Faith & Reason Honors Program

SENIOR THESIS

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An Analysis of the Quality of Care Provided by the American Health Care System

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Introduction:

One of the key issues discussed and heavily debated in current American politics is health care and the future of the American health care system. While almost every policy and reform decision is highly controversial in today’s exceedingly polarized political environment, the future of American health care and the question of how to improve our current system seem to take the forefront. Although Washington politics have turned the issue of health care into a highly controversial political battle ground, almost all Americans can agree that some changes do need to be made to our current system. The question seems not to be whether health care reform needs to take place in America, but instead how do we go about changing such a large, complex, and cumbersome system. This pressing question will continue to be debated for years and the solution will not be simple, but what is often overlooked is that ethical issues are at the root of the health care crisis in America. One of the central ethical questions concerning health care is what does it mean to provide high-quality health care? The goal of any society is to provide high-quality care for its people and the medical profession has an ethical mandate to provide the highest quality of care possible. The medical profession has sought to fulfill this crucial role by professionalizing the field of medicine and creating health insurance, but as the health care system has become more complex and expensive, so has the ability to provide high-quality health care.

This paper will give a sweeping overview of the development of America’s health care system in order to examine how the goal of providing quality care has been approached in the past. The focus will be on the professionalization of American medicine, the emergence of health insurance, and the problem of increasing health care costs. Health care costs are a continually growing and significant component of the United States gross domestic product, but the health
care outcomes in the United States do not match the significant expenditures. Many international models of health care are spending much less per capita on health care than the United States and achieving better health outcomes. One such model is the Swedish health care system. This alternative model will be analyzed for its applicability to and potential for success in the unique environment and culture of America. Finally, there will be a brief look at a future direction for American medicine: primary preventative care.

**The Professionalization of Medicine:**

The field of medicine has changed drastically over time, and many of the changes can be linked back to the common goal of improving the quality of care. So what is good, high-quality health care? It has been defined as, “care that assists healthy people to stay healthy, cures acute illnesses, and allows chronically ill people to live as long and fulfilling a life as possible.”¹ There are five main components of high-quality health care: adequate scientific knowledge, competent health care providers, organization of health care institutions to maximize quality, separation of financial and clinical decisions, and access to care.¹ Throughout history, the field of medicine has evolved in such a way as to address and better meet the components of high-quality health care. The professionalization of medicine has specifically targeted the first three components of high-quality health care by defining who should be qualified to practice medicine, connecting medicine to the developments of science, and developing a medical infrastructure.

From the early colonial era until the early nineteenth century, health care was very poorly organized and medicine was not professionalized in the United States.² A physician was not considered a prestigious occupation and medical techniques were very primitive.² Treatments often included bloodletting and the use of mineral cathartics, which are strong laxatives, as
means to restore the balance of the body and improve health. The lack of effective treatments led to a general distrust by the public in the medicine of physicians. As Paul Starr states in his book, *The Social Transformation of American Medicine*, “there were three spheres of practice relatively equal in importance—the medicine of the domestic household, the medicine of the physicians, and the medicine of lay healers.”

From the time of the American Revolution and the Western Frontier, Americans have displayed an individualistic and independent spirit and this sentiment led to an appeal of Americans for lay healers and medicine of the domestic household. Hospitals were regarded as dangerous and people who could afford it, would receive care at home. Hospitals were mainly centered in major cities and populated with travelers and outcasts. A profession, “by its nature, is an inegalitarian institution; it claims to enjoy a dignity not shared by ordinary occupations and a right to set its own rules and standards.” This goes against the democratic spirit and is partly why early efforts of professionalizing medicine in America were so difficult.

The movement to professionalize medicine was strengthened by the establishment of the first medical school in Philadelphia in 1765, the College of Philadelphia. Proper medical training was still a great concern in America. By 1776, there were approximately 3,500 to 4,000 physicians in the colonies; 400 had formal medical training, and only about half had a formal medical degree. The apprenticeship model was the primary means of medical training in the colonial period. Typically, young men would serve as assistants for physicians for three years and then be given a certificate of proficiency. Medical schools were seen as supplemental to apprenticeships and were not required to be affiliated with hospitals. Medical schools in the eighteenth century originally offered both a bachelor’s and a doctoral degree in medicine, but most students took a bachelor’s degree because it was all that was needed to be a physician.
1789 the medical school at the College of Philadelphia set the new standard and eliminated the bachelor’s degree.\textsuperscript{10} The formation of medical societies and medical licensure also accompanied the movement to professionalize medicine.\textsuperscript{17} The first medical society was formed in New Jersey in 1766.\textsuperscript{8} The American Medical Association (AMA) was formed in 1847.\textsuperscript{23} In England, professional medical societies had the power to license, and unsuccessful attempts were made by early prominent American physicians, such as John Morgan, to attain a similar structure in America.\textsuperscript{17} Some licensing did occur in the early colonies, but it was mainly honorary in nature and did not exclude those without licenses from practicing medicine.\textsuperscript{17} There was a great deal of early resistance to licensing because much of the medical care was provided by domestic and lay practitioners.\textsuperscript{17} Following independence in 1776, many state legislatures began to extend licensing power to medical societies.\textsuperscript{17} Licensure powers proved to be ineffective because, “no standard was set for education or achievement, no power was given to rescind a license once awarded, no provision was made for enforcement against unlicensed practitioners, and no serious penalties were imposed by violating the law.”\textsuperscript{17} Further weakening licensing attempts by medical societies was the fact that boards often did not turn down applicants because they did not want to lose licensing fees.\textsuperscript{18} Additionally, diplomas from medical schools were often seen as licenses to practice medicine in and of themselves.\textsuperscript{18} Attempts were made to define the medical profession on the basis of graduate versus non-graduate of a medical school, member versus non-member of a medical society, and licensed versus unlicensed, but it would take decades for the establishment of rules that allowed for only graduates to be licensed and for only licensed practitioners to be able to legally practice medicine.\textsuperscript{19} States began to rescind licensing laws in the 1820’s: Illinois in 1826, Alabama in 1832, Mississippi in 1836, and South Carolina,
Maryland, and Vermont in 1838, to name a few. Public opinion that licensure was a matter of favor rather than competence was what ultimately destroyed early licensure efforts.

