National Healthcare Reform

Blake Roth

Need for Reform in United States National Healthcare

Beginning with the Great Depression in late 1920's, the United States Federal Government has initiated and carried out numerous social welfare programs in order to aide those American citizens in need. As time has passed, many of these programs have faded into the annals of history while still others have remained an integral part of our present day system. One of these systems is this nation's health care system, formally known as Medicare. Since its induction in the 1960's Medicare has served as the United States' national healthcare system but has been amended, adapted, and changed very little. Due to the lack of change and adaptation in Medicare's more than forty year history, this nation's healthcare system has reached a point where its old coverage, administration, management, and the overall program have been surpassed by the medical industry and has been left in danger of insolvency due to recent and rapid socioeconomic change in the United States. This text will attempt to illustrate the current problems and inadequacies of the current Medicare system in order to show that reform for the current system is far past due. Once the demand for reform has been established, this text will outline what a revised system should encompass in order to produce a program capable of being successful, able to serve the future generations of America indefinitely.

In order to say there is a need for reform in any situation, there must be easily identifiable problems bringing scrutiny and concern for the program. In the case of Medicare it is almost impossible to look at an area of the program and *not* find something that needs adaptation or reform. As healthcare expense is increasing exponentially, access to readily available healthcare and overall wellness are decreasing. Every year there is a *decrease* in the uninsured. The United States today is rated lower in healthcare outcomes such as life expectancy and infant mortality

rate than any other industrial nation in the world. This country also holds claim to some of the highest rates of obesity, diabetes, and other chronic diseases due to lifestyle choices when compared to other industrialized nations. Finally, if the current system is not reformed, it is very doubtful that the country will be able to maintain any sort of dependable national healthcare for its citizens in the not so far off future.

With some of the more obvious issues being mentioned, this text shall delve into the more serious and detrimental issues plaguing Medicare today. The first of these problems is Medicare's lack of adaptation with the medical industry. The medical industry was at first nothing more than an unregulated, so-called trade in the late 1800's and has evolved into a highly sophisticated and rapidly changing modern industry today. When Medicare was inducted into the United States' social welfare system in the 1960's, the medical field had begun to evolve at a rapid pace, primarily due to the beginning formation of a global economy, that had begun following World War II, providing opportunities for the sharing of technology and medical methodology. While the medical industry has enjoyed rapid evolution and improvements, Medicare has failed to maintain pace with the industry in its own coverage and providing of benefits. During the 1960's, the medical field relied on fee-for-service (FFS) type of delivery of benefits system for payment (Shelby). With this type of system, every procedure has a line item price tag and when a patient receives a treatment or procedure, the price assigned to the performed procedure or treatment is paid in full by the patient, insurer, or some combination of the two. Because this was the current system in use when Medicare was started, it only makes sense for Medicare to have mimicked this system in its own coverage and benefit packages.

Over the years, however, the FFS delivery of benefits system for payment has been all but abandoned by the medical industry in favor of varying forms of managed care systems. A typical

managed care system is a system of incorporation of all parties involved in the healthcare system; one in which there is encouragement for the development of links and partnerships among and between critical stakeholders such as consumers, advocates, federal agencies, states, counties and local communities, purchasers, and providers working within the healthcare systems. Managed care systems also meaningfully include all involved parties in the planning, development, delivery, evaluation, research and policy formation of managed care systems including the determination of "medically necessary" services. The end result is typically the ability to provide *affordable* care at all levels in the continuum of care, ensure *reasonableness* of out-of-pocket costs while still providing full access to critical services, and the capability to allow appropriate mechanisms for consumers who want to seek care from providers *not included* in the system's established networks. The end product is a much more affordable and flexible system resulting in better healthcare outcomes then can be provided in an FFS type system.

