SPECIAL  SECTION

"ONCE MORE UNTO THE BREACH!"

Why We Must Renew the Struggle for Healthcare Reform

BY CHARLES J. DOUGHERTY, PhD

"Once more unto the breach, dear friends, once more!" —Shakespeare, *Henry V*

In 1994 the last great effort to reform the American healthcare system came to an inglorious end. The push for reform that had begun with a bang in the primary season of the 1992 presidential campaign went out with a whimper. In spite of (or perhaps because of) the finely crafted detail of the Clinton administration's plan and the personal prestige of Hillary Rodham Clinton, who led the effort to develop it, the plan died in Congress. No alternative reforms were seriously considered. When the end came, no mass protests occurred; indeed, there was little apparent shock. Although the Republicans won control of Congress in the November 1994 election, this had no clear connection to healthcare reform's failure. The issue just seemed to go away.

There were and continue to be multiple interpretations of this political fiasco.[1] For example:

- The Clinton plan had been composed by policy wonks "in secret."
- The plan was overly ambitious.
- The plan was contradictory; "managed competition" (which the plan promised) was an untenable mix, perhaps an oxymoron.
- The plan was too complex.
- The effort behind the Clinton plan was from the start curiously partisan, with nearly unanimous Republican opposition and little explicit Democratic support.
- The plan's supporters had overestimated the insecurity of the middle class concerning health insurance. And those Americans who had coverage—by far the vast majority—did not identify with the problems of the uninsured.
- Single-payer advocates and others on the political left saw the Clinton plan as too tame.
- Many people, including those on the political right, saw too much "big government" in it.
- Special interest opposition to the plan was determined and well-financed.
- The lobbying power of the health insurers and small business organizations was underestimated, as was the ability of the "Harry and Louise" commercials to befuddle the public.
- What little real debate occurred revealed a depth of cynicism and mistrust not only of the government but also of major healthcare institutions.
- Finally—and perhaps most important—there was a fundamental contradiction in the American psyche: our desire for universal health coverage, on one hand, versus our refusal to pay the necessary financial and political costs of it, on the other.

Given these and other diagnoses, the failure of healthcare reform was overdetermined. It had many, many causes. In fact, there are so many reasons for the reform effort's failure, it seems odd in retrospect that so many people were so hopeful about its prospects in the first place.

The Catholic Ministry and Reform

Whether those hopes were overly optimistic, even naive, is an important political and cultural question for Americans to answer. Advocates of reform whose early 1990s political assessments

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were central to their backing of either the Clinton plan or one of its competitors must draw lessons from this miscalculation. These political lessons will inform their future strategies.

But the lessons of history ought to appear different to American Catholics. The Catholic healthcare ministry, through the leadership of the Catholic Health Association (CHA), was an important voice for healthcare reform throughout this period. CHA was a player—not primarily because it had an optimistic political assessment of what was possible, but because it understood that reform was the right thing to do. Universal coverage and the associated reforms needed by the system are too central to the principles that motivate Catholic healthcare for CHA to have been silent or only marginally involved.

Recognition of this imperative is evident in a series of CHA documents, the association's insistence on reform becoming ever clearer from the mid-1980s through the demise of the reform effort. The first, 1986's *No Room in the Marketplace: The Health Care of the Poor*, was an early statement of the problems of the uninsured, on one hand, and, on the other, of the moral imperative to reform the system. Two years later, CHA issued *A Time to Be Old, a Time to Flourish: The Special Needs of the Elderly-at-*

THE CONSEQUENCES OF HAVING NO COVERAGE

Compared with the insured, uninsured Americans are:

- Four times less likely to have a regular source of care
- Up to 66 percent less likely to have had a recent physician visit
- Almost four times less likely to obtain dental care
- More than four times less likely to obtain prescription drugs
- More than three times less likely to obtain needed eyeglasses

Because they lack insurance, the uninsured are:

- Seventy percent more likely to be diagnosed at a late stage in the disease when they have colon cancer
- Thirty percent less likely to have received any mental health treatment before hospitalization
- More than three times as likely to die during a hospital stay

Uninsured Children

Because millions of children are uncovered, they have demonstrably less access to healthcare. Compared with insured children, the uninsured are:

- Eight times less likely to have a regular source of care
- Almost three times less likely to have had a recent physician's visit
- Four times more likely to delay seeking care
- Six times more likely to have gone without medical, dental, or other healthcare

The consequences are all too predictable. Children without insurance are:

- Seventy percent less likely to receive medical treatment for a sore throat or tonsillitis
- Seventy percent less likely to receive it for asthma
- Ninety percent less likely to receive it for an acute earache
- Nearly 200 percent less likely to receive it for a recurrent earache
- Thirty percent less likely to receive medical attention for any injury and up to 40 percent less likely to receive medical attention for a serious injury

When hospitalized with appendicitis, uninsured children have waited almost twice as long before seeking care. Their subsequent hospital stays are nearly twice as long.