The public’s skepticism over medical licensure carried over into skepticism over the growing complexity of medicine and the belief that it was in fact an artificial complexity. Many still believed that medicine could be easily understood and that self-treatment and medical treatment by lay healers was just as effective as orthodox medical practices. Scientific developments would eventually convince the public that the complexity of medicine is legitimate and that there are limits to lay and domestic medicine. One such influential scientific advancement was Louis Pasteur’s development of the germ theory of disease in 1862. Prior to Pasteur’s germ theory, disease was generally attributed to evil forces, poisonous vapors called miasmas, or supernatural events. Spontaneous generation was used to explain how life could seemingly emerge from decaying organic matter. Pasteur’s work disproved the theory of spontaneous generation and attributed the cause of disease to microbe-sized life-forms. Whereas the previous miasma model of disease offered only methods to prevent disease through increased public health movements, Pasteur’s germ theory provided a means for combating disease after a person was already inflicted. Medicine and science entered an era of greater precision and speed in which many significant developments allowed physicians to better combat disease (see Figure 1 below).
Surgery was also revolutionized with the use of ether anesthesia at Massachusetts General Hospital in 1846, the first use of antiseptics in 1867 by Joseph Lister, and the development of X-rays in 1895. Surgery had previously been viewed with great skepticism and was generally only tried after all else failed, but respect for surgeons gradually increase throughout the 1860’s and 1870’s, beginning with the Civil War. The National Academy of Sciences was established in 1863, during the Civil War, showing the publics’ increased confidence in the sciences.

One of the greatest obstacles to the professionalization of medicine was internal division amongst practitioners across the United States. As stated earlier, a profession, “claims to enjoy a dignity not shared by ordinary occupations and a right to set its own rules and standards.” The issue with early efforts to professionalize medicine in America was that physicians could not agree on the criteria for belonging to the profession and what rules and standards needed to be implemented. There was also a growing sectarianism in medicine. A radical movement of
botanic medicine emerged as an alternative to the medical profession in the early nineteenth century. Its followers were called Thomsonians. The movement focused on the use of botanic medicine and was based on a few simple principles: all disease was the effect of one cause, cold, and could be removed by one remedy, heat. Thomsonianism declined and by the second half of the nineteenth century the principal sects in America were the Eclectics and homeopaths. The Eclectics movement followed heavily from the Thomsonians, but did not deny the importance of conventional medical science. The homeopaths viewed disease as a matter of spirit. They held three central doctrines: “first that diseases could be cured by drugs which produced the same symptoms when given to a healthy person…second the effects of drugs could be heightened by administering them in minute doses…and third, nearly all diseases were the result of a suppressed itch, or psora.” These two large sects did not downplay the complexity and centrality of the medical science of orthodox medical schools, but they disagreed on therapeutic treatments for diseases.

As a result of the inability to professionalize early medicine, the class position of early physicians in America did not carry the prestige and financial security as it does today. The prominence of physicians may not have been low, as seen by the fact that four medical practitioners—Benjamin Rush, Josiah Bartlett, Lyman Hall, and Matthew Thornton—signed the Declaration of Independence, but the status of the profession as a whole was low. Being a physician was generally viewed as an undesirable occupation. An 1851 report by the AMA reported the results of a study following the careers of 12,400 men who graduated from eight leading, prominent colleges (Amherst, Brown, Dartmouth, Hamilton, Harvard, Princeton, Union, and Yale) from 1800 to 1850, and found that about twenty-six percent became clergymen, about twenty-six percent became lawyers, and only eight percent became physicians. In 1904 the
Journal of the American Medical Association published a report finding that the average income for a doctor was only $750, with the average income of all occupations being $540.\textsuperscript{36} The personal rifts and medical sectarianism produced an unclear class position for physicians in America and made the move to professionalize medicine ever more challenging. Efforts to reinstall licensing and reform medical education were futile.\textsuperscript{28}

Although the rifts continued, particularly by hardliner orthodox members of the American Medical Association (AMA) against the sects, progress was made as seen by the addition of a homeopathic division into the University of Michigan Medical School in 1875.\textsuperscript{29} Much of the ensuing progress was made due to public pressure on the orthodox physicians and sectarians to compromise.\textsuperscript{29} With increased specialization of medicine came more interdependence between the two sects and the orthodox physicians.\textsuperscript{30} The specialists relied on homeopathic and Eclectic general practitioners for referrals and the sectarian general practitioners depended on the specialists for access to facilities as hospital usage began to grow.\textsuperscript{30} Beginning in the 1870’s and 1880’s, educated orthodox physicians and sectarians began to unite and collaborate to win licensing laws to protects themselves against competition from untrained practitioners.\textsuperscript{30} A critical test of the legitimacy and strength of medical licensing occurred in 1888 in the U.S. Supreme Court case of Dent v. West Virginia.\textsuperscript{31} A physician, Frank Dent, who had practiced for six years was convicted and fined under an 1882 licensing statute in West Virginia requiring physicians to hold a reputable medical degree, pass an examination, or prove that he had been in practice for ten years.\textsuperscript{31} The State Board of Health did not accept Dent’s degree from the American Medical Eclectic College of Cincinnati and the Supreme Court upheld the decision. Justice Stephen Field stated, “few professions required more careful preparation…than that of medicine” and everyone may have the right to consult a doctor, but
“comparatively few can judge of the qualifications of learning and skill which he possesses.”

Justice Stephen Fields was speaking about the monumental importance of the medical profession in any society. Medical professionals make life and death decisions on a daily basis. This unique responsibility of the medical profession necessitated the professionalization of the field in order for regulatory standards to be set to determine who was allowed to practice. The establishment of medical licensing was crucial in improving the medical professions ability to fulfill its ethical mandate to provide the highest quality of care possible. As medical licensing and medical societies strengthened and unified, organized medicine developed. For example, in 1900 the AMA’s membership was 8,000, but by 1910 it had increased to 70,000 and by 1920 sixty percent of physicians in the country were members. The medical profession was beginning to unify and its social structure was changing. Physicians began to rely more on one another for access to patients and facilities, and for defense against the increasing number of malpractice suits arising.

One of the key issues left for the medical community to address was the control and standardization of medical education. There were great inconsistencies in the criteria for admissions, curriculum, and length of time required to complete medical training. As stated by Paul Starr:

Nominally, the requirements for an M.D. in the eighteenth century were a knowledge of Latin and natural and experimental philosophy; three years of tutelage as an apprentice; the attendance of two terms of lectures and passing all examinations; and a thesis. To graduate a student also had to be at least twenty-one years of age. These requirements were not well enforced. Latin was neglected; many schools failed to require certificates for the three years’ apprenticeship; the theses were generally unoriginal and occasionally barely literate. The examinations were less rigorous in part because professors were paid by a student only if he passed…An institution that raised its standards stood the risk of losing its students and its income.