While these managed care systems exist and are currently the trend in the private sector, our national healthcare system has taken little notice of the evolution. Currently, approximately ninety percent of employer-sponsored healthcare packages follow some form of managed care system. Concurrently, in our national healthcare system, only fourteen percent of Medicare recipients are enrolled in this type of program (Shelby). These numbers illustrate a tremendous lag or falling behind by our federal healthcare system. Improved methods exist yet our tax funded system has not taken heed of the change nor does it show any signs of making any sort of adaptation or change to reflect the new managed care systems in providing national healthcare.

If not adapting to the changing medical industry was not enough of a concern, then one should look at the second major problem facing Medicare today; the dilemma of indefinite funding of our current healthcare system for future generations. The financial crisis facing

Medicare is not only in producing appropriate funding for the program, but also ensuring that the funding accomplishes the aims of the program itself. Currently, fourteen percent of the United States' gross domestic product (GDP) is spent on healthcare, approximately twice the number that countries such as Germany, Japan, and France put towards their healthcare systems, and the number in the United States is expected to increase to seventeen percent by 2011. Despite the staggering difference in our expenditures towards healthcare in comparison to other industrialized nations, both the OECD and World Health Organization report that the United States provides poorer medical care than other comparable nations. Additionally, both target effectiveness, efficiency, and value of care as the primary shortcomings of the American system (World). If the system currently is not allocating funding appropriately, what is to be expected in the future?

Beyond efficiency and effectiveness of financial allocation, Medicare faces the problem of confronting what economists term as **galloping inflation** in the cost of medical care. This means that over the past years, the cost of medical care has experienced inflation at nearly twice that of the core inflation rate. Presently, the cost of medical care is increasing at double-digit rates and is expected to continue to increase at a rate of twelve to eighteen percent over the coming years.

As if the increase in cost were not enough of an issue, couple the increase in cost with the problem of increased life expectancy due to technological advances in medicine. If life expectancy increases, so does the period during which citizens will expect to be covered by national healthcare. Today, the life expectancy of an adult is seventy-four years old, the life expectancy of a twenty year old is one hundred twenty-five years old, and it is estimated that a new born today could live indefinitely. With Medicare being an open ended entitlement program

and a mandatory spending program, it will be very difficult to control overall expenditures.

With thirty-four million people on Medicare currently and estimates of that number increasing to sixty-one million by the year 2025, the prospect of financing the current system becomes even bleaker. Under the current conditions every one person on Medicare is funded by five other citizens' contributions to the program through taxes. When the baby boomer generation reaches the age of retirement and enrolls on Medicare, instead of five people supporting every one on Medicare, it will be two people supporting every one person on Medicare (Shelby). If the program is in financial straits now, what might one predict for a future where there are fewer people funding per people benefiting? Eventually, without reform, Medicare will reach the point of insolvency and this country will be left without a healthcare program and in its place, a large debt to repay.

The final major problem presented by our current national healthcare system is that of its economic implications. The soaring costs of providing healthcare to individuals is substantially hurting companies that provide their employees with health benefits. In attempting to absorb the cost of health care, such companies have been set back in the global market. These companies, in response, have been forced to look for solutions to the problem themselves and typically, these solutions are detrimental to our economy, our employees, and sometimes both. Typical solutions include decreasing insurance costs directly by reducing the level of employment, decreasing insurance costs by cutting back on the amount of coverage and number of benefits provided by their health plans, decreasing their share of the burden by increasing the employees' contribution, and increasing the amount of co-payments and deductible in order to get a cheaper premium. In the end, the actions taken to decrease medical costs leads to increasing numbers of underinsured, uninsured, and unemployed; three *negatives* for the well being of our population and our

economy.

As stated above, Medicare and the cost of healthcare in the United States are very problematic and are in dire need of reformation. Medicare's system of payment and benefits is severely outdated and in need of updating. Medicare's current method of financing is in need of complete reformation and change in order to meet the increasing costs and future demands of an ever growing senior population. Medicare needs to be changed to better reflect the present medical industry and to be more flexible with those using it in order to better cover the needs of those enrolled in the program.

