

Universal Health Care: Concerns For American Physicians, Using The Canadian Experience as a Model

"Social, political and economic myths prevent us from learning from other countries' experiences in financing health care. Perhaps the only advantage of being the last industrial democracy without universal health insurance is that we can learn from the experience of others. We will learn little, however, if we credit the many myths about foreign experience regularly repeated by critics of national health insurance. If ever there was an obvious American opportunity for cross-national learning, it is Canada's path to and experience with universal health insurance."¹

I. INTRODUCTION

The health care problems facing America today are at a critical point. One out of four people, or approximately sixty-three million people, will lose health insurance coverage for some period during the next two years.² Thirty-seven million Americans have no insurance and another twenty-two million lack adequate coverage.³ Polls suggest that a majority of Americans are insecure about their health care coverage and are discouraged about the soaring cost of health care, which rose from \$250 billion in 1980 to more than \$900 billion in 1993.⁴ Health care costs have been expanding at a rate of ten percent a year, faster than the nation's overall economic growth.⁵ As a percentage of gross domestic product, health care costs will grow from fourteen percent to nineteen percent during the next decade if left unchecked.⁶

1. *Testimony Prepared For The Senate Committee on Finance, Health Care: The International Perspective*, FEDERAL NEWS SERVICE, October 14, 1993, available in LEXIS, NEWS Library. [hereinafter *Hearings*] (testimony of Prof. Theodore Marmor). Marmor is a Professor of Public Policy and Management at Yale University and is an expert on the Canadian health system.

2. *Clinton's Health Plan, Excerpts From Final Draft Of Health Care Overhaul Proposal*, N.Y. TIMES, September 11, 1993, at A8.

3. *Id.*

4. Karen Riley, *Health Plan's Fate Hinges on Who Benefits; Clinton Promises Plan Will Be Safety Net For Poor*, WASH. TIMES, September 20, 1993, at A1.

5. Edwin Chen and Robert A. Rosenblatt, *Clinton Promises Sweeping Coverage In Health Care Plan*, L.A. TIMES, September 11, 1993, at A1, A16.

6. *Clinton's Health Plan*, *supra* note 2.

The United States has the highest quality health care in the world and is envied by other countries for its technological and research capabilities.⁷ Although the United States has the best health care, it has the worst health care delivery system in the industrialized world.⁸ All other industrialized countries provide some form of universal and comprehensive health care to their citizens.⁹ To improve its health care delivery system, the United States should critically review the experiences of other industrialized countries and implement cost-effective reforms that will reverse the rising cost of health care.

Canada's approach to health care is worthy of review. The Canadian health care system "offers the United States an opportunity for cross-national learning, with its path to and experience with universal health insurance."¹⁰ The United States and Canada share a common language and political roots, a comparably diverse population with similar living standards, increasingly integrated economies, and similar political disputes.¹¹ Until Canada consolidated national health insurance in 1971, delivery of medical care in the United States and Canada was nearly identical.¹² Therefore, as the United States plans to implement some form of universal health care, the problems that faced health care providers during Canada's implementation of national health insurance should be reviewed.

This Comment focuses on the basic structures of President Clinton's universal health care proposal and the Canadian national health system. First, it provides a summary of how health care will be delivered and financed in President Clinton's plan in comparison to the Canadian system. Second, it offers an analysis of the issues that faced Canadian physicians after implementation of national health insurance and whether American physicians will encounter similar issues in a universal health system. Finally, the Comment includes several recommendations for Congress to consider as the public debate over universal health care evolves.

II. PRESIDENT CLINTON'S PROPOSAL

On September 22, 1993, President Clinton proposed his plan for universal health care, which he entitled the American Health Security

7. Frank Clemente, *Universal Health Care For Americans*, 40 HENRY FORD HOSPITAL MED. J. 38 (1992).

8. *Id.*

9. *Id.*

10. *Hearings*, *supra* note 1.

11. Theodore R. Marmor, *Commentary On Canadian Health Insurance: Lessons For The United States*, 23 INT'L J. HEALTH SERVICES 45, 47 (1993).

12. *Id.*

Act of 1993 (AHSA). The proposal guarantees comprehensive health coverage for all Americans regardless of health or employment status.¹³ Health coverage would continue without interruption if an individual lost or changed his or her job, moved from one area to another, became ill, or confronted a family health crisis.¹⁴ The plan's goal is to reform the current health care system by eliminating various discriminatory insurance-market practices and organizing consumers into giant "alliances."¹⁵ The plan aims to achieve savings by encouraging the vast majority of Americans to move from traditional fee-for-service care to health care networks.¹⁶ It pushes Americans away from private doctors into less expensive group medical practices, such as health-maintenance organizations (HMOs).¹⁷ If enacted, the plan anticipates bringing the inflation of health care costs down to a manageable four percent.¹⁸

Under the plan, the federal government would set a basic standard of health insurance, insisting that all Americans have comprehensive coverage for doctor and hospital bills, mental health care, and prescription drugs.¹⁹ No individual could be denied coverage because of a particular occupation or a pre-existing condition.²⁰ Each person would receive a national health security card that could be used at a hospital or doctor's office.²¹ The guaranteed benefits package for hospital services includes in-patient bed and board, routine care, and laboratory, diagnostic and radiology services.²² Other benefits include twenty-four-hour emergency room care, regular physical examinations, immunizations, and mental health treatment.²³ Extended care in nursing homes, outpatient prescription drugs, and routine eye, hearing exams and preventive dental services for children under eighteen are also provided.²⁴ Services that are not medically necessary, like cosmetic surgery, orthodontia, hearing aids, eyeglasses and contact lenses for adults, private duty nursing, and sex-change surgery, are excluded.²⁵

13. *Clinton's Health Plan*, *supra* note 2.

14. *Id.*

15. *Chen*, *supra* note 5, at A1.

16. *Id.* at A16.

17. Dan Goodgame, *Ready To Operate*, *TIME*, September 20, 1993, at 54.

18. *Chen*, *supra* note 5, at A16.

19. *Id.* at A1.

20. *Id.* An example of a pre-existing condition is heart disease.

21. *Id.*

22. *Id.* at A17.

23. *Id.* Mental health and substance abuse treatment may also be made available.

24. *Id.* Extended care in rehabilitative facilities is also covered.