After the War of 1812, the number of medical schools in America began to increase rapidly, and by 1850 there were forty-two medical schools in the United States. In 1900, the main source of
economic distress to physicians was the fact that there was an oversupply of doctors due to the large number of medical schools across the country. For example, the population of the United States grew 138 percent from 1879 until 1910, while the number of physicians grew by 153 percent. Reform of medical education and American universities in general began around 1870 and was led by President Charles Eliot of Harvard and President Daniel Coit Gilman of Johns Hopkins. With a growing economy, there was now enough capital and philanthropic endowments to upgrade curriculums and standards of admission. More advanced medical schools formed the Association of American Medical Colleges (AAMC) in 1890 and they set a minimum standard of three years of training (six months per year) and required laboratory work in histology, chemistry, and pathology. By 1893, licensing boards continued to increase in power and more than ninety six percent of all schools required three or more years of work. In 1893, Johns Hopkins became the first medical school to require a college degree prior to matriculation and rooted its education in basic science and hospital medicine. Faculty and students were carefully chosen from all around the country and abroad. Medical students would no longer train as apprentices, but instead would learn the workings of the medical practice through exposure in teaching hospitals. The model of John Hopkins Medical School would eventually spread throughout the country, joining science, research, and clinical hospital instruction.

In 1910, Abraham Flexner, commissioned by the Carnegie Foundation for the Advancement of Teaching, published the Flexner report noting the curriculum inconsistencies present between medical schools and the lack of adequate faculty and facilities. Flexner’s famous Bulletin Number Four recommended that the number of medical schools in the United States be cut by seventy percent. The Flexner report had a great impact in that there was great
national concern over the quality of American medicine, giving rise to great philanthropy to medical education. The Flexner Report and increased requirements by state licensing boards led to the closing of many smaller medical schools. In 1904 there were 160 medical schools, but by 1935 the number fell to only 66. By the 1930’s, almost twice as many people were applying to medical school as those being accepted. The number of medical schools would continue to decline throughout the country as requirements were enhanced by state licensing boards.

Higher tuition fees and increased lengths of academic years led to a decline in the number of medical students. The American model of medical training became dominated by researchers and scientist and this in turn led to a greater number of doctors being trained as scientists and specialists.

Although the issue of eliminating untrained practitioners and improving medical training had been improved substantially, another issue arose as a result. With the increased cost of medical training and the decrease in the output of medical schools came a shortage of physicians in poor and rural areas. A 1920 study revealed that the distribution of physicians across the United States correlated very closely with per capital income. Regional disparities also arose, as poor states lost physicians relative to their population size. For example, in 1870 there was a doctor for every 894 persons in South Carolina, but one doctor for every 712 persons in Massachusetts. By 1910, there were 1,170 people per doctor in South Carolina compared with 497 people per doctor in Massachusetts. Many small towns and rural areas lost access to any physicians. A study by AMA President William Allen Pusey revealed that more than a third of 910 small towns which had physicians in 1914, lost them by 1925. Pusey stated, “As you increase the cost of the license to practice medicine you increase the price at which medical service must be sold and you correspondingly decrease the number of people who can afford to
buy this medical service.” The supply of doctors did not keep pace with the population growth through the first half of the twentieth century. The issue of unequal distribution of health care resources would come to be an ethical problem that would plague the American health care system to this day. Regional and socioeconomic disparities continue to persist and debate continues over how health care services can be allocated to provide more equal access to quality health care.

Another major issue for the medical community to address was that medical practitioners were not the only source of therapeutic treatments throughout the nineteenth century. Patent medicine companies or nostrum makers were direct competitors to physicians, many of which prepared their own medicines. Through propaganda, nostrum makers sought to undermine the authority of the medical profession and exploit the public’s misunderstandings. For example, in the late 1880’s William Radam made the Microbe Killer, playing upon the recent findings of Pasteur, and claimed that it could cure all diseases by killing all germs in the body. In truth the medicine was almost completely water with small traces of red wine, hydrochloric acid, and sulfuric acid. Between 1900 and 1910, the medical profession was able to begin to control the distribution of pharmaceutical information due to the establishment of a regulatory commission of the AMA, muckracking journalists pushing for the regulation of patent medicine, and a general increase in the public’s reliance on professional medical advice for medication decisions. In 1905 the AMA set up a Council on Pharmacy and Chemistry to set standards for and test drugs. As public opinion gradually shifted and skepticism arose in the often false advertisements and dangerous medicines of nostrums, the AMA’s regulatory system improved the safety and effectiveness of pharmaceuticals. Additionally, drug purchasing was largely rechanneled through physicians, giving physicians a much greater share of the purchasing power
of their patients. Patent drug companies became more concerned with meeting drug regulations and convincing the medical professionals of the effectiveness of their pharmaceuticals.

Hospitals had traditionally been viewed as religious and charitable institutions for caring for the poor and sick. Hospitals were mainly centered in major cities, populated with travelers and outcasts, and regarded as dangerous. Between 1870 and 1910, hospitals became the center of medical education and medical practice. The first permanent general hospital was built to care for the sick in 1752 in Philadelphia and was called the Pennsylvania Hospital. In 1875 there were only 178 general hospitals in the United States, but by 1900 there were more than 4,000. Several developments were crucial for the making of the modern hospital in America. The first development was the professionalization of nursing in 1873. In 1873 the first three training schools opened for nurses. The centrality of the nursing profession to the growth of hospitals can be seen by the fact that by 1900 there were 432 training schools and 1,129 by 1910. The advent of antiseptic surgery in 1867 by Joseph Lister was also crucial. By the 1890’s and early 1900’s, with the invention of new diagnostic tools, like X-rays in 1895, surgery began to increase in popularity and this brought about even greater expansion of hospitals. By the late 1920’s, hospitals were no longer a place for only the poor, but became a place where middle class patients would receive care. Three types of surgeries—obstetrical deliveries, appendectomies, and tonsillectomies and adenoidectomies—and accidents accounted for about sixty percent of all hospital admissions in the late 1920’s. Hospitals became not only a place for increased medical education, training, and development, but an opportunity for increased physician incomes as many well-off patients, who could pay for their treatments, became centralized in one location. This allowed physicians to optimize their productivity and efficiently, rather than having to make individual house calls.
Physicians began to receive good compensations for their work and American medicine began to truly emerge as a profitable industry. Hospital admissions continued to increase and in the century between the ending of the Civil War and the beginning of the civil rights movement, hospital use increase two hundredfold while the population increased fivefold. In 1946, Congress passed the Hill-Burton Act, also known as the National Hospital Survey and Construction Act. The program provided federal funding to subsidize the building of hospitals in areas of bed shortages. The infrastructure and usage of health care expanded greatly throughout the 1900’s. In 1929, health care represented only 3.6 percent of the GDP of the United States, but by the 1993 that number had risen to about fourteen percent of the GDP, or $3,600 per head. In 1960, the number of persons per active physician in the United States was 735, but by 2000 that number had decreased to 369. By 2010, eighty percent of adults in the United States had visited a health professional within the past year, with fourteen percent making ten or more visits per year. The average adult made 3.8 medical visits per year. The United States health care industry is now the largest in the world and health care expenditures are projected to increase to 19.3 percent of the GDP by 2019.