With the problems in our current healthcare system outlined, it is time to develop a positive solution that solves the aforementioned problems and is capable of adapting in order to meet head on with future and unforeseen problems in the future. This is the dilemma facing the United States **today**. How can Medicare's FFS system be changed to be more like that of managed care systems? How and where can Medicare find funding for the increasing healthcare costs and growing senior population? What can Medicare do to ease the burden of providing healthcare on the economic sector? These are the questions being asked and these are the questions that must be answered in order to derive a reformed and successful American healthcare system.

With the above questions being asked, several proposals have been made with the goal of reforming Medicare. The most obvious proposal made is to simply increase the age eligibility from sixty-five to sixty-seven. The logic behind this solution is based purely on life expectancy. In 1960, a sixty year old's life expectancy was approximately fourteen years. In 1998, a sixty year old's life expectancy was estimated to be seventeen years. With this increase in life expectancy, it is proposed that the eligible age be increased and that the average senior citizen

would still receive the same number of years of medical coverage from Medicare. A second proposal asks that **means testing** be implemented as a component of Medicare. This would mean that the benefits provided would be directly related and inversely proportional to one's income. A senior citizen with more means with which to pay medical expenses would receive less funding from Medicare for medical bills. Conversely, a senior citizen with fewer means would receive more funding. Finally, a third proposal calls for the modernization of the benefits package provided for Medicare and to redesign the financial structure of the entire program combining all money put towards Medicare into one fund paying for the entire program, as opposed to the two types of funds Medicare receives presently (discussed later). While all these proposals provide improvements and/or savings for Medicare, no single one solves the problem faced today. In order to solve the current dilemma, ***delivery of and financing for our healthcare system must both be reformed and effective management be implemented.***

In order to accomplish the above goal, this text will propose a healthcare system based upon a mix of the two leading theories in healthcare reform: **universal healthcare** and **healthcare by free market principles**. As described previously, the current trend in healthcare is that of managed healthcare systems where all affected parties are involved in the process. Any decisions or actions described hereon will be assumed to be made under such circumstance as it is an integral part in assuring every basis is covered in any proposed plan.

With this being said, the first step in reforming the current system is defining a hybrid benefits package; a package incorporating elements of universal healthcare in addition to elements characteristic of free market principles. Such a package would be tiered in the benefits it provided, with the most basic and needed benefits being universally provided and supplements to the basic coverage being available at additional expense. A basic package would be agreed on

providing benefits covering treatment of illnesses, disease prevention, health education, and protections for more acute medical accidents or episodes (severe illnesses, etc). This basic package would be provided universally, would cover the most common incidents, and would also be aimed at educating the population about healthier lifestyles in order to promote healthier overall lives. In order to keep pace with the changing medical field, this basic benefits package would be evaluated biannually and revised as needed to best meet the needs of the American public, something that is a severe problem in our current system.

With a basic benefits package being defined and provided at no cost other than that of taxes, it is inevitable that some will want more coverage than is provided. In these cases, clearly defined supplemental packages will be purchasable at affordable rates based upon free market standards. These supplemental benefit packages would be partially funded by the healthcare system, but primarily funded by those who opt to make use of them. This measure would also help the reformed system handle varying needs, wants, and desires. As with the basic benefit packages, the supplemental packages would be evaluated biannually and adjusted and reformed as needed considering the medical industry and variation in medical costs.

The last part of this benefit package would quite possibly be the most important and beneficial portion of the entire package; health education. As mentioned before, America boasts some of the highest rates of obesity, diabetes, and other chronic diseases caused by lifestyle choices. The health education portion of this package would be allocated primarily towards younger generations as opposed to the senior population. This health education would stress things such as *the importance of regular exercise, how to properly exercise, and the importance of a proper diet.* The aim of the program would be to decrease the percentage of those Americans afflicted by diseases caused by poor lifestyle choices. The program itself would be

treated as an investment aimed at decreasing future costs of providing universal healthcare. With proper lifestyles, the cost of healthcare could be dramatically decreased. People leading healthy lifestyles are ill less often and thus spend less on annual healthcare.