Uninsured Women

Uninsured women are at special risk. Compared with the insured, such women are only half as likely to have had a mammogram or clinical breast examination in the previous two years. Uninsured women aged 50 to 64 are:

- More than twice as unlikely to have had a recent mammogram
- Ninety percent less likely to have had a recent pap test
- More than twice as unlikely to have had a recent clinical breast examination

When uninsured women contract breast cancer, they have an adjusted risk of death 49 percent higher than that of insured women. This, no doubt, reflects the fact that they are 40 percent more likely to be diagnosed with breast cancer at a late stage.

Uninsured women without health insurance obtain prenatal care much later in their pregnancies than insured women. Only 2 percent of uninsured women are cared for during their pregnancies by a private physician. As a result, uninsured women are 31 percent more likely to have adverse hospital outcomes.

Poverty and the Uninsured

Many of the uninsured are also poor. A fourth of those who live in households with family incomes of less than $25,000 a year are uninsured. Low-income Americans are more than twice as likely to go without health insurance as the rest of the population. Nearly 31 percent of those living at or below the poverty level are uninsured. Low-income Americans make up 13.7 percent of the U.S. population, but they are 27 percent of the uninsured population.

These, and other data in this article comparing the uninsured and the insured in terms of health status and access to care, are from "No Health Insurance? It's Enough to Make You Sick," American College of Physicians–American Society of Internal Medicine, Philadelphia, 2000.

Risk, which identified and decried the problem of long-term care—including the fragmentation that harms so many frail elderly. Prodded in part by Medicaid rationing in Oregon but also by a moral intuition that real reform of the system requires conscious and principled measures to set and enforce limits, in 1991 CHA issued *With Justice for All? The Ethics of Healthcare Rationing.* Finally, in 1993, the association threw its full weight behind healthcare reform by publishing *Setting Relationships Right: A Proposal for Systemic Healthcare Reform.*

Setting Relationships Right was a detailed plan based on much input from CHA members. It called for rapid universal coverage, a uniform and comprehensive benefit package, a delivery system reformed around integrated delivery networks, and explicit and fair methods of limiting the growth of healthcare spending. The 1993 CHA reform plan anticipated many of the elements of the Clinton proposal. Despite CHA's prescience, its plan, like the Clinton plan itself, was quickly forgotten once the reform movement came to an abrupt halt in 1994. In the years immediately thereafter, CHA staff focused on helping members deal with what was left after the reform effort collapsed: the implications for the ministry of the spread of managed care, significant reimbursement cutbacks to providers, and the merger mania resulting from rapidly changing market pressures.

But changing political vicissitudes do not change fundamental moral realities. In 1999 CHA adopted a strategic plan that calls for building a national consensus on the need for accessible and affordable healthcare for all. A Special Committee on Healthcare Reform was established to reassert CHA's values and principles in this area and to offer guidance on the components of a plan for reform.

In the present political climate, active leadership on this issue may be regarded by many as hopelessly naive. It is certainly countercultural. In light of this, it is worth restating the fundamentals that drive the Catholic health ministry to this position. It may also be valuable to review some of the facts that make our healthcare system morally dysfunctional.

Persons, Community, and Limits

The primary driver for the Catholic healthcare ministry in the realm of health policy is Catholic social teaching. This is a rich and complex tradition that can be expressed in many ways and in many idioms.[2] Let me offer a framework for appreciating the main thrust of the tradition that I hope is simplifying without being simplistic. On this account, three complementary insights drive Catholic thinking in this area:

- Every person is incalculably valuable, with dignity and human rights.
- Persons are not only individuals but are fundamentally social, united to one another through multiple overlapping communities.
- Persons, communities, and the natural world that makes them possible are the result of divine creation and therefore have divinely established goals and limits.