The professionalization of medicine allowed for medical providers to better meet their ethical mandate to provide the highest quality of care possible. Educational and licensing standards were set to assure that unqualified practitioners would not be permitted to practice medicine. Medicine was linked to the developments of science, allowing for rapid improvements in care and the ability to not only prevent disease, but to combat disease. The medical community began to regulate the pharmaceutical industry to assure public safety, and the medical infrastructure of America improved significantly. Hospitals became central to medical education and medical practice. The professionalization of medicine was a monumental step in
improving the quality of health care for Americans, but new issues arose that would prove
difficult to address and would threaten the ability of the medical profession to meet its most
central ethical obligation to society. These problems include a greater demand for orthodox
medicine placing a larger burden on the health care system, regional and socioeconomic
disparities in access to health care, and increasing health care costs.

The Emergence of Health Insurance:
A much greater demand was placed on the American health care system due to the
professionalization of medicine. People became more confident in the profession and began to
expect a certain level of care. As a result, there was an increased burden on the system to provide
for a growing number of Americans. It became clear that something would need to be done to
continue to provide quality care for such a large number of people. The advent of health
insurance was developed to keep up with the rising demands of the population and to continue to
fulfill the ethical mandate of the medical profession in providing high-quality health care.

The first modern American health insurance plan was developed in 1929 by Justin Ford
Kimball, the vice president at Baylor University. The plan covered 1,500 teachers in the
university system in Dallas, Texas. The Baylor University Hospital would provide up to twenty
one days of hospital care for those teachers who chose to make the prepaid premium of six
dollars per year. The significance of the Kimball plan is that it extended coverage beyond just
work-related accidents and disability. The Kimball plan and similar plans that arose restricted
care to a particular hospital, but in 1937 the American Hospital Association (AHA) established
statewide non-profit Blue Cross hospital insurance plans which allowed for free choice of the
hospital. By 1940, there were thirty nine Blue Cross plans controlled by the private-hospital
industry, covering more than six million people. Prepaid insurance plans to pay for physician services in the hospital, rather than just hospital care, was initiated at the turn of the twentieth century in lumber and mining camps in the Pacific Northwest. These programs led to the establishment of the first Blue Shield plan to cover physician services in 1939 by the California Medical Association. In 1951 the Internal Revenue Service (IRS) ruled that employers’ costs for insurance premiums were tax-deductible expenses and this lead to the development and spread of private health insurance. Private insurance grew rapidly during World War II, where wage and price controls prevented companies from increasing wages, but permitted fringe benefits. Companies were able to compete for workers by offering health insurance and unions began to negotiate for health benefits after the war. In 1940 there were 12 million people enrolled in group hospital plans and by 1955 there were 101 million people. The Blue Cross Association and the National Association of Blue Shield Plans merged in 1982 to form the Blue Cross and Blue Shield Association.

Employers generally pay for all or part of the premium which purchases health insurance for their employees under employer-sponsored health insurance. Due to the 1951 IRS ruling, employer premium payments are tax-deductible. Additionally, the government does not view health insurance fringe benefits as taxable income for the employee. As stated by Thomas Bodenheimer and Kevin Grumbach in their article, “Paying for Health Care”, in The Sociology of Health and Illness: Critical Perspectives (2001), “Because each premium dollar of employer-sponsored health insurance results in a reduction in taxes collected, the federal government is in essence subsidizing employer-sponsored health insurance…this subsidy is enormous, estimated at $75 billion in 1991.” Commercial insurance companies eventually began to compete with the Blues for customers. All health insurance contains a subsidy which redistributes funds from the
healthy to the sick.Originally, the Blues used a community rating system where within each group of people under an insurance plan the healthier paid premiums while receiving little care and the sick received care in excess of their premiums. At the same time, as a whole the groups that use less healthcare than their premiums help to pay for higher risk groups that receive health benefits in excess of their premiums. Commercial insurance companies used experience rating which is much less redistributive than community rating in that as a whole, the healthier groups do not subsidize the high-risk groups. In doing so, commercial insurance companies could offer less expensive premiums to low-risk groups and this allowed them to outcompete the Blues in the private-insurance market. To compete, most Blue plan had to switch to a more experience based rating system. In 1945, nineteen million people were enrolled in Blue plans and ten million in commercial insurance companies, but within just ten years there were fifty-one million Blue enrollees and fifty-four million commercial company enrolless. The third-party payment system in American medicine replaced out-of-pocket cash payments as the dominant financial transaction between patient and physicians. The private health insurance industry grew from $1 billion in 1950, to $8.7 billion in 1965, and to $848.7 billion in 2010. The private health insurance industry is projected to grow to a $1.4954 trillion industry by 2021. Insurance ensured a steady flow of income for hospitals and health care providers. Hospitals and physicians prospered greatly and health care overconsumption became more of a serious problem. Inequities in health insurance coverage also became a national concern. Employer-sponsored health insurance was effective, but only for those who were employed by a company that provided health insurance. This left a large number of people, including the retired elderly, without health insurance coverage. As a result the federal government had to start to become involved to fill this void.
Universal health insurance has never been widely supported in America, reflecting the tradition of a highly decentralized government playing a small role in regulating the economy or social welfare. Germany was the first country to establish a national system of compulsory sickness insurance in 1883, followed by similar programs in Austria in 1888, Hungary in 1891, Norway in 1910, Britain in 1911, Russia in 1912, and the Netherlands in 1912. In 1906, the American Association for Labor Legislation (AALL) began endorsing comprehensive public insurance, which included compulsory health insurance. Their support peaked with the Progressive movement founded by Theodore Roosevelt, but he was defeated in the Presidential election of 1912. The movement for universal health care was further weakened during World War I as anti-socialist sentiment increased. During the 1930’s, the discovery of antibiotics and sulfa drugs gave physicians the power to cure diseases, not just prevent them. Increased demand for health care, coupled with the financial hardships of the Depression brought the issue of universal health care into the public focus again. In 1932 the Committee on the Costs of Medical Care, composed of economists, physicians, and public health specialist, endorsed universal health insurance, with different degrees of compulsory requirements. The AMA fervently and successfully opposed government control of medical care. They did so by appealing to the individualistic spirit of Americans, the fear of universal health care being economically unfeasible, and publicly calling the “choice to endorse a universal health insurance scheme as being one of Americanism versus Sovietism for the American people.”