With the basic benefits package being defined and supplemental packages being available, the total basic benefits package, including the health education portion, would be aimed at and designed to provide the most utility to the population. This would mean that the package would be aimed at providing the greatest amount of good for the greatest amount of people. In essence, it would be based upon social justice and be focused on the good of the entire population rather than based upon the good of each individual. At first light, this approach sounds discriminatory; however, a program designed as such would prove itself as fair, just, and capable of improving the overall health of the nation, resulting in better overall health for that individual in the end (the idea that something is only as strong as its weakest link). For the overall health of the nation to be improved, the overall health of the individual would also be inevitably improved.

With benefits determined, how the benefits will be delivered becomes the next important issue. The freedom for physicians to practice freely must be protected, but benefits provided by the system must also be readily available to those seeking them. For this reason, under the reformed healthcare system there would be a blend of a free-market system and one controlled by the federal government. While the freedom of physicians to set work environment and hours would be preserved, participation by physicians in providing healthcare services covered by the healthcare system would be *mandatory,* and physicians would be reimbursed based upon previously negotiated fees and/or prices set by a board of physicians and the government dependant upon the services rendered. The ability for those covered by national healthcare to

receive treatment readily would be of the utmost importance; hence, the mandatory participation by physicians in providing services covered by the basic national package.

Another area of importance in delivery is that of monitoring the health of patients. This responsibility would fall to primary care providers such as physicians and pediatricians, family doctors. These primary care providers would be paid a base fee every month dependant upon number of citizens enrolled at their office, benefits covered by the basic benefit package, age of patient, gender of patient, and any other variable affecting medical care expenses. Patients coming to see their primary care providers would not be charged for visits as the monthly fees paid by the government would cover the medical expense outlay undertaken by the primary care provider. In the case that a patient was covered by one of the supplemental benefit packages, that patient would already be paying a monthly sum to the government for that coverage and that would be reflected in the monthly government payment to the primary care provider for that patient.

The final area that must be considered in the delivery of benefits is the handling of prescription drugs. It is one thing to provide medical care for a person, but without medication the care is often of little use. To cope with the cost of prescription drugs, the first requirement would be the use of generic drugs, when deemed equivalent in effectiveness, by those covered under national healthcare. Additionally, pharmacies would have to register with the federal government and enroll consumers covered by the national healthcare system. Much like the primary care providers, these pharmacies would receive monthly payments from the government. These payments would be based upon average monthly cost plus an adjustment to incorporate some profit for the pharmacy. The amount of the payments made to the pharmacies would aim to cover a significant portion of the consumer's cost for prescription drugs needed for the treatment

and/or prevention of illness and/or disease. While it is unlikely that the entire cost of prescription drugs would be absorbed by such a program, the cost could and would be significantly reduced for those covered.

With a benefits package and method of delivery derived, it cannot be forgotten that this entire program will not be free. The current healthcare system is divided into two portions. Portion A is funded by tax revenue while Portion B is funded by monthly premiums paid by those enrolled. Since the induction of Medicare to present, Portion A has always provided a surplus while Portion B has always covered its intended cost with little or no surplus remaining. Under the current system, the surplus in Portion A does not get put back into the healthcare system, but, instead, reallocated to other areas of government spending. A reformed system would call for Medicare's finances to be restructured in a manner somewhat like that of Social Security where surplus funds cannot be reallocated but are stored for future use in the program. Surplus money would be invested by the government and not used until needed by the healthcare program.

In addition to the change concerning surplus funds, Portion A and Portion B would be combined into one fund rather than separated into two funds. Instead of those not on healthcare only paying for the program through taxes and those enrolled paying through taxes and monthly premiums, *everyone* would pay a monthly fee towards the program for the duration of their life. The result would be **lower monthly payments** for the entire population and **increased funding** for the national healthcare system. While over the course of one's life they would pay more in total to the program, the payments would be more affordable and the benefits provided due to the additional funds would be more substantial than what is currently provided.