25. *Id.*

A. *The Alliance Concept*

At the heart of President Clinton's plan is the concept of managed competition. Anyone who does not work for a large corporation would join a purchasing alliance to get their health insurance, either on their own or through their employer.²⁶ Specifically, health-insurance buyers would band together in large "alliances" to bargain with competing networks of doctors, hospitals, and other health care providers for the best service at the lowest price.²⁷ The alliances are "essentially purchasing pools through which people would obtain health insurance, similar to a consumer buying food by joining a consumer cooperative."²⁸

President Clinton's proposal calls for two types of health care alliances. First, regional health alliances are to be created by the states.²⁹ Second, corporate health alliances could be established by large employers who have more than 5,000 workers.³⁰ However, such employers would have the option of joining the regional health alliances.³¹

Under President Clinton's plan, the alliances would offer several health care options. The most expensive would be the traditional fee-for-service plan obtained from an individual doctor.³² Less expensive plans would include preferred-provider organizations (PPOs), which require workers to go to specified doctors and hospitals that are part of the plan.³³ An even cheaper option would be a health maintenance organization (HMO) that provides health care at a fixed price, with some waiting and rationing of specialists' services.³⁴ Since consumers will have a choice, health care economists believe that consumers will economize by shifting away from basic fee-for-service care toward HMOs and PPOs and drive down health care costs.³⁵

B. *State and Federal Roles*

By 1997, every state would have to establish one or more health alliances.³⁶ Although there is a strong federal role, President Clinton's

26. Mike Oliver, *Clinton Pledges Insurance For All; The Vision Is To Change How Health Benefits And Medical Care Are Bought And Sold*, ORLANDO SENTINEL, September 19, 1993, at A15.

27. Goodgame, *supra* note 17, at 55.

28. Susan Dentzer, *Who's In Good Hands?*, U.S. NEWS & WORLD REPORT, September 20, 1993, at 24, 27.

29. Clinton's Health Plan, *supra* note 2, at A8.

30. *Id.*

31. *Id.*

32. Goodgame, *supra* note 17, at 56.

33. *Id.*

34. *Id.*

35. *Id.*

36. Dentzer, *supra* note 28, at 27.

plan leaves the states enough flexibility to implement their own reform measures under the national framework.³⁷ Beyond the traditional approaches of fee-for-service, PPO, and HMO, a state may choose to implement a Canadian-style "single-payer" system, in which the state would pay its residents' medical bills from tax revenues.³⁸ Single-payer plans should be more prevalent in rural areas that have too few health care providers to allow for the managed-competition approach.³⁹

States would also have the responsibility of certifying networks of doctors, hospitals, and other providers, who then would be able to bid for customers in the alliances.⁴⁰ The states would be responsible for the creation and governance of the consumer alliances, including developing mechanisms for selecting board members for various advisory boards.⁴¹ Finally, states would oversee the administration of premium subsidies for low-income citizens, families, and businesses.⁴²

At the federal level, President Clinton's plan establishes an independent National Health Board, responsible for setting national standards and overseeing the establishment and administration of the new health system by the states.⁴³ The Board's responsibilities would include establishing the requirements of the state plans, monitoring compliance with those requirements, interpreting and updating the nationally guaranteed benefit package, and establishing baseline budgets for the alliances.⁴⁴ In addition, the Board would monitor the quality of health care and investigate new drug prices to ensure they are not unreasonably high.⁴⁵ The National Health Board would consist of seven members, appointed by the President with the advice and consent of the Senate.⁴⁶ At least one member would represent the interests of the states.⁴⁷

If a state fails to meet the deadline for establishing the health alliances or fails to operate the alliance system in compliance with federal requirements, the National Health Board would ensure that all eligible individuals have access to services covered in the comprehensive

37. Chen, *supra* note 5, at A1.

38. Goodgame, *supra* note 17, at 56.

39. *Id.*

40. Chen, *supra* note 5, at A17.

41. *Id.*

42. *Id.*

43. Clinton Administration Description Of President's Health Care Reform Plan, *American Health Security Act Of 1993*, BNA-DLR, September 10, 1993, available in LEXIS, NEWS Library.

44. *Id.*

45. Clinton's Health Plan, *supra* note 2.

46. *Id.*

47. See *supra* note 43.

benefit package.⁴⁸ To induce a state to act, the National Health Board would inform the Secretary of the Department of Health and Human Services and the Secretary of the Treasury of a state's failure to operate an alliance properly.⁴⁹ The Secretary of Health and Human Services would have the authority to order the withholding of federal health appropriations to that state and the Secretary of the Treasury could impose a payroll tax on all employees in the non-complying state.⁵⁰

C. *Financing*

All companies with fewer than 5,000 workers would join the alliance system.⁵¹ As a result, approximately three quarters of all Americans would participate in the alliance system.⁵² For each full-time worker, companies would pay an alliance eighty percent of the cost of the average insurance premium in that area, with a lesser, prorated share to cover part-time workers.⁵³ Workers contribute the rest of the cost, but would pay no more than 1.9 percent of their earnings.⁵⁴ For example, if the average cost of a comprehensive plan was \$2,000 a year, the company would pay \$1,600 and the worker \$400.⁵⁵ If a worker chooses a more expensive plan, with an average cost of \$2,400 a year, the company would still be responsible for the same amount (\$1,600), and the employee would pay the difference for a total of \$800.⁵⁶ Low-income individuals would be eligible for subsidies, and the self-employed would pay premiums based on a fixed percentage of their income, similar to the contributions of a small business.⁵⁷

According to the Clinton administration, no business participating in the alliance system would spend more than 7.9 percent of its payroll on health coverage.⁵⁸ Smaller firms with fewer than fifty employees would be eligible for caps on their contributions.⁵⁹

Federal subsidies, totalling \$160 billion over six years, would be directed to the alliances in covering the costs of insuring workers in

48. *Id.*

49. *Id.*

50. *Id.*

51. Dentzer, *supra* note 28, at 27.

52. *Id.*

53. *Id.*

54. *Id.*

55. Chen, *supra* note 5, at A16.

56. *Id.*

57. Dentzer, *supra* note 28, at 27.

58. *Id.*

59. *Id.*

small businesses.⁶⁰ In addition, these subsidies would help fund the coverage of the unemployed and others who do not fall under any employer-supported plan.⁶¹ These subsidies would be paid for by restraints on the growth of government health programs like Medicare, and \$105 billion in new taxes.⁶² This may include another \$124 billion in Medicare cuts above the \$56 billion included in President Clinton's 1993 budget package.⁶³ These cuts would come mainly by slowing inflation of payments to doctors and hospitals.⁶⁴ Providers would be unable to shift costs to non-Medicare patients due to new federal cost controls.⁶⁵ Moreover, new "sin taxes" would be introduced that would increase the price of cigarettes, while fees would be levied against large corporations who stay out of the regional alliances.⁶⁶