The New Deal, a series of domestic programs enacted during President Franklin D. Roosevelt’s administration from 1933 to 1935, extended the federal government’s role in health care. Programs such as the Federal Emergency Relief Administration, Civil Works Administration, and Farm Security Administration provided public health and medical care
financing. The Farm Security Administration, in collaboration with the United States Public
Health Service, enrolled 650,000 people into prepaid medical cooperative plans by 1942. The
Social Security Act of 1935 provided unemployment compensation, old-age pensions, and other
benefits, but had initially also included national health insurance. Due to fear of jeopardizing
the whole law, the national health insurance was excluded from the final legislation. In 1936,
Roosevelt had the Interdepartment Committee to Coordinate Health and Welfare Activities
assess the nation’s health needs. The report, like that in 1932 by the Committee on the Costs of
Medical Care, proposed expanding federal financing for health services, hospital construction,
and medical care. It also called for the creation of state-based insurance programs and
recommended considering compulsory national health insurance. Acting on the
recommendation of the report, Senator Robert R. Wagner of New York introduced a bill to
provide federal grants to states for the organization of insurance programs that would cover
workers and their dependents. Due to the onset of World War II, a shift in conservative control
of the Senate, and an attack by the AMA, the bill was never passed. President Harry Truman
was the first President to formally call for the creation of a federal health insurance fund that
would be accessible to all Americans, but the plan was never enacted due to lobbying by the
AMA, continued fear of socialism, union strikes, and entry into the Korean War.

In 1965, during the Presidency of Lyndon B. Johnson, Congress passed the Medicare
program for the elderly and the Medicaid program for the poor, as a response to the continued
inability of the employer-based system to adequately provide health insurance for all
Americans. They were passed as amendments to the Social Security Act of 1935. Medicare
and Medicaid dramatically increased access to health care, but were responsible for the largest
increase in health care spending ever seen throughout the world. Health care spending
increased 42.5 percent in the thirty years prior to Medicare and Medicaid, but increased by 140.4 percent in the thirty years following their enactment.75 A change occurred in the 1970’s, where there was a shift of primary focus from providing access to health care, to health care cost containment.76 With pressure to restrain growing costs, President Nixon turned to Paul Ellwood, MD who was a professor at the University of Minnesota and was president of think tank called InterStudy.77 The think tank was creating models to improve health but contain cost, and it was from them that Nixon adopted the health maintenance organization (HMO) model.77 Under HMOs, an enrollee pays an advanced fixed fee and in return they receive comprehensive health services.78 As stated by Elizabeth H. Bradley and Lauren A. Taylor in their book The American Health Care Paradox: why spending more is getting us less:

A core principle of HMOs was the plan’s role in medical decision-making, meaning that the HMO would oversee and approve physicians’ decisions such as whether to admit a patient, how long to keep the patient in the hospital, and whether to order expensive diagnostic tests for the patient, all of which heretofore had been made autonomously by physicians. The HMO in effect “managed” care, with the goal of limiting high costs due to overutilization, without compromising patient outcomes.77

The Health Maintenance Organization Act was passed in 1973.78 Efforts to manage care expanded beyond the basic HMO model in the following decades.79 In 1983, the Prospective Payment System (PPS) was introduced under President Ronald Reagan.80 The PPS classified illnesses into one of 468 diagnosis-related groups (DRG’s) and each DRG was given a treatment rate at which hospitals would be reimbursed by Medicare.80 If the hospital spent less on treatment they made a profit, but if they spent more they had to assume the costs.80 Managed care grew to include about 97 percent of the employer-based health insurance market.79 Managed care would slow the increase in health care costs briefly in the mid-1990’s, but by the late 1990’s costs would continue to soar.79

The most recent development in the United States health care system is the Patient Protection and Affordable Care Act (ACA). The ACA, amended by the Health and Education
The Reconciliation Act, was signed into law by President Barack Obama on March 23, 2010. Its full implementation occurred on January 1, 2014 and represents the most comprehensive change to the United States health care system since Medicaid and Medicare. The ACA will implement state health insurance exchanges, expand Medicaid, and give subsidies to individual and small-employer groups. The ACA established, “a near-universal guarantee of access to affordable health insurance coverage, from birth through retirement.” The ACA is expected to reduce the number of uninsured Americans by more than half, resulting in health insurance coverage for about 94 percent of Americans. National health care spending is estimated to rise 7.4 percent in 2014 due to the ACA. Medicaid enrollment is projected to increase by 19.6 million in 2014, reaching over 76.0 million total Americans. By 2021, Medicaid spending is projected to account for over twenty percent of national health expenditures. A report by the Centers for Medicare and Medicaid Services (CMS) states that:

In 2014, the ACA is expected to result in a shift in health care financing towards the federal government primarily because of federal premium and cost-sharing subsidies for exchange-based plans and an initial 100-percent federal match rate for Medicaid coverage expansion costs. By 2021, government financing is projected to account for nearly half of all health spending (up from 48 percent in 2014) reaching a total of $2.4 trillion, of which, the federal government is projected to pay two-thirds.

The goal of the ACA is to improve the quality and affordability of health insurance and health care, increase access to primary care, and invest in public health initiatives, but it is unclear how long it will take for the ACA to reach these objectives and what economic toll the act will take.