With the benefits package outlined, benefit delivery described, and a plan for financing

the new healthcare system, one more aspect remains; management. Lawmakers may develop the most sophisticated and capable healthcare system on the planet, but without proper management, the program will *not* work efficiently or be a productive asset for the nation. **For success, *proper management* is essential.** Currently, Medicare is managed by CMS, Center for Medicare and Medicaid Services, who is also in charge of managing Medicaid, State Children's Insurance Program, and individual's insurance compliance with Health Insurance Portability and Compliance Act of 1996 (GAO). How can a management group be responsible for such a broad spectrum of programs and duties and still perform efficiently and effectively? The answer is, they cannot. While Medicare's cost per processing claims is cheaper than that in the private sector (efficiency), it is estimated that almost *twelve billion dollars* in errors were made in the fiscal year 2000, alone. A national healthcare system **cannot** squander such large sums of money and funding on errors. This type of operating, while appearing efficient at first, is neither efficient, effective, nor cost-effective.

To ensure success, the reformed national healthcare system should be managed by a management team with the sole responsibility of managing the healthcare system. The management team should consist of representatives from **all** those affected and involved in the system. Pharmacists, primary care providers, physicians, beneficiaries, etc. should all have representatives in the management portion of the system. The effect of such a management team is two-fold: first, it helps to ensure that no one sector is affected negatively by the decisions made concerning the health care system and, secondly, it should increase the likelihood of the management team being knowledgeable in how healthcare at all stages is administered, should be administered, and could be improved upon across the board. With a management team solely focused on administering the healthcare system and consisting of those involved in all stages of

providing healthcare, the chances of running a successful healthcare system are greatly increased over the current system; a system not focused solely on healthcare and not comprised of those involved in providing healthcare.

In the end, the need for healthcare reform in the United States is undeniable and inevitable. The system is outdated, not reflecting changes in the way medical care is administered or the increased costs of medical care. The system, without reform, will reach a point of insolvency due to lack of appropriate funding for the ever increasing population of seniors coupled with increased life expectancy. Finally, the system puts significant economic strain on American companies trying to compete globally while providing health insurance to employees.

While reforming the healthcare system will not be a simple task, it is one that must be undertaken to ensure the health of the American population. While the struggle of creating a social healthcare system in a capitalist society will be a difficult one, it can be accomplished and the benefit for the population will be extraordinary. Capitalist ideals will have to be overcome and the greater good of American society put before that of the individual in the healthcare arena. While at first this approach will seem to go against individualism and everything America stands for, the end result will be the improvement of the individual, and all individuals, originally overlooked and an improved national healthcare system resulting in better health for the entire nation. With a defined basic benefit package coupled with supplemental benefit packages, a clear plan for available delivery of benefits, an improved method for funding, and appropriate management, our current failure of a healthcare system can be successfully reformed into a productive asset for this great nation.

Civil Service and National Healthcare

Blake Roth
Collaborated with Karah Shelly and Patrick Ladd

Beginning with the Great Depression in the late 1920's, the United States Federal Government has initiated and carried out numerous social welfare programs in order to aide those American citizens in need. As time has passed, many of these programs have faded into the annals of history while still others have remained an integral part of our present day system. One of these systems is this nation's health care system, formally known as Medicare. Since its induction in the 1960's, Medicare has served as the United States' national healthcare system but has been amended, adapted, and changed very little, Due to the lack of change and adaptation in Medicare's more than forty year history, this nation's healthcare system has reached a point where its old coverage, administration, management, and the overall program have been surpassed by the medical industry and has been left in danger of insolvency due to recent and rapid socioeconomic change in the United States. The following text will attempt to illustrate the current problems and inadequacies of the current healthcare system in order to show that reform for Medicare is far past due. Once the demand for reform has been established, this text will outline one of many things which a new, reformed system should include in order to produce a program capable of being successful, able to serve the future generations of America indefinitely.