Money that is now directly paid to private insurance companies would go to the health alliances instead.⁶⁷ The alliances would distribute the funds among health care providers it has approved for the area in which it operates.⁶⁸ Such providers might include nonprofit organizations like Blue Cross and Blue Shield, insurance companies, and health maintenance organizations.⁶⁹ The Clinton Administration did not want to sever the link between health coverage and employment, leaving the health alliances to collect health premiums from employers and individuals, and negotiate prices with health care providers.⁷⁰

III. THE CANADIAN UNIVERSAL HEALTH SYSTEM

Canada provides all of its citizens access to medical care, but it does not charge them directly for the services provided.⁷¹ The responsibility for financing the comprehensive set of medical benefits is placed

60. *Id.*

61. *Id.*

62. *Id.*

63. Riley, *supra* note 4.

64. Goodgame, *supra* note 17, at 57.

65. *Id.*

66. Dentzer, *supra* note 28, at 27.

67. Chen, *supra* note 5, at A16.

68. *Id.*

69. *Id.*

70. Dana Priest, *Central Health Care: "Undoable" But No Longer on Political Fringe*, WASH. POST, May 7, 1993, at A11.

71. John Iglehart, *The United States Looks At Canadian Health Care*, 321 NEW ENGLAND J. MED. 1767 (Dec. 21, 1989). Iglehart has published a series of articles analyzing the Canadian health system in THE NEW ENGLAND JOURNAL OF MEDICINE.

squarely on the federal and provincial governments.⁷² Canadian patients are free to choose their physician and hospital.⁷³ Physicians can provide the treatment they recommend without having to obtain approval from administrators.⁷⁴ The system is an example of a single-payer system, in which one government entity collects taxes to pay for its residents' health care.⁷⁵ This single entity disburses the funds to doctors, hospitals, and other providers.⁷⁶ Health benefits are not linked to employment and the health insurance industry has no role.⁷⁷

A. *Basic Benefit Package*

To assure universal access, every Canadian is issued a card administered at the provincial level which allows them to seek care when they need it and from whom they need it, regardless of their economic or health care status.⁷⁸ The care is comprehensive, meaning that there are no co-payments, no deductibles, and no extra costs for services.⁷⁹ The services are primarily provided by private physicians, who operate on a fee-for-service basis and in not-for-profit hospitals.⁸⁰ The insured services of physicians include all medically required services rendered by licensed practitioners in a hospital, doctor's office, or clinic.⁸¹ The insured services of hospitals include all inpatient services provided at the standard ward level and all necessary drugs, biological products, supplies, and diagnostic tests, as well as a broad range of outpatient services.⁸²

A good example of the basic benefits provided in a provincial plan is the Ontario Health Insurance Plan (OHIP). Benefits include physicians' services at home, at doctors' offices, in the hospital, or in other

72. *Id.*

73. Theodore R. Marmor and Michael S. Barr, *America's Health Care: Which Road to Reform? Making Sense Of The National Health Insurance Reform Debate*, 10 YALE L. & POL'Y REV. 228, 242 (1992).

74. *Id.*

75. Priest, *supra* note 70.

76. *Id.*

77. *Id.*

78. Clemente, *supra* note 7, at 39.

79. *Id.*

80. R. G. Evans, *The Canadian Health-Care Financing and Delivery System: Its Experience And Lessons For Other Nations*, 10 YALE L. & POL'Y REV. 362, 369 (1992). Evans has been called Canada's foremost health economist.

81. John K. Iglehart, *Canada's Health Care System Faces Its Problems*, 322 NEW ENGLAND J. MED. 562, 563 (February 22, 1990).

82. *Id.*

eligible institutions.⁸³ This would include diagnosis and treatment of illness and injury, prenatal and postnatal obstetrical care, laboratory services, and clinical pathological services.⁸⁴ OHIP also covers occupational therapy, physiotherapy, speech therapy, audiological services, and psychological services, when prescribed by a physician.⁸⁵ Lastly, long-term care in nursing homes is covered, but patients are asked to make a small contribution.⁸⁶ Services not covered by the plan are visits solely for the administration of drugs, dental care, eyeglasses, cosmetic surgery, examinations for employment, acupuncture, and psychological testing.⁸⁷ The OHIP benefit package is similar to President Clinton's basic benefit package.

B. Federal and Provincial Roles

Canada's universal health insurance allows for flexibility at the local level.⁸⁸ The system is largely financed and wholly administered by the provincial governments, and each is adapted to reflect local preferences.⁸⁹ Public agencies in each of the ten provinces of Canada pay for all of the costs of "medically necessary" hospital and medical care received by their residents.⁹⁰ In order to receive federal funding, the provincial programs must "provide universal access to care with equal terms and conditions for all, cover all medically necessary services as determined by physicians, provide portable benefits . . . , and be publicly administered on a nonprofit basis."⁹¹ The federal government provides funds only to provincial plans which comply with the federal terms and conditions.⁹²

C. Financing

Before fully implementing universal health insurance in 1971, Canada financed its health care in a manner similar to the current American

83. John K. Iglehart, *Canada's Health Care System*, 315 NEW ENGLAND J. MED. 778, 780 (September 18, 1986).

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

88. Marmor, *supra* note 73, at 243.

89. *Id.*

90. Evans, *supra* note 80, at 369. Canada also has two territories which participate in the national health system.

91. Iglehart, *supra* note 81, at 563. Portable benefits are those that are accessible throughout the whole country.

92. Raisa B. Deber, John E. F. Hastings, and Gail G. Thompson, *Health Care In Canada: Current Trends and Issues*, 12 J. PUBLIC HEALTH POLICY 72, 73 (1991).