Health insurance emerged as a means for the medical profession to meet the rising demands of the population and continue to provide high-quality care. Regional and socioeconomic disparities in access to health care began to arise and the federal government became involved with health insurance to make up for the inability of the employer-based system to adequately provide health insurance for all Americans. Health insurance provided greater
access to health care, but cost control was not highly regulated because consumers did not see the realities of health care costs.

**Rising Health Care Costs:**

The cost of health care poses a serious threat to the ability of the American health care system to provide high-quality care. All five components of high-quality care are jeopardized by the growing costs of health care in America, particularly the ability to separate financial and clinical decisions and to provide equal access to care. The cost of health care has continued to increase dramatically for a variety reasons. Some have proposed that health care cost inflation is partly due to the fact that there is a general increase in public expectations about the United States’ health care system and a growing notion that health care is right. Others have attributed increased medical care costs to a “medical arms race” amongst hospitals, insurance companies, and third-party payers, and the purchasers of health care, which for too long ignored the issue of increasing health care costs. Yet others argue that nearly all the medical care price inflation of recent years can be attributed to, “general inflation, the labor intensity of health industries, the behavior of wage rates during inflation, and the pattern of labor-productivity changes.” Many others attribute increased costs to medical malpractice and medical liability, and advances in technology.

Medical malpractice can broadly be defined as “any unjustified act or failure to act on the part of a doctor or other health care professional that results in harm to the patient”. The first recorded malpractice suit in the United States occurred in 1794 in Connecticut in the case of *Cross v. Guthre*. Between 1812 and 1835, *The Boston Medical and Surgical Journal*, reported only three malpractice cases, but between 1835 and 1865 there were forty five cases reported.
The malpractice insurance system in the United States entered a crisis in the 1970’s and 1980’s due to a great increase in medical malpractice suits.\textsuperscript{85} Malpractice insurance premiums increased over three hundred percent from 1974 to 1975.\textsuperscript{85} The General Accounting Office (GAO) reported that malpractice premiums rose forty five percent from 1982 to 1984 and premiums rose to nine percent of physicians’ total costs.\textsuperscript{85} The average annual malpractice premiums for all types of physicians increased from $6,900 in 1983 to $14,500 in 1990, with much higher premiums seen for certain specialists.\textsuperscript{83} A 2005 study in the Journal of American Medicine found that the cost of a standard primary-layer policy from the largest insurer for Philadelphia general surgeons increased from $33,684 in 2000 to $72,518 in 2003, and these numbers are excluding mandatory payments to the state’s secondary-layer insurance fund which were forty three percent of the primary premiums.\textsuperscript{86} A 2011 study in the New England Journal of Medicine reported that for physicians in low-risk specialties, thirty six percent were projected to face their first malpractice claim by the age of forty five years.\textsuperscript{87} Eighty eight percent of physicians in high-risk specialties were projected to face their first malpractice claim by the age of forty five years.\textsuperscript{87} By the age of sixty five years, seventy five percent of physicians in low-risk specialties and ninety nine percent of those in high-risk specialties were projected to face a claim.\textsuperscript{87} According to the National Practitioner Data Bank 2012 Annual Report, the mean medical malpractice payment in 2012 ranged from $160,323 to $572,199.\textsuperscript{88} As a result, many physicians report great concern over malpractice and immense pressure to practice defensive medicine.\textsuperscript{87} Defensive medicine poses a serious threat to the ability of health care providers to separate financial and clinical decisions, a key component of high-quality health care. Positive defensive medicine refers to physicians who over-treat a patient by overprescribing diagnostic and treatment procedures in order to protect themselves against potential malpractice lawsuits.\textsuperscript{89} Negative defensive medicine refers to
physicians who avoid certain procedures and patients due to fear of liability. For example, defensive medicine is especially prevalent in the field of obstetrics. A 2013 study in the Journal of Maternal-Fetal and Neonatal Medicine reported that obstetric malpractice lawsuits are associated with a higher likelihood of physicians recommending cesarean delivery. It was predicted that malpractice costs under the current tort system amounted to $24 billion in 2002.

Another major factor contributing to the increased health care costs in the United States is health care technology, which includes medical equipment, medical techniques, and pharmaceuticals. Advanced medical technologies, such as human organ transplantation, have saved and improved the quality of many lives, but they have contributed to rising cost. Today it is common for medical intervention to include technologies such as magnetic resonance imaging (MRI), computerized tomography scans (CT), kidney dialysis, laser surgery, arthroscopic surgery, magnetoencephalography (MEG), and positron emission tomography scans (PET), just to name a few. New diagnostic techniques, such as MRI scans which usually range from at least $600 to $800, are becoming simpler and safer and as result they a being used at a much higher rate. This is adding substantially to the costs of health care. One major issue is that hospitals are not competing for patients on the basis of price, so they do so by offering the latest and most advanced services available. As a result, the costs of these new technologies are passed on to insurance companies. There are many technologies that have both a high cost and a high benefit, but at the same time there are wasteful technologies that are high cost and low benefit. Many economists argue that new health care technologies are the greatest single factor driving up health care costs in the United States, and predict that they account for fifty percent of the increase in costs. Rising health care costs exacerbate the problem of inequities in health insurance coverage, and the two issues coupled together have resulted in the health care crisis in
America. Reform of the American health care system is imperative in order for high-quality health care to be provided for the American people. A European model of health care and a preventative model of health care may provide the answers to reforming America’s health care system.

A Scandinavian Alternative:

An analysis of an international model of health care provides insight into how the United States is performing in its ability to provide high-quality health care for its people. There are a variety of international models and approaches to health care which are studied and evaluated for their potential to aid the United States in alleviating some of the problems with its current health care system. A region that has consistently performed at a very high level, achieving the best health care outcomes in the world and at total health expenditures comprising a much lower percentage of their gross domestic product than the United States, is the social democracies of Scandinavia.98 This includes the countries of Sweden, Denmark, and Norway.98 Table 1, reveals some of the findings of a 2008 study by the Organization for Economic Cooperation and Development (OECD) highlighting the differences in health care spending, both per capita and as a percentage of gross domestic product (GDP), between the United States and the Scandinavian countries.99

<table>
<thead>
<tr>
<th>Country</th>
<th>Per Capita</th>
<th>Percent GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>$3,5401</td>
<td>9.7 %1</td>
</tr>
<tr>
<td>Norway</td>
<td>$5,0032</td>
<td>8.5 %2</td>
</tr>
<tr>
<td>Sweden</td>
<td>$3,470</td>
<td>9.4 %</td>
</tr>
<tr>
<td>United States</td>
<td>$7,538</td>
<td>16.0 %</td>
</tr>
</tbody>
</table>

Table 199: Total health care spending in select OECD countries in 2008
12007
2Estimate
The social democracies of Scandinavia have a greater number of physicians and hospital beds per ten thousand people than the United States, and one hundred percent of citizens are covered by the publicly financed health insurance systems. In 2012, about fifteen percent of Americans were uninsured. Life expectancies are lower in the United States and infant mortality rates are higher than in Sweden, Denmark, or Norway. Scandinavian countries spend slightly more than fifty percent of what the United States spends per capita on health care.