Persons Are Incalculably Valuable Every human being is created by God. This endows each person with a dignity that is inalienable. It cannot be given away or taken away, precisely because the dignity itself is neither created nor given by humans. Thus every person, regardless of station in life or condition, has the human right to protect and enhance that God-given dignity. This entails a right to life. Closely associated is the right to what persons need to sustain life and to live it in a condition of dignity. These include the personal liberties that Americans take for granted and have by and large enshrined in our fundamental laws. They also include rights—which Americans are more reluctant to respect and enact into law—to certain necessary goods and services: adequate food, clothing, shelter, education, employment, and healthcare.

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The very notion of what it is to be a person on the Catholic account thus entails the right to some decent amount of healthcare. Because one must be "covered" in order for this right to be guaranteed in the systems created in advanced countries around the world (covered by private insurance, by a direct contract with providers, or by a government program), persons have a consequent right to healthcare coverage. Universal coverage is, then, a moral obligation founded in respect for the dignity of human persons.

This conclusion is stark, sweeping, but also, I believe, ineluctable. The Catholic view of a person entails a right to healthcare, which entails a right to coverage. Alternatively put, the right of persons to healthcare necessitates universal coverage.

Persons Are Not Only Individuals Taken alone, the insight concerning persons and rights might be said to follow from the European Enlightenment or from any broadly liberal tradition. But there is a "both/and" Catholic principle that is equally important and substantially affects this interpretation of the human person.

Persons are not only individuals. We are not isolated, atomic units seeking our own selfish

interests. Instead, persons are inherently social. Were our American ideology of individualism not so culturally blinding, this insight would appear as obvious to us as it does to most cultures around the world. Our social selves begin with the body. Although our genes are individual (excepting those of twins), they are drawn from a common source, a universal "pool" that has intermingling strains constituting ethnic groupings and families. A person's social character is obvious in the manner he or she acquires language as a child and in the innumerable and profound ways his or her personality is shaped by relationships with others, including that powerful and superpersonal other called culture.

But it is not just the fact that people are shaped by society that makes them social beings. They are, indeed, in dynamic interaction with their societies. In its best expression, this means "community": the circumstance in which persons are aware of their social bonds with one another and of the impact these bonds have on them as individuals and as members of groups. Communities can be small or large, natural or intentional, short or long lasting. Whatever their quality, communities—because they help shape persons and vice versa—have a moral reality. Their members, therefore, have obligations to them. The overarching obligation to community is service to the common good—that is, the duty to help shape relationships and institutions so as to secure lasting benefits for human communities and the persons they comprise.

In the Catholic view, solidarity is a specific obligation within that of the common good. Solidarity can be regarded as a social expression of the golden rule insight: that persons should put themselves imaginatively in the positions of others when choosing and acting. To be in solidarity with others means that persons or groups should perform this kind of imaginative reversal with respect to members of other communities, especially those communities whose interests may be opposed to theirs or are simply difficult to fathom. Put another way, solidarity is the moral obligation to see the communities that bind groups together despite the communities that separate.

Since the great majority of Americans are well-off by any reasonable material standard, the challenge of solidarity for us is captured by the preferential option for the poor. This is the obligation of the well-off to see themselves in community with those who are least well-off, and to act on their behalf. Obviously, this includes those who are living in relative poverty. But it also means those who are in any especially vulnerable situation because of communities or circumstances that separate them from the fortunate, including age, race, ethnicity, or health status. Thus the fact that persons are inherently social entails an obligation to the common good: a duty to stand in solidarity with others, especially those who are less well-off.

Persons Are Divinely Created and Have Divinely Set Goals and Limits Persons, communities, and the natural world that supports them are all products of God's creation. In the Catholic view, creation has an intention, namely, salvation. This overarching goal shapes all other goals of persons in communities. In the healthcare arena, for example, the spiritual destiny of human beings places limits on the obligations of patients and providers when care is extraordinary, when, that is, it can provide no reasonable hope of benefit or does so only while imposing a disproportionate burden.

The goal of healthcare for individuals must generally be consonant with the overarching goal of human life. The goal of healthcare cannot, therefore, be physical immortality, or even one more day at any cost. Death is the natural and divinely ordained end of human life. It is appropriate for medicine to struggle against premature death and unnecessary human suffering. However, it cannot set as its goal the vanquishing of death itself or the end of all human suffering.