In order to say there is a need for reform in any situation, there must be easily identifiable problems bringing scrutiny and concern for the program. In the case of Medicare, it is almost impossible to look at an area of the program and *not* find something that needs adaptation or reform. As healthcare expense is increasing exponentially, access to readily available healthcare and overall wellness is decreasing. The United States today is rated lower in healthcare outcomes such as life expectancy and

infant mortality rate than most other industrial nation in the world (OECD). This country also holds claim to extremely high nursing shortages reaching upwards to twenty-five percent in some areas resulting in decreased quality and/or quantity of care in health facilities, primarily publicly run hospitals (Health Resources). Additionally, Americans today do nothing to qualify for healthcare more than obtaining an age determined by the government which entitles them to health insurance through Medicare. While these are only a few of the issues facing our current national healthcare system, they do begin to paint a picture of the problems facing it which this text will address in the later pages. The picture painted shows a current system that this nation will not be able to maintain as a dependable national healthcare system for its not so future generations.

To understand how Medicare has been left behind by the medical industry, one should look at the history of the medical industry. At first, this industry was nothing more than an unregulated, so-called trade in the late 1800's and, since then, has evolved into a highly sophisticated and rapidly changing modern industry. In the 1960's when Medicare was first inducted as a social welfare program, the medical field had just then begun to evolve at a rapid pace, primarily due to the beginning formation of a global economy following the Second World War This global economy made the sharing of technology and medical methodology more predominant and the result was rapid growth in most medical fields. While the medical industry flourished and enjoyed rapid evolution and technological improvements, Medicare failed to maintain any sort of pace with the industry in its own coverage or method for provision of benefits. One such indicator of Medicare's inability to maintain pace with the medical industry is in the way Medicare handles payments. Medicare still uses a fee-for-service method in which every

procedure has a line item price tag and when a patient receives a treatment or procedure, the price assigned to the performed procedure or treatment is paid in full by the patient, insurer, or some combination of the two. While this is the system that was in use when Medicare was started, it has since been abandoned by the private sector in favor of managed care systems where all involved parties are included in decision making which typically results in *affordable care* and *reasonableness* of out of pocket costs for all parties. While this particular example has no correlation to this paper's proposition, it clearly shows an example where Medicare has lagged and now there are drastic differences which result in poorer care and/or management.

With the case being made that Medicare has lagged and failed to adapt to the ever changing medical industry, it is time to move on to the issue with which this paper is primarily concerned; funding Medicare on a long term basis. Today, the financial crisis facing Medicare is not only in producing appropriate funding for the program, but also ensuring that the funding accomplishes the aims of the program itself. Currently, fourteen percent of the United States' gross domestic product is spent on healthcare, approximately twice the number that countries such as Germany, Japan, and France put towards their healthcare systems. While this number is extremely high relative to other countries, it is predicted that this percentage will continue to rise to seventeen percent by the year 2011. Some may claim that this difference in expenditures is because this nation provides superior healthcare to these other listed nations but this is simply false. Despite the staggering difference in our expenditures towards healthcare in comparison to other industrialized nations, both the OECD and World Health Organization report that the United States provides poorer medical care than other comparable nations. Additionally,

both target effectiveness, efficiency, and value of care as the primary shortcomings of the American system. If the current system is spending more than other comparable industrialized nations yet is providing inferior healthcare, what is to be expected in the future without some sort of reform?

Beyond the issue that the United States spends more than any other comparable nation while providing inferior healthcare, there is the fact that our system also faces what can be termed as galloping inflation in the cost of medical care in this country. This means that over the past years, the cost of medical care has experienced inflation at nearly twice that of the core inflation rate. Presently, the cost of medical care is increasing at double digit rates and is expected to continue to increase at a rate of twelve to eighteen percent over the coming years.

As if this increase were not enough to cause more concern, couple it with the problem caused by increased life expectancy due to technological advances in medicine. As life expectancy increases, so does the period during which citizens will expect to be covered by national healthcare. Today, the life expectancy of an adult is approximately seventy-four years old, the life expectancy of a twenty year old is projected to be as high as one hundred twenty-five years old, and it is estimated that a newborn today could possibly live indefinitely. As Medicare is an open ended entitlement program *and* a mandatory spending program, it will be extremely difficult to control overall expenditures.