Out of the Scandinavian countries, Sweden’s health care system has had some of the greatest success. Sweden ranks in the top five out of thirty-four OECD nations for mortality amenable to healthcare, seventh for life expectancy, fourth for the least potential years of life lost for females, and first for the least potential years of life lost for males. The Swedish health care system is financed from general taxation and is a universal public service. Access to health care is universal and the system is based on the principle of subsidiarity. The Swedish model is a decentralized, localist approach rather than a centralist approach to delivering health care. This means that “responsibility for healthcare financing and provision lies within the lowest appropriate administrative level.” The local government in Sweden entails twenty-one counties and 290 municipalities. The local government manages the day-to-day responsibilities of the health care system and raises over seventy percent of the financing for the system via local taxation. Local governments can decide how health services are organized in their localities and possess ownership of hospitals and clinics. Local bodies run by locally elected officials have the authority to balance between the financing of health and of social services to create a health care system that best serves their local community. The Swedish localist approach keeps, “the management of the system in closer proximity to voters and users…” and “in this way creates greater responsiveness and accountability, driving up service quality and
strengthening public ownership and willingness to pay for quality health services.”

Although the majority of funding comes from local and municipal taxation, more than twenty-five percent of the remainder comes from block grants from the central government. Block grants are financed from national taxation. This balance between local and national funding is important for two main reasons. The first is that it prevents local variations in wealth distribution from dictating the quality of service on the basis of regional wealth. There is still a great deal of local autonomy, but the block grants provide a redistributive measure towards poorer regions. The second reason is that this balance in financing keeps the localities still dependent on the national government for funding and this allows the national government to maintain control over national standard setting and provide an oversight role over the localist system.

Another feature of the Swedish health care system is that people have the right to choose to receive elective treatment from any hospital, whether it is in their county or not. The importance of this feature is that it further empowers patients in having control over their health care and creates competition between public hospitals. Health care services in Sweden have also been consolidated into fewer, but larger hospitals. This has enabled health care providers to increase their skills through specialization and experience because of the increased flow of patients. In the United States there exists a “fee-for-service model” and this enables doctors to increase their incomes by prescribing additional tests. In Sweden, most Swedish doctors are salaried employees and therefore have no such incentive to order additional procedures. The one weakness of the Swedish health care system is waiting times. Sweden ranked ninth out of eleven countries in an OECD ranking for both waiting times of four weeks or more for specialist appointments and waiting times of four months or more for elective surgery. Fifty-five percent
of people waited four weeks or more for specialist appointments and twenty-two percent waited four months or more for elective surgery.\textsuperscript{108,109}

It is clear that the Swedish health care system has been very effective in Sweden, as can be seen by some of the best health care outcomes in the world, but the question remains as to whether the Swedish system could work in America. Sweden is just slightly larger than the state of California, so besides the obvious geographical difficulties of implementing such a decentralized model of health care in the United States, it is also unclear whether such a system could fit with the cultural constructs of American society.\textsuperscript{110} The World Values Survey, which is an international system of data collection on individuals’ values in regards to politics, economics, and health collected through face-to-face interviews, reveals that Americans and Scandinavians share many core values concerning personal freedom, self-determination, political involvement, and technological advancement.\textsuperscript{111} Although these similarities exist, key cultural differences are present that would make the implementation of the Swedish model of health care very difficult in the United States.\textsuperscript{112}

One of the greatest obstacles would be the differing views of Scandinavians and Americans on the social contract. As stated by Jean-Jacques Rousseau in his 1762 book \textit{Of the Social Contract, or Principle of Political Right}, the social contract is, “an implicit agreement among members of a community to submit a certain degree of their personal freedom to a government that will protect them from one another and from nature.”\textsuperscript{113} Scandinavians have a more favorable view of government and see government as a positive force.\textsuperscript{114} The role of citizens is generally seen as working to better society and creating a shared pool of resources and services that should be available to all individuals.\textsuperscript{114} Equality of rights is central to Scandinavian societies, as can be seen with the Danish public system in which everyone is covered and no one
is allowed to refuse state-provided benefits, regardless of personal finances. Scandina

vians embrace democracy and place a large emphasis on the redistributive function of government. In contrast, Americans have a long history of distrust and skepticism of government and a strong emphasis on individual rights and liberties. Americans generally have a negative view of government and feel an increasing amount of disconnectedness with government. Although Americans generally accept that the government must provide financial assistance to the underprivileged, there has always been great discomfort with redistributive taxation. For example, the United States spends less than ten percent of its GDP on social welfare services, whereas Sweden, Denmark, and Norway each spend between sixteen and twenty-one percent of their GDP on such services. Scandinavians and Americans also hold very different conceptions of health. Scandinavians generally view health as a condition for achieving prosperity in life, or in other words they view health as a means to an end. Conversely, Americans seem to view health as the result and goal of a prosperous life. For Americans, health is viewed as simply an end in itself. Scandinavians also regard health care as a public matter and a social responsibility, whereas Americans generally view health as a private matter. Americans view poor health more as a matter of poor personal choices and as result feel that society has limited responsibility to help alleviate those suffering from health complications.

The different values and views that Americans hold concerning the role of government and the pervasiveness of the social contract, in addition to the American association of universal health insurance with socialism dating back to World War I and World War II, would make the implementation of a universal health care system unfeasible at this time. American culture is built upon individualism and individual liberty, and these core values would cause resistance to increased redistributive taxation and expansion of a governmental welfare state as in Sweden.
General Scandinavian cultural constructs shape a concept of health that differs greatly from the American concept of health. In conclusion, the Swedish model of health care does not provide a comprehensive and fully compatible system to reform American health care.