Closely associated with these limits on individual patients and providers are limits on the healthcare system itself. The common good of any society requires balance in what it spends—that is, a reasonable allocation of resources to a wide variety of human needs. A social system that, for example, devoted all its resources to healthcare and none to education would be fundamentally dysfunctional.

Our own system is adrift in this direction. There is probably no major American city that does not have the most sophisticated and most expensive medical technology situated within a short drive of a deteriorating educational system, tattered social safety nets, dilapidated housing, and masses of uninsured people. Linkages here are not straightforward. Capping spending on healthcare will not, for example, necessarily divert money to improve education or help solve the problem of homelessness.

On the other hand, it cannot serve the common good to allow a single sector of the economy to so imperiously absorb more and more of the nation's resources while other sectors go wanting. This is especially clear given the fact that decent education and good housing, say, will do more to improve the health and longevity of

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greater numbers of people than will highly expensive medical technologies.

A God-centered context for human persons and communities provides an ultimate orientation for decision making and for the allocation of resources. Creation is limited, as is human life. To deny either is hubris. To acknowledge these facts and to work rationally and humanely within reasonable limits is responsible stewardship.

The Right to Healthcare Not Respected

From a Catholic perspective, the major dysfunction of the American healthcare system is its failure to recognize and enforce a right to healthcare. For the reasons sketched above, this right has been recognized in recent Catholic tradition. At least two popes, John XXIII and John Paul II, have explicitly named medical care as a right.[3] The National Conference of Catholic Bishops has issued multiple statements identifying healthcare as a right. CHA has been definitive on the issue, on a regular basis.

Despite this insistence, the number of Americans who are without health insurance and therefore uncovered for healthcare services continues to grow. In 1997, 43.3 million Americans, or 16 percent of the population, had no health insurance. On the basis of current trends, health policy experts at the Lewin Group estimate that the number of uninsured will reach 54 million, 19 percent of the population, by 2007. The uninsured are not equally distributed across the United States. In Minnesota, Wisconsin, and Pennsylvania, for example, less than 10 percent of the population are uninsured. But in California, Arizona, New Mexico, and Texas more than 20 percent of the population are uninsured. Thirty percent of young adult Americans (ages 18 to 24, the cohort most likely to lack coverage) have no insurance.[4]

Working people employed by small firms are the least likely to have employee-sponsored health coverage. In companies with 25 or fewer employees, 71 percent are without employment-based health insurance. So lack of insurance is not necessarily linked to a lack of employment. Of those who were uninsured in 1998, nearly half (48 percent) were working full-time. More than three-fourths of the uninsured are either employed or the dependent of someone who is employed. Despite the unprecedented prosperity of today's U.S. economy, an increasing number of employees are declining employer coverage because they deem it too costly. The Lewin Group estimates that for every 1 percent increase in premiums, another 300,000 persons drop their coverage.

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No other advanced democracy in the world has this problem. In other comparable nations, universal coverage for healthcare is an established social fact.

Unfortunately, a myth persists in our society that Americans have access to healthcare regardless of their insurance status. Many of us believe that people get the care they need whether they are covered or not. This is simply not the case (see **Box**, p. 35).

And lack of access to healthcare means increased morbidity and mortality—unnecessary suffering and premature death. A recent study by the American College of Physicians reached this pointed conclusion: "In short, uninsured Americans tend to live sicker and die earlier than privately insured Americans."[5] This is so partly because, as 55 percent of the uninsured report, they postpone needed medical care because of their insurance status. (Only 14 percent of those with private insurance and 8 percent of those on Medicare postponed such care.) As might be expected, people without insurance are three times more likely than the insured to have problems paying their medical bills. The uninsured are four times more likely than the insured to report that they had to change their lifestyle significantly in order to pay medical bills. As a result, uninsured Americans are, when compared with the insured, 3.6 times more likely to delay seeking care. These realities have their inevitable consequences.

In sum, the American healthcare system fails the fundamental moral test of guaranteeing a right to healthcare. It allows huge numbers of Americans to go uncovered—thus depriving them of access to care and causing them to suffer preventable disease and death. Given the evidence, anyone motivated by Catholic social teaching would have to seize every reasonable opportunity to insist on universal coverage.

