unaffordable rate increases is that starting in 2014, insurers will no longer be able to deny coverage to people with pre-existing conditions — a requirement that America's Health Insurance Plans, the insurer trade association, has predicted will lead to an explosion in premiums because

the legislation will not create universal coverage. In the early going, premiums are indeed predicted to rise to those who earn too much to merit government subsidies; but other individuals will see their premiums drop, according to the Congressional Budget Office. Moreover, as insurance companies get 32 million new customers, they will receive a tremendous infusion of cash that should enable them to reduce their prices.

The next question was if the Act would substantially increase access to affordable and adequate coverage for those with the highest health care needs, including those with chronic illnesses, by spreading health care risk broadly? The requirement of health insurance companies to allow citizens regardless of previous medical illness will come into effect only in 2014. This provision as well as the individual mandate provision would also come into effect only in 2014, this would lead to insurance companies getting 32 million new customers, and they will receive a tremendous infusion of cash that should enable them to reduce their prices. This means, premiums would most probably fall and people with chronic illness and the highest health care needs would be able to buy health insurance either from the private players or from the public option available without prejudice or discrimination. So yes, the Act is quite likely to increase access and coverage for average and needy citizens alike.

In all these aspects, the Act will manage to mitigate rising cost of premiums and insurance itself, and the provision of insurance companies not to deny coverage to citizens with pre existing conditions is a great move. The individual mandate is the only answer to meet the costs that would follow and the bill provides for subsidies to those in need of help. So yes the Act would seem to answer quite a few of the problem areas in the health care system. But it also leaves some gaping holes in the quagmire.

I feel that there are two themes that cut to the heart of the health care debate. First, Obama has made a mistake in moving toward the narrower goal of "health insurance reform" when what the country truly needs is health system reform. Imposing a mandate for universal insurance will only make things worse if it doesn't change the process so that it becomes more efficient and less costly. The system prevalent today is gradually bankrupting the country; expanding that system without changing the internal dynamics is folly.

Second, reformers obsessed too much on the need of a "public option" in the plan. Yes, there is a need for a yardstick for measuring costs and effectiveness. It should have started by fixing the public options already available. Dennis Cortese (Chief Executive of the Mayo Clinic) counts six existing public options that should be laboratories for reform: Medicare, with its 45 million patients and a fee-for-service structure that all but guarantees bad medicine; Medicaid, with an additional 34 million beneficiaries; military medicine, through which government doctors deliver state-of-the-art care; the Department of Veterans Affairs, which has improved performance at its hospitals by embracing new technology; the "Tricare" insurance plan for military retirees; and the Federal Employees Health Benefits Program.

Adding a new public option for insurance, as the Act contains, would be useful. But it's not necessary now, and it is creating a poisonous debate that's undermining the more important reforms -- which are in the delivery system, not insurance. The public option is not a bad thing; it's just that it wasn't the real panacea needed to overhaul the underperforming health care system.

A lot of experts including Dr. Cortese believe reform should begin with the existing single-payer behemoths, Medicare and Medicaid. Dr. Cortese argues that the White House should mandate that, within three years, these programs would shift from the current fee-for-service approach to a system that pays for value -- that is, for delivering low-cost, high-quality care. If doctors performed unnecessary tests that ballooned costs, their compensation would be reduced. And doctors would be compensated by regional formulas, to encourage them to work cooperatively in local networks where they could all make more money by practicing better medicine.

What difference would such Medicare reform make? A look at estimates prepared by the Dartmouth Institute for Health Policy and Clinical Practice, at current spending rates, Medicare will run a $660 billion deficit by 2023. But by cutting the annual growth in per-capita spending from the current national average of 3.5 percent to 2.4 percent (the rate in San Francisco, for example), Medicare could save $1.42 trillion and post a big surplus. (Ignatius, 2009)

This "pay for value" approach would amount to a cultural revolution in American health care. It would take the bloated system and make it cheaper and better. The adjustments wouldn't be easy, and the medical profession would balk unless respected

doctors such as Dr. Cortese led the way and he's already doing what the American health care system needs - that is, providing high-quality health care at relatively low cost.

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