The Future Outlook: A Preventative Model of Care

As previously mentioned, health care costs are a continually growing and significant component of the United States gross domestic product and a proportionate component of State budgets, but the health care outcomes in the United States do not match the significant expenditures. While it is clear that this continued growth in health care expenditures may be unsustainable, it is unclear how the health care system can be modified and improved to better control costs and improve outcomes to allow the system to better provide high-quality health care. An increased focus on preventative care, specifically primary preventative care, may be the long-term solution to controlling the health care crisis in America.

Preventative care is not a new concept and includes a variety of interventions. The United States has generally excelled at some forms of preventative interventions, such as vaccinations and screenings, but lacks in its use of preventative care focused more on the nonmedical determinants of health. Preventative care needs to include an increased focus on behavior and lifestyle changes that can improve the quality of life and ultimately improve the overall health of the American people. Factors in five different domains influence health and they are behavioral patterns, genetics, social circumstances, health care, and environmental exposures. Behavioral causes account for forty percent of all premature deaths in the United States, more than any of the five domains. Obesity combined with physical activity, and smoking are the top two behavioral causes of premature deaths in the United States. The use of
tobacco is responsible for more than 430,000 deaths per years and is the single largest cause of preventable morbidity and mortality in the United States. According to the United States Centers for Disease Control and Prevention, smoking costs the United States approximately $193 billion per year, taking into account direct health-care expenditures and productivity losses. An estimated 26.7 percent of adults in the United States were reported as being obese and around 300,000 deaths per year may be attributed to obesity. In 2008, obesity health care cost the United States an estimated $147 billion per year. Adding to the nation’s problems is that Americans are not incorporating enough physical activity into their lives. According to a report of the Surgeon General on physical activity and health, more than sixty percent of adults in the United States do not engage in the recommended amount of activity and about twenty-five percent of adults are not active at all. Inactivity in the United States is estimated to cost between $24 and $76 billion annually, or 2.4 to 5.0% of national health care expenditures.

Policy makers in the United States have begun to realize the importance of primary preventative care. Section 4108 of the Patient Protection and Affordable Care Act (ACA) set up the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) grant program. This program authorizes grants to States to provide incentives to Medicaid recipients who participate in prevention programs and change their health risks by adopting healthy behaviors. The programs must use evidence-based research and in order to be applicable for grants, States must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or in the case of a diabetic, improving the management of the condition. States must commit to operating the programs for at least three years and fulfill evaluation and reporting requirements. Ten states are participating in the MIPCD program, including California,
Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin. A variety of different programs and approaches are being implemented in each states. For example, Montana has set up a program that, “promotes diabetes prevention and reduction of cardiovascular disease in high-risk adults with Medicaid through weight loss promoted by healthy diet choices and regular physical activity.” Participants will be assisted by certified diabetes educators, registered dieticians, registered nurses, exercise physiologists, and physical therapists in achieving a seven percent weight loss over a time period of ten months.

Programs such as those in Montana under the MIPCD represent a start in the right direction towards improving the primary preventative care in the United States, although their method of cash incentives for participants is not a sustainable long-term solution. Additionally, these programs are isolated to Medicaid beneficiaries. The biggest challenge of implementing a more prevention based model of health care will be educating the American people as a whole on the behaviors that can result in a healthier life. This will mean educating people on behaviors conducive to a healthy life and on behaviors detrimental to healthy living. This educational approach cannot be ex post facto, meaning that it should not be isolated to only high-risk groups or groups that have already experienced preventable behavior related illnesses. In order to have its full effect on decreasing the burden on the American health care system, the education must come from an early age and truly be preventative in nature, not retroactive. This is by no means a small feat and will take generations to fully and successfully implement a change in the general lifestyle of Americans. The cost-reducing effects of such programs will not be immediate and will likely not even be realized in the near future, but if successful, such programs could eventually significantly decrease health care expenditures in the United States. A statement in a
recent report for the National Health Policy Forum clearly demonstrates the urgency of
America’s health care crisis, “unless the need for health care is reduced by significantly
improving the health of the American people, it will be difficult if not impossible to bring health
care costs under control.”130 If health care costs are not brought under control, the quality of care
provided by the American health care system will surely suffer.

Conclusion:

When looking at the profession of medicine it is often times hard to see beyond the
science that permeates the field, from the constant development of new diagnostic instruments to
the study of new treatment options such as gene therapy. It is through the reason and logic of
science that the field of medicine has progressed and continues to rapidly evolve and improve.
What is often overlooked is that the profession of medicine is intrinsically laced with numerous
ethical issues. Many of these issues are based on the central ethical mandate of the profession to
provide high-quality health care for all people.

The medical profession has sought to provide quality care through the professionalization
of the field of medicine and the creation of health insurance, but the current problem of
increasing health care costs threatens the ability of the profession to accomplish its ethical
commitment to society. The implementation of a preventative model of care would address the
problem of increasing health care costs by improving the health of the American people and
therefore decreasing the burden on the American health care system. While a model of primary
preventative care addresses the cost issue, it does not address the problem of health insurance
and uninsured Americans. Inequities in health insurance coverage and in access to quality health
care have long been elusive issues in America. A comprehensive review conducted by the U.S.
Congress Office of Technology Assessment and a study by the Institute of Medicine both found that people lacking health insurance receive less care and have worse health outcomes.\textsuperscript{131} In fact, the Institute of Medicine estimates that lack of health insurance accounts for nearly 18,000 deaths each year in the United States.\textsuperscript{132} It is clear that health insurance does make a difference, so the next question for the American medical profession to address in its pursuit to meet its ethical mandate is how to insure a growing and aging American population. The challenge of this task is to enhance the quality of health care and distribute health care services more fairly, but to do so without stimulating health care cost inflation. The most recent attempt to address the problem of uninsured and underinsured Americans is the Patient Protection and Affordable Care Act (ACA). Policy changes such as the ACA often times do offer some relief for a pressing problem, in this case the inequities in insurance coverage, but commonly give rise to numerous side effects. It remains to be seen whether the ACA will successfully improve access to and quality of health care in America by expanding health insurance coverage, without substantially increasing health care costs.

The principles of medical ethics were developed centuries ago, drawing from the writings of Hippocrates. These principles have continued to develop and be refined as medicine has evolved and become more complex, but the ethical mandate to provide the highest quality of care possible for all people has always been of fundamental importance. America’s health care system is flawed; rising costs and inequities in health insurance coverage threaten the ability of health care professionals to fulfill their most central societal responsibility. Reform must continue to be enacted and an alternative model of health care must be developed in America to address the health care crisis and enable the medical profession to provide high-quality care for all Americans.
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