system.⁹³ Currently, a Canadian patient will never be required to pay a fee or make any financial contribution.⁹⁴ Doctors and hospitals in Canada receive all payments from one source, a provincial ministry, which keeps track of eligibility requirements and administrative procedures.⁹⁵ Physicians bill provincial authorities on a fee-for-service basis.⁹⁶ The physician is reimbursed according to fee schedules negotiated at periodic intervals between the provincial ministry of health and the corresponding provincial medical association.⁹⁷ The schedule in each province is binding on all physicians working in that province, and physicians may not bill their patients additional fees above the scheduled rates.⁹⁸ However, hospitals do not receive reimbursement for particular services.⁹⁹ Instead, each hospital negotiates an annual global budget with the provincial reimbursement agency.¹⁰⁰ These global budgets are to cover operating costs only, including staff salaries, costs of equipment, and supplies.¹⁰¹ The global budgets do not include capital costs, depreciation, or interest charges.¹⁰²

The provincial plans are financed largely by general revenues provided by the federal government and the individual provinces.¹⁰³ Each contributes approximately fifty percent of the funding, although less wealthy provinces and territories receive more federal support.¹⁰⁴ In Canada's largest province, Ontario, individuals generally participate through their employers or on a direct-payment basis.¹⁰⁵ Employers pay the Ontario Health Insurance Plan premiums directly on behalf of fifty-nine percent of the plan's participants.¹⁰⁶ The remaining participants, the majority of whom are self-employed, pay their own premiums.¹⁰⁷

93. Marmor, *supra* note 73, at 244.

94. Evans, *supra* note 80, at 369. Instead, the Canadian health system is paid through federal and provincial tax revenues.

95. Hearings, *supra* note 1.

96. Marmor, *supra* note 73, at 242. Payment is usually received within three weeks.

97. Evans, *supra* note 80, at 370. The fee schedules are negotiated annually.

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. Iglehart, *supra* note 83. Most of the financing comes from income, payroll, and sales taxes. Marmor, *supra* note 73, at 243.

104. *Id.*

105. *Id.* at 779.

106. *Id.* at 779-80.

107. *Id.*

Individuals and families who lack the resources to pay premiums are eligible for government assistance.¹⁰⁸

IV. ISSUES THAT FACED CANADIAN PHYSICIANS AFTER UNIVERSAL HEALTH CARE WAS IMPLEMENTED AND THE LIKELIHOOD OF SIMILAR ISSUES IN AN AMERICAN SYSTEM

Public financing of medical care has worked in Canada, yet no system of health care financing is free of problems or is easily administered.¹⁰⁹ Because Canada and the United States are similar, many of the problems encountered in implementing universal health care in Canada are potential problems for an American system. The following discussion examines the issues and problems that faced Canada in implementing universal health care and the possibility of similar issues occurring in the United States. As Congress assesses the pros and cons of universal health care, it should look to the Canadian experience as a model and implement measures to prevent similar problems from happening in an American system.

A. *Physician Payment Issues*

1. *Physician Payment in the Canadian System*

a. *Fee Schedules*

Canada pays its health care providers based on the negotiation of physicians' fees and hospital budgets.¹¹⁰ The federal government gives money to those provincial governments who comply with the national directives.¹¹¹ The provinces negotiate physician fees and costs for hospital services and then pay the bills.¹¹² Provincial health ministers are empowered to negotiate physicians' fee schedules, to set overall operating hospital budgets, and to approve hospitals' capital acquisitions.¹¹³

The provincial health plans wield their purchasing power through negotiation with provincial medical associations for binding physicians'

108. *Id.*

109. *Hearings, supra* note 1.

110. Iglehart, *supra* note 71.

111. Clemente, *supra* note 7, at 38, 39.

112. *Id.*

113. Iglehart, *supra* note 84, at 781.

fee schedules.¹¹⁴ Negotiations that establish physicians' fee schedules involve representatives of the provincial medical associations and representatives of the provincial plans.¹¹⁵ The government has a fixed amount to spend each year and physicians receive only a specified amount for each service performed.¹¹⁶ Physicians may not receive any more than the set fee and cannot bill their patients for extra services.¹¹⁷ The "budget negotiations between Canadian medical care providers and provincial health care administrators are periodic, noisy, and contentious; but, unlike the negotiations between private insurance companies and providers of managed care in the United States, the negotiations are open to the public."¹¹⁸ Therefore, the negotiations are subject to public influence.¹¹⁹

Negotiators concentrate on making fee increases on an aggregate basis.¹²⁰ This translates into a certain percentage increase in provincial payments for all physicians' services.¹²¹ The provincial medical associations decide how those increases will be divided according to medical specialty.¹²² The result is that the Canadian fee schedules provide little differentiation between types of office visits.¹²³ Practitioners that perform long and detailed examinations are penalized.¹²⁴ In addition, fees are paid only for physician services, not for employees like nurses or secretaries.¹²⁵ Therefore, the possibility of generating increased income by delegating tasks to subordinates is limited.¹²⁶ The fee schedules are structured so that an increase in billings requires a physician to invest additional time in his or her practice; however, because the number of hours in a day is limited, the expansion of physicians' billings is constrained.¹²⁷

b. *Extra-billing by Canadian Physicians*

A trend that existed between physicians, patients, and the Canadian provincial health plans was that in times of increased fee restraints,

114. *Id.*

115. *Id.*

116. Clemente, *supra* note 7, at 39.

117. *Id.*

118. Marmor, *supra* note 73, at 243.

119. *Id.*

120. Iglehart, *supra* note 83, at 781.

121. *Id.*

122. *Id.* at 782.

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.*

doctors tended to "extra-bill."¹²⁸ Physicians would bill patients for amounts above those allowed by government fee schedules.¹²⁹ It provided physicians a way to opt out of the provincial plans and thereby gain the option to extra-bill their patients at rates of their own choosing.¹³⁰ Physicians received reimbursement from the government only at the insured fee schedule rates.¹³¹ Physicians used extra-billing as a way to recoup the income they had lost under economic controls and to offset the provincial restrictions on fees.¹³²

Some provinces permitted extra-billing because it shifted to consumers a share of the expense of medical services and reduced the pressure for sizable increases in physicians' fee schedules.¹³³ The provincial health ministries considered extra-billing to be an appropriate response to strict governmental limits on health spending, while the provincial medical associations considered it to be a necessary safety valve in response to the monopsony powers of the government.¹³⁴

c. *The Canadian Health Act of 1984 and The Doctors' Strike of 1986*

Concern in Canada grew over the issue of whether the increase in the practice of extra-billing was eroding the access to care, particularly in the provinces of Ontario and Alberta.¹³⁵ The federal government created a commission to examine the question of whether extra-billing was limiting access to care.¹³⁶ The commission released a report in 1980 which criticized extra-billing for its harmful effects on the access to medical care.¹³⁷ The result was implementation of the Canada Health Act in 1984, which reasserted federal power over the provincial plans.¹³⁸ Namely, the Canadian Parliament directed that the provinces end the

128. *Id.*

129. *Id.*

130. Richard M. Kravitz and Martin F. Shapiro, *Duration and Intensity of Striking Among Participants In The Ontario, Canada Doctor's Strike*, 30 MEDICAL CARE 737 (1992).