Currently, there are thirty-four million people benefiting from Medicare and this number is estimated to increase to sixty-one million by the year 2025 making the prospect of financing the current system very bleak. Today under the current conditions,

every one person on Medicare is funded by five other citizen's contributions to the program through taxes paid. When the baby boomer generation reaches the age of retirement and enrolls in the Medicare system, instead of five people supporting every one person on Medicare benefits, it will be two people supporting every one person on Medicare. If the program is in financial straits currently with five people supporting every one person, what might one's conclusion be for the proposition of funding Medicare with only two people funding every one person? It is neither realistic nor logical to believe that the current system will be feasible without change for many more years to come. Eventually, without reform, Medicare will reach the point of insolvency and this country will be left without a healthcare program and in its place, a large debt to repay will be found.

The final major problem this paper will discuss concerning our national healthcare is that of its economic implications. The soaring costs of providing healthcare to individuals is substantially hurting companies that provide their employees with health benefits. In attempting to absorb the cost of health care, such companies have been set back in the global market. These companies, in response, have been forced to look for solution to the problem themselves and typically theses solutions are detrimental to our economy, our employees, and sometimes both. Typical solutions include decreasing insurance costs directly by reducing the level of employment, decreasing insurance costs by cutting back on the amount of coverage and number of benefits provided by their health plans, decreasing their share of the burden by increasing the employees' contribution, and increasing the amount of co-payments and deductibles in order to get a cheaper premium. In the end, the actions taken to decrease medical costs lead to

increasing numbers of underinsured, uninsured, and unemployed; three *negatives* for the well being of our population and our economy.

As it has been stated above, Medicare and the cost of healthcare in the United States are very problematic and are in dire need of reformation. Medicare as a healthcare system is outdated and in need of reformation in order to catch up to where the medical industry stands today. The current method of financing the system is in need of complete reformation and change in order to meet the increasing costs and the future demands of an ever growing senior population. Regardless of which angle one looks at our current national healthcare system, it is incapable of continuing in its current state for any extended period of time.

With all the problems facing the current healthcare system there is much work to be done in reformation. Inevitably, the question will arise: "Why should the government care?" When did health care become the problem of the government and not the problem of the individual? In response, some would claim that the government is politically and/or constitutionally obligated to provide health care for all their citizens. Some where along the line health care began to be considered as an individual's right to good health and that the government should be the guarantor and provider of this right. Additionally, the private sector is viewed as catering to those who can pay providing for a profit and as a result neglecting the poor. In the case of providing health care, the methodology of the private sector in seeking profits would not correlate well with the purpose of a national healthcare system. The private sector solely administering a healthcare program would inevitably lead to market failures in that the poor would be excluded from the process and receive no benefits from said program. Furthermore, if one considers economic theory

concerning the role of the government, health care, or at least parts of healthcare, could be considered public goods; that is, they are non-exclusionary and non-rival. If this is the case, such parts of healthcare deemed to be public goods would not be provided if it were not for the government stepping in and providing the service (Mosquito spraying would be a prime example). If health care is to be considered a right and/or a public good, then the government has the responsibility to provide such care and service for its citizens (Harding).

With it being established that with some reasoning, the government is responsible for providing health care services to its citizens, Medicare cannot be abandoned by our government; thus, reform is a necessity. With the necessity for reform established, it must be determined as to what shall be reformed. This paper will focus on redefining the prerequisites for qualification for an individual to receive Medicare while at the same time attempting to solve the urgent labor shortage in public hospitals. What shall be proposed is a restructuring of Medicare from a social welfare program into a two tier social "workfare" program that provides health insurance to those who put something into the program. The aim of this restructuring will be to require citizens to partake in helping out with the current healthcare crisis in order to receive future benefits; in other words, American citizens will be required to put something into the system in order to earn a return in the future.