No Preferential Option

The American healthcare system does not respect the rights of persons by providing them with universal coverage. Nor does it express solidarity or serve the common good through special protections for vulnerable groups. There are, for example, 11 million uninsured children in this nation. The consequences of not having insurance are, for children, every bit as bad as they are for adults. Since childhood health sets the stage for health status throughout life, it is in fact much worse.

There is also a racial and ethnic dimension to the issue.[6] Whereas 14 percent of native-born

Americans are without health insurance, 34 percent of the foreign-born lack it. Among foreign-born Americans, 19 percent of naturalized citizens have no insurance; 43 percent of those who are not citizens are uninsured. Sixty-nine percent of white employees have employer-sponsored coverage, but only 52 percent of black employees and 44 percent of Hispanic workers have it. These disparities remain even for full-time workers for large employers in heavily unionized industries. Among workers in the manufacturing sector, for example, 85 percent of whites are covered whereas only 71 percent of blacks and 60 percent of Hispanics are.

Overall, minority Americans are twice as likely to lack health insurance as white Americans are. Almost one-third of them report little or no choice as to where they receive medical care. Lack of insurance runs especially high among Korean-Americans (41 percent) and Hispanic adults (38 percent). In 1996 Hispanics represented approximately 11.6 percent of the U.S. population under the age of 65, but more than 21 percent of the uninsured population. Hispanic-Americans living below the poverty line were highly likely to lack insurance; in 1996, 39.5 percent of this group were uninsured.

There is no preferential option for the poor and vulnerable in the American healthcare system. In fact, the opposite is the case. This means unnecessary death and suffering among groups already bearing a large burden in our society. To a conscience shaped by Catholic social teaching, this is an intolerable situation.

Costs without Limits

The American healthcare system does not produce such large and unfairly distributed numbers of the uninsured because it lacks the capacity to treat them. Despite a reduction in nongovernment hospital beds from 841,000 in 1993 to 770,000 in 1997, excess capacity in beds actually rose in those years from 185,000 to 203,000.[7] Nor are we short of physicians. In 1965, there were 139 physicians for every 100,000 Americans. By 1980 the number had reached 195 per 100,000. The most recent figure (1997) is 276 physicians per 100,000.

Nor is the system underfunded. Although the rate of increase in healthcare costs stabilized somewhat in the mid-1990s, it has since begun moving upward again. In 1970 the United States committed 7.1 percent of its gross domestic product (GDP) to healthcare. In 1998 it was 13.7 percent. The Lewin Group predicts that health spending will reach 14.5 percent of GDP by 2001 and 16.6 percent by 2007.

Out-of-pocket costs to consumers have also been on the rise, reaching $184 billion in 1998 and projected to hit $311 billion by 2007. One of the main drivers of this new round of cost increases is prescription drugs. From 1996 to 1998, for example, the cost of hospital care rose less than 1 percent and the cost of physicians rose 2.1 percent. The cost of prescription drugs, on the other hand, rose 6.6 percent. This has put pressure on the cost of premiums to employers. While the average annual percentage increase in premiums paid by employers fell each year from 1991 to 1996, it rose again in both 1997 and 1998.

The U.S. healthcare system continues to add numbers to the ranks of the uninsured. At the same time, it remains the most expensive healthcare system in the world, costing more by over half again than any other nation's system.

There are many explanations for the high cost of our healthcare system, including—ironically—the fact that it lacks universal coverage. One of the most expensive sites for the provision of healthcare is the hospital emergency room. Because uninsured Americans have no regular source of care, they are four times more likely than the insured to use the emergency room as a regular site of care. (Uninsured children are five times more likely to use it.) Uninsured Americans are also more likely to experience avoidable hospitalizations. Compared with the insured, they are 2.8 times more likely to be hospitalized for diabetes, 2.4 times more likely to be hospitalized for hypertension, 60 percent more likely to be hospitalized for pneumonia, and 60 percent more likely to be hospitalized for a bleeding ulcer.

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Our healthcare system seems to recognize no limits on spending for those who are covered for healthcare. At the same time, it radically limits the care of the uninsured. Responsible stewards could not accept such a system.