131. Judith Globerman, *Free Enterprise, Professional Ideology, And Self-Interest: An Analysis Of Resistance By Canadian Physicians To Universal Health Insurance*, 31 J. HEALTH & SOCIAL BEHAVIOR 11, 13 (1990).

132. John K. Iglehart, *Canada's Health Care System*, 315 NEW ENGLAND J. MED. 202, 207 (July 17, 1986).

133. *Id.*

134. Iglehart, *supra* note 83, at 782.

135. Iglehart, *supra* note 132, at 207.

136. *Id.*

137. *Id.*

138. Iglehart, *supra* note 83, at 782.

practice of extra-billing or forfeit a substantial portion of their federal funding.¹³⁹

The Canadian Health Act provided that "any provincial government which either charged patients for covered services, or permitted anyone else to charge for them, would lose an amount from its federal grant equal to the estimated total amount of their direct charges."¹⁴⁰ Over the strong opposition of organized medicine, every province enacted legislation implementing a ban on extra-billing, fearing the loss of federal grants.¹⁴¹ Ontario introduced legislation forcing physicians to accept the insured fees as full payment for their services.¹⁴² Thus, if a doctor wanted to remain eligible for reimbursement by the provincial plans, he or she could not extra-bill patients by charging an amount in excess of the negotiated reimbursement rate.¹⁴³

The move against extra-billing was viewed by the medical profession as a direct assault on its autonomy.¹⁴⁴ Physicians and their professional organizations condemned the Canadian Health Act as "an unwarranted intrusion on professional freedom that reduced the profession to a public service."¹⁴⁵ The Ontario Medical Association (OMA) claimed that the ban on extra-billing infringed upon the rights of physicians to contract directly with their patients.¹⁴⁶ Ultimately, physicians claimed that the Act undermined the quality of care by eliminating the safety valve for occasions when the government failed to provide adequate financial support to the system.¹⁴⁷

Opposition to the ban on extra-billing culminated in the Ontario Medical Association's call for an unlimited strike, to begin on June 12, 1986.¹⁴⁸ In an effort to force the provincial government to abandon its plan to ban extra-billing by physicians,¹⁴⁹ the strike called for doctors to provide only emergency services and to cancel elective surgery.¹⁵⁰

139. Kravitz and Shapiro, *supra* note 130, at 737.

140. Evans, *supra* note 80, at 373.

141. Iglehart, *supra* note 81, at 565.

142. H. Michael Stevenson, A. Paul Williams, Eugene Vayda, *Medical Politics and Canadian Medicare: Professional Response to the Canada Health Act*, 66 *MILBANK QUARTERLY* 65, 70 (1988).

143. Marmor, *supra* note 73, at 242.

144. Stevenson, *supra* note 142, at 70.

145. *Id.*

146. Kravitz and Shapiro, *supra* note 130, at 738.

147. *Id.*

148. Stevenson, *supra* note 142, at 71. The Ontario Medical Association is the most powerful professional association in Canada. *Id.* at 70.

149. Iglehart, *supra* note 83, at 782.

150. Stevenson, *supra* note 142, at 71.

In addition, the OMA asked that all hospital chiefs-of-staff and chiefs-of-services resign.¹⁵¹ The result was an Ontario strike that lasted for twenty-five days.¹⁵² Overall, the strike failed in its fundamental political objective of obstructing the federal government's resolve to extend its control over health insurance.¹⁵³ The strike "not only failed to avert the ban on extra-billing, but was viewed as a public relations disaster for physicians."¹⁵⁴ Today, physicians sit with the government on a Joint Management Committee that tries to reach a consensus on fees.¹⁵⁵ If the two sides cannot agree, physicians have agreed to a process of mediation and independent binding arbitration.¹⁵⁶

d. *Physicians' Ability to Privately Contract*

In most Canadian provinces, patients are not prohibited from paying privately for their medical or hospital care.¹⁵⁷ Physicians and hospitals, however, are prohibited from treating both patients whose care is financed by the provincial plans and patients who pay directly.¹⁵⁸ Thus, it is still technically possible for physicians to withdraw from the public plan and see patients on a purely private basis.¹⁵⁹ Neither the patient nor the physician are reimbursed by the public plan.¹⁶⁰ A group of physicians could set up a purely private hospital or diagnostic facility, but their patients would have neither public nor private insurance.¹⁶¹ Therefore, a physician who is contemplating whether to contract privately with his patients must decide whether to be "all in" or "all out" of the provincial plans.¹⁶² The provider "would have to be able to make a living purely in the private market, rather than playing both the private and public markets, like in countries with dual systems."¹⁶³

151. *Id.*

152. *Id.*

153. *Id.*

154. Richard L. Kravitz, Lawrence S. Linn, and Martin F. Shapiro, *Risk Factors Associated With Participation In The Ontario, Canada Doctors' Strike*, 79 AM. J. PUBLIC HEALTH 1227 (1989).

155. Clyde H. Farnsworth, *The Bill Comes Due: Canada's Health Care Costs—A Special Report*, N.Y. TIMES, March 7, 1993, at A18.

156. *Id.*

157. Iglehart, *supra* note 81, at 563.

158. *Id.*

159. Evans, *supra* note 80, at 371.

160. *Id.*

161. *Id.*

162. *Id.* at 372.

163. *Id.*

As a result, no private market has developed in Canada, even though it is permissible.¹⁶⁴

e. *Canada's Movement Toward Caps as a Way to Control Rising Health Costs*

The Canadian fee schedules have moderated the growth of doctors' incomes at levels below what they would be in a free market.¹⁶⁵ Not only are physicians' fees set through consultation with the government, but some provinces have also placed annual limits or restrictions on how much a doctor can earn.¹⁶⁶ In Ontario, reimbursements after a doctor has grossed \$320,000 are made at 75 cents on the dollar, and the province is threatening to reduce that ceiling for certain kinds of doctors who are perceived to be in oversupply.¹⁶⁷ In Quebec, the government has put an expenditure cap,¹⁶⁸ or ceiling, on certain kinds of income.¹⁶⁹ Expenditure caps are prospectively determined, fixed budgets that restrict further funding once the cap is reached.¹⁷⁰ Thus, in Quebec, any fees earned by a general practitioner in excess of \$164,108 (Canadian) a year will be reimbursed at a rate of twenty-five percent.¹⁷¹ The province of British Columbia has capped the growth of physicians' payments at three percent per year.¹⁷²

2. *Physician Payment Under President Clinton's Proposal*

a. *Negotiation of Premiums and Budget Controls*

President Clinton's plan seems to have more federal control in budgeting procedures than the Canadian system. In general, the national health care budget would be based on the weighted average premium for the guaranteed benefits package, which will act as a

164. *Id.*

165. Iglehart, *supra* note 83, at 782.

166. Anne Swardson, *Canada's National Health Plan; The Model Is Tempting, But . . .*, WASH. POST, June 22, 1993, at F10, F12.

167. *Id.*

168. Iglehart, *supra* note 71, at 1771.

169. Ronald Bronow, *A National Health Program; Abyss at the End of the Tunnel—The Position of Physicians Who Care*, 263 J. AM. MED. ASS'N 2488 (May 9, 1990).

170. Iglehart, *supra* note 71, at 1771.

171. Bronow, *supra* note 169.

172. *Id.*

benchmark for market action.¹⁷³ The budget procedure for the health alliances is somewhat complicated. First, a national per capita-based premium would be set by the National Health Board, with an adjustment at the alliance level for risk factors like age and other demographic information.¹⁷⁴ Alliances would then receive an average premium from the National Health Board.¹⁷⁵ Next, health plans would submit bids to the alliances, either blindly or with knowledge of the average premium target.¹⁷⁶ Finally, the alliances would submit their average premiums to the National Board, which would either approve or reject the average premium.¹⁷⁷ If not approved, the alliances would renegotiate their average premium.¹⁷⁸ Once accepted, if an alliance exceeds its average premium, it has a two year recoupment period to comply.¹⁷⁹ Corporate alliances would use an equivalent target, but would be terminated if the target is missed two out of three years.¹⁸⁰

The American Medical Association (AMA) strongly opposes the setting of a national budget, claiming that "health care decisions based mainly on economics and not on patients' needs will not be in the best interests of patients."¹⁸¹ Unlike the fee schedule negotiations in Canada, which occur between the provincial health ministries and provincial medical associations, no physician involvement occurs in President Clinton's proposal. The AMA believes "a participatory process that includes physicians' input might be useful to establish true goals that can be flexible and are based on patient needs."¹⁸² The result of a Clinton-type budget process will be disgruntled physicians who have no voice in how the system works. In the end, the AMA thinks such a process will lead to the rationing of health care.¹⁸³

Physicians may have other problems if an alliance becomes insolvent. According to President Clinton's plan, each state would operate a guaranty fund to provide financial protection to health care providers

173. *An AMA Analysis of the Clinton Reform Plan*, AMERICAN MEDICAL ASSOCIATION, September 24, 1993, at 6.

174. *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

and others if a health plan becomes insolvent.¹⁸⁴ These guaranty funds would pay health providers if a health plan is unable to meet its obligations.¹⁸⁵ The guaranty funds would cover liability for services rendered prior to the plan's insolvency for all services under the comprehensive benefits package.¹⁸⁶ However, when a health plan cannot meet its financial obligations to providers, the providers have no legal right to seek payment from patients.¹⁸⁷ Moreover, health providers must continue caring for the patients until they are enrolled in a new health plan.¹⁸⁸ Thus, physicians would be forced to provide care for patients without recourse for payment. Physicians again have been left out of the planning process and may suffer by providing services for which there is no recourse for payment.

b. *Prevention of Physician Fraud and Abuse Under President Clinton's Plan*

The practice of extra-billing in President Clinton's plan seems unlikely. In President Clinton's proposal, accountability standards are implemented which make provider fraud and other misbehavior automatic grounds for exclusion from all health plans.¹⁸⁹ The plan penalizes health care providers and institutions that impose excessive charges or engage in fraudulent practices.¹⁹⁰ Current federal authority would be amended to allow forfeitures of proceeds derived from health care fraud.¹⁹¹ The federal government could use either criminal or civil remedies to seize assets derived from fraudulent or illegal activities.¹⁹²

Tougher standards and stiffer penalties would be implemented to prevent the types of extra-billing that occurred in Canada. New criminal penalties would be directed at health care fraud, related to the payment of bribes and gratuities to influence the delivery of health services and coverage.¹⁹³ Civil monetary penalties would be assessed against providers who submit false claims.¹⁹⁴ In addition, tighter restrictions in the private

184. *Clinton Health Care Reform Plan*, *supra* note 43, at 23.

185. *Id.*

186. *Id.*

187. *Id.*

188. *Id.*

189. *Clinton's Health Plan*, *supra* note 2.

190. *Id.*

191. *Clinton Health Care Reform Plan*, *supra* note 43, at 87.

192. *Id.*

193. *Clinton's Health Plan*, *supra* note 2.

194. *Id.*

sector would eliminate financial kickbacks and new standards would prohibit physicians from prescribing services delivered at institutions where they hold financial interests.¹⁹⁵ The current anti-kickback statute would be expanded to include not only Medicare and Medicaid, but all health payers.¹⁹⁶ Overall, the plan stresses physician accountability for services provided and stiff consequences if fraudulent conduct occurs.

c. *Physicians' Ability to Privately Contract*

Under President Clinton's plan, physicians would still be able to bill for each procedure.¹⁹⁷ However, since fee-for-service plans are expected to be the most expensive options, planners believe most consumers will choose less expensive managed care plans,¹⁹⁸ like PPOs and HMOs. If doctors want patients, they will have to join the managed care plans.¹⁹⁹ In managed care plans, physicians team up with hospitals to compete against other plans, on both price and quality, to attract patients.²⁰⁰ The patients pay fixed amounts per month, as capitation payments.²⁰¹ The end result is that physicians will lose the ability to privately contract on a fee-for-service basis with individual patients and will, instead, operate on fixed fees in managed care plans. This is similar to the Canadian system, where private contracting is permissible, but because of provincial coverage constraints put on consumers and physicians, it has not evolved.

d. *Salary Caps as a Way to Control Costs*

Although caps are not specifically stated in President Clinton's proposal, indirect caps may result. Drastic constraints on existing government health programs which cut Medicare's twelve percent growth rate roughly in half, would necessitate deep cuts in payments to doctors and hospitals.²⁰² Moreover, physicians in fee-for-service plans would be required to charge patients on the basis of a regional or state-established

195. *Id.*

196. *Clinton Health Care Reform Plan*, *supra* note 43, at 86.