Moral Conscience and Practical Wisdom

Our current and foreseeable healthcare system is fundamentally at odds with core elements of Catholic social teaching. Growing numbers of Americans are without health insurance and are thus left without assured access to healthcare. The human right to a decent amount of healthcare is thereby violated on an ongoing basis. The dignity of persons is undermined conceptually because people are not regarded as having an

incalculable value. Their dignity is undermined practically by their difficulty in gaining access to needed care and by the resulting deterioration in their health status. Millions of Americans are treated as if their shortened lives and increased pain and suffering just do not matter.

Worse yet, the burdens created by the absence of universal coverage fall disproportionately on the poor and the most vulnerable among us. Children, women, and minorities are especially disadvantaged by lack of health insurance. This is the reverse of what one would expect were the preferential option for the poor an operating social principle. Failure to provide universal coverage disserves the common good and undermines solidarity. Indeed, the root moral cause of the persistence of large numbers of Americans uncovered for healthcare may simply be the refusal of the insured majority to identify with their plight. The uninsured are ignored as if they shared no bonds of community with the insured.

More than 16 percent of the U.S. population is uncovered—at a time when the healthcare system continues to absorb a historic proportion of our economy's overall wealth. The system, far from being unable to afford universal coverage, is awash with excess hospital beds and physicians. After what appears to have been a temporary cooling of rising costs, healthcare seems to be returning to the feeding of its voracious appetite for resources.

It is clear, then, that American healthcare is morally dysfunctional when judged by the norms of Catholic social teaching. It is also dysfunctional with respect to whatever norms of civility or social contract led the rest of the industrial democracies to their own commitments to universal coverage.

Yet our proximity in time to the failure of the last attempt to address this issue gives us pause. How prudent is it to commit the ministry's time, resources, and political capital to another try at a goal that seems to have been so roundly rejected by the nation's leaders and, through their relative silence, by the American people?

Would it not be wiser to wait until the political winds change again, to say less about universal coverage and to focus instead on incremental measures? Hasn't our recent experience with unintended consequences of the Balanced Budget Act taught us that the very existence of our ministry could be jeopardized by unfavorable changes in reimbursement? Wouldn't it be better to preserve our resources and our influence for future battles of this sort?

There is some truth in these concerns. CHA certainly must be vigilant on issues that threaten the ministry's survival. We must surely take advantage of every opportunity for incremental improvements. And, in general, we must admit that the right idea at the wrong time can be the wrong idea.

Despite these admissions, the issue of universal coverage is too close to the core of Catholic beliefs about persons and community to be a fair-weather advocacy position. The high profile CHA assumed in the early '90s was certainly reinforced by the sense that a historic objective had become politically possible. But CHA's role was also firmly rooted in values and principles. Those values and principles, and the Catholic social teaching from which they are drawn, have not changed. Of course, prudence is required in determining where and how hard to push on an issue that no longer seems to trouble the public's conscience. But CHA, a credible healthcare organization known for its faith-based positions, can exert the leadership needed to bring the issue to the surface again.

Perhaps this is not the time to develop another detailed plan for systemic reform. Perhaps a detailed plan is not even the best contribution the Catholic healthcare ministry can make. Others may have more policy development resources, for example. But this surely is the time to reassert the moral imperative of universal coverage, and to keep on asserting it until the issue ignites with the public. CHA can and should make this contribution. □

Millions of Americans are treated as if their shortened lives and increased pain and suffering just do not matter.

NOTES

1. See, for example, Walter Zelman and Lawrence D. Brown, "Looking Back on Health Care Reform: 'No Easy Choices,'" *Health Affairs*, November-December 1998, pp. 61-68.
2. See, for example, "Sharing Catholic Social Teaching," National Conference of Catholic Bishops/U.S. Catholic Conference, Washington, DC, 1999.
3. In *Pacem in Terris*, 1963, (section 11) and *Laborem Exercens*, 1981, (section 19), respectively. Both are available online at www.catholic-forum.com/links/links.html.
4. These and the following data on the characteristics of the uninsured are drawn from "Problems/Disincentives in the Health Care System," a data book prepared by the Lewin Group for CHA.
5. "No Health Insurance? It's Enough to Make You Sick," American College of Physicians–American Society of Internal Medicine, Philadelphia, 2000, p. 6.
6. The data on race and ethnicity are from *AHA News*, March 1, 1999, p. 3; *AHA News*, October 6, 1997, p. 3; *Nation's Health*, April 1995, p. 13; and *Business Insurance*, March 8, 1999, p. 22.
7. The cost figures are from "Problems/Disincentives in the Health Care System."