197. Ruth Sorelle, *Doctors Hesitant About Plan*, *HOUSTON CHRON.*, September 11, 1993, at A15.

198. *Id.*

199. *Id.*

200. Joseph P. Newhouse, *Health Care Reform: A Reader's Guide*, *N.Y. TIMES*, September 12, 1993, at 32.

201. *Id.*

202. Dentzer, *supra* note 28, at 25.

fee schedule.²⁰³ This, coupled with a ban on balance billing,²⁰⁴ will cause physicians' fees to be fixed. Finally, under the Clinton plan, annual caps on private insurance premium increases and fee schedules for providers in fee-for-service plans would be established.²⁰⁵ Combined with the ban on balance billing, premium caps will equate to price controls for physicians' services.²⁰⁶ Therefore, physicians' salaries may eventually be capped if President Clinton's proposal is enacted without any changes.

B. *The Standard of Health Care*

1. *Availability of Services*

a. *Canadian Accessibility*

An important feature of Canada's approach to hospital budgeting is the separation of operating and capital expenditures.²⁰⁷ Through this process, the provincial plans have contained the growth of hospital resources, including equipment and supplies.²⁰⁸ Provincial governments limit the proliferation of hospital capacity and expensive diagnostic equipment by funding them separately through the hospital capital and operating budgets, instead of through fees per item of service.²⁰⁹ For example, a hospital that wishes to acquire an expensive piece of equipment, like an MRI (Magnetic Resonance Imaging), must receive both planning approval and capital commitment from the provincial ministry of health.²¹⁰ Private physicians may purchase and use such equipment, but if no corresponding service is in the fee schedule, reimbursement for its use will not be provided.²¹¹

The result is that physicians claim a shortage of capacity.²¹² There are considerably fewer MRIs and other high-technology items in Canada

203. *Physicians And The Changing System: The Preliminary Clinton Reform Plan*, AM. MEDICAL ASS'N, September 24, 1993, at 1.

204. *Id.* Balance billing is the standard procedure physicians use in fee-for-service office visits.

205. *Id.*

206. *Id.*

207. Iglehart, *supra* note 81, at 565.

208. *Id.*

209. Evans, *supra* note 80, at 376.

210. *Id.*

211. *Id.*

212. *Id.*

compared to the United States.²¹³ Waiting lists have developed for services like open-heart surgery and MRIs.²¹⁴ Moreover, the diffusion of several major forms of technology have been slowed, including open-heart surgery, cardiac catheterization, organ transplantation, and radiation therapy.²¹⁵ This puts the Canadian physician in the position of having to provide care on the basis of most urgent medical need rather than rendering it to all who could benefit.²¹⁶ Recent government limits on medical spending have led to waiting lists for certain expensive non-emergency procedures.²¹⁷ In some provinces, patients have had to wait as long as eighteen months for a hip replacement, twelve months for cataract surgery, and three to six months for elective coronary bypass surgery.²¹⁸ In Ontario, hospital directors have responded to government cost freezes by reducing services and shrinking the number of beds available.²¹⁹

b. *Accessibility Under President Clinton's Plan*

Currently, the United States has waiting lists for certain elective procedures and some essential ones.²²⁰ In larger cities, patients who are being treated in emergency rooms often wait hours for critical care.²²¹ Private hospitals routinely turn away uninsured patients, leaving the already overburdened public sector to take care of them.²²² The goal of the Clinton plan is to end such discriminating insurance-market practices and provide each person with a national health security card that could be used at any hospital or doctor's office in their alliance area.²²³ There would then be no denial of coverage because of a particular occupation or pre-existing condition.²²⁴ In theory, such a plan should increase accessibility to services; however, it remains to be seen whether, in practice, the Clinton proposal can provide every American ready access to care.

213. *Hearings*, *supra* note 1.

214. Marmor, *supra* note 73, at 243.

215. Iglehart, *supra* note 81, at 565.

216. *Id.*

217. Farnsworth, *supra* note 155.

218. *Id.*

219. Swardson, *supra* note 166, at F10.

220. *Hearings*, *supra* note 1.

221. *Id.*

222. *Id.*

223. Chen, *supra* note 5.

224. *Id.*

2. *Physician-Patient Relationship*

a. *Physician Choice in Canada*

Canadian citizens are guaranteed comprehensive care, whatever their economic status, while having the freedom to select their own physicians.²²⁵ For physicians, the Canadian system offers the ease of billing a single provincial payer, with virtually no questioning of their clinical judgment.²²⁶

If a patient feels a need for care, he or she may seek out the services of any physician who is willing to accept him as a patient.²²⁷ Patient and provider have complete freedom of choice.²²⁸ Usually, a patient will contact a general practitioner, who then acts in a "gate keeper" role.²²⁹ The physician will either provide diagnostic and treatment services himself, or refer the patient to a specialist.²³⁰ Specialists tend to discourage self-referral by patients through direct contact, because specialists receive a higher fee if a general practitioner refers the patient. In addition, general practitioners might resent a patient bypassing their services.²³¹

b. *Physician Choice Under President Clinton's Plan*

Once a year, probably in a ten day open enrollment period, an alliance would mail a directory to all local residents offering a choice of certified health plans offered by approved providers.²³² A person would select a plan for that year and receive all medical care exclusively from that organization's network of doctors and hospitals.²³³ If a person

225. Iglehart, *supra* note 71, at 1767.

226. *Id.*

227. Evans, *supra* note 80, at 369.

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.*

232. Chen, *supra* note 5, at A16.

Consumers would receive useful information about each of the plans in the alliance. Quality performance reports would contain information on cost of premiums, out-of-pocket costs, and any restrictions on access to providers and services. This information would be subject to Labor Department audits. *Id.*

233. *Id.*

needs care outside the network, he or she would have to pay the full bill.²³⁴ More costly fee-for-service plans would also be available as an option, offering a larger selection of doctors and hospitals.²³⁵ However, there would be an out-of-pocket limit of \$1,500 for an insured individual if a fee-for-service plan is selected.²³⁶ Because the fee-for-service plans will be more costly than the managed care plans, most Americans will be forced to give up their choice of physician in favor of the cheaper HMOs and PPOs. Traditional physician choice will change if a managed care plan is chosen, because individuals will choose from a group of approved providers, not their own physician.

3. *Health Care Rationing*

a. *Canada's Position*

Critics of the Canadian health system warn that health care is rationed to its citizens.²³⁷ Rationing is the effort to distribute scarce resources equitably.²³⁸ Canada attempts to provide more uniform access to health care among its entire population.²³⁹ As a result, medical care depends more on a professional assessment of health needs rather than on one's insurance status, as in the current American health care system.²⁴⁰ Because Canada provides uniform access to health care, many non-essential services are not provided when financial resources are not available. Canada is faced with a system in which funding is finite and limited, while the demands of patients are not.²⁴¹ To cope with rising federal transfer payments for health care, Canadian politicians are restricting access to medical care.²⁴² To keep down the costs of health care, hospitals throughout Canada are taking beds out of service, limiting the number of operations they perform, and cutting back on other services.²⁴³ For example, Ontario's hospital directors recently suggested that they will have no choice but to reduce services and

234. *Id.*

235. *Id.*

236. *Id.*

237. *Hearings, supra* note 1.

238. Daniel Callahan, *Symbols, Rationality, and Justice: Rationing Health Care*, 18 AM. J. LAW & MED. 1, 3 (1992).

239. Marmor, *supra* note 11, at 57.

240. *Id.*

241. Bronow, *supra* note 169.

242. *Id.*

243. *Id.*

shrink the number of available hospital beds.²⁴⁴ Similarly, in Quebec, vision exams for those ages twenty to forty and dental treatments for all but low-income children are no longer covered services.²⁴⁵ The reality is that not all health services can be covered in a universal health system and non-essential services are the first to be cut.

b. *Rationing Under an American System*

Presently, the United States limits services by ability to pay and accordingly shows a significant difference in access to health care by race, class, and employment circumstances.²⁴⁶ This is a form of rationing health care. In addition, Americans who participate in HMOs and other systems of managed care face corporate rationing.²⁴⁷ Participants in HMOs do not know whether they will be denied a referral to a specialist in the event of a rare disease or difficult procedure.²⁴⁸ Because the thrust of President Clinton's plan is to shift Americans away from fee-for-service care towards less costly PPOs and HMOs, some form of rationing is certain to occur.

Under President Clinton's plan, the National Health Board would strictly enforce limits on health care spending by deciding when health care providers were spending too much.²⁴⁹ Some providers think this may lead to the rationing of health care and result in the development of fewer new drugs.²⁵⁰ One suggested rationing scenario is requiring an elderly patient in declining health to be denied such operations as hip replacements and cardiac bypasses.²⁵¹ President Clinton's proposal also calls for sharp limits on private health insurance premiums.²⁵² In theory, if health insurers raised premiums faster than the government allowed, the Treasury could tax away the increase.²⁵³ Opponents of President Clinton's plan believe this will turn insurers into health services policemen, and result in the rationing of medical care.²⁵⁴

244. Swardson, *supra* note 166, at F10.

245. *Id.* at F11.

246. Marmor, *supra* note 11, at 57.

247. *Id.* at 58.

248. *Id.*

249. Goodgame, *supra* note 17, at 55.

250. *Id.*

251. *Id.*

252. Dentzer, *supra* note 28, at 28.

253. *Id.*

254. *Id.*

V. CONCLUSIONS AND RECOMMENDATIONS

Universal health care is a noble undertaking and President Clinton should be commended for possessing the leadership to confront our nation's health care problems. As discussed, if Congress adopts President Clinton's proposal for universal health care, physicians will face many changes in the way they practice medicine. Canada's experience with implementing universal health care exemplifies the problems American physicians may encounter. Mechanisms to deal with physician payment and measures to ensure that the standard of care remains high are not addressed in President Clinton's proposal. Because physicians were left out of the planning phase of President Clinton's proposal, their interests have not been represented. Instead of allowing the American Medical Association to participate in the closed-door hearings, other special interest groups were permitted to influence the plan. Decisions were based on economics and not on patient needs.²⁵⁵ In the end, President Clinton's plan does not represent the needs of American health care consumers, but instead seems an effort to please special interest groups.

As Congress debates the merits of President Clinton's plan, three events should occur. First, if a national health budget is going to be established, a participatory process that includes representatives of the health insurance industry, hospitals, the medical profession, and the pharmaceutical industry should be established.²⁵⁶ These groups will be the participants who will carry out any legislation that is passed. By doing so, a more realistic budget will result, and health care providers will feel that their interests have been represented. Moreover, by having a better informed health care industry, a smoother transition process may result once any legislation is put into action. Second, if all Americans are going to have access to health care, incentives to stay healthy need to be incorporated into the system. Otherwise, those that lead unhealthy lifestyles will overburden the system, leading to the rationing of, and limited accessibility, to health care discussed previously. Monetary incentives in the form of reduced insurance premiums could be established if an individual regularly exercises or refrains from tobacco and alcohol consumption. Ultimately, American physicians and the entire universal health system will be less burdened if Americans are more healthy. Third, preventive medicine should be stressed in the basic benefits package. Annual physicals for children and adults should

255. *The AMA Analysis of the Clinton Reform Plan*, *supra* note 173, at 6.

256. *Id.*

be mandatory so that medical complications and illnesses can be discovered before costly procedures are required. Moreover, physicians should be receptive to such a requirement, because it will result in consistent fees and more familiarity with their patients' medical histories.

President Clinton's proposal is a good start, but many issues are not addressed. Hopefully, our democratic system will create the best solution for our health care delivery problems. Congress should scrutinize the strengths and weaknesses of each of the major proposals with one goal in mind—do what is best for the patient.

*Michael Roth**

* J.D. Candidate, 1995, Indiana University School of Law—Indianapolis.