What exactly will happen one may ask? The idea is to have a compulsory civil service program that is operated much like a draft. Upon graduation of high school, students will have the option to volunteer to work in the healthcare industry as an "unskilled" worker. Unskilled is in quotation marks because this type of worker will be

defined as any worker whose job can be trained for in six or fewer weeks. Participation in said program will *not* be mandatory but there will be incentives for individuals to participate.

This is where the proposal gets into the restructuring of Medicare into a two tier social "workfare" program as opposed to what it is today. If an individual chooses to *not* participate in the national program, there will be no penalty other than that when said individual comes of age to receive medical benefits through Medicare; however, those benefits will be drastically less than they would have been had that same individual participated. In essence, the two tiers will be separated into benefits for those who participated and then minimal benefits for those who did not participate. The bottom tier would only cover such things as emergency hospital care and other extreme instances. Things such as doctor visits, prescription drugs, and other less severe cases would not be covered in the bottom tier of coverage. For those who choose to participate in the program, they would receive first tier benefits which would be very equivalent to what an individual would be able to obtain through a private health insurance provider. The incentive to participate in the program is obvious, yet individuals have the choice to participate or to not participate so as the program will not be violating anyone's rights or freedom.

At this point, one may be wondering why exactly someone would make such a proposal. Currently, as stated previously, one of the main problems facing our current healthcare system is that of rising costs and the inability of the system to remain solvent for any extended period of time as is. At the same time, the healthcare industry is experiencing major work shortages across the board resulting in exorbitant amounts of

money being spent on sign-on bonuses, overtime wages, and hiring temporary workers. Currently, hospitals are paying on average sixteen percent of their employees overtime wages. Recruitment costs due to labor shortages have risen fifty to seventy-five percent in just the previous two years. As an example, one may look at an unnamed Midwest hospital experiencing an eighteen percent vacancy rate for nurses. In this hospital alone, recruitment costs have more than doubled to eight hundred thousand dollars in two years and base salaries have increased 3.3 million dollars in eighteen months. This definitely shows that there is a dire need for solving the labor shortage issue for public hospitals. In addition to the horrible labor shortages, many so-called "unskilled" jobs are being done by workers at high wages. Both issues would be solved by this proposal in that it would introduce a large workforce into an industry suffering from large shortages already and this new work force could easily be paid less than the same jobs are currently being paid.

At this point, one begins to see an outline of the proposed reformation and, at the same time, begins to see some of the benefits offered by such a program. The proposed plan offers many quantifiable and unquantifiable benefits. One major unquantifiable benefit is that it will provide America's youth with a sense of making a difference. They will be working towards improving America and its healthcare system as opposed to working an unskilled job at a local fast food chain. *However, on the opposite spectrum, the result of decreased spending is highly quantifiable. Not only will money be saved; it will be put to work.* There will be cuts in health care costs across the board and the savings could be used to create new programs such as food for the elderly or other programs existing in countries comparable to the United States but that do not exist yet here.

As briefly mentioned before, this proposal introduces a new source of labor into an economy suffering from labor shortages already. The medical field is severely short of nurses and other skilled workers and by training these unskilled workers to do some of the time-consuming labor that eats away at nurses' time, we will allow nurses to focus on the more important duties that they were trained to perform. In addition to aiding nurses, it will redistribute current employees whose jobs are replaced with new graduates into fields experiencing shortages such as nursing. In most cases, the employees who already work in the hospital have some basic nursing experience already in most cases and could easily put through accelerated registered nurse programs in order to qualify them to fill spots vacant and in need of nurses already. This will cut overtime pay paid to nurses currently and help with hospitals' already rampant problem of nurse shortages.

According to the FCG projection, hospitals will pay at least $71 million this year for using agencies or traveling nurses instead of staff nurses. If hospitals were to fill their vacant positions, they would pay about $81 million this year alone in sign on bonuses. According to John A. Forsman, Jr. in an article from the "Academic Journal of Healthcare Financial Management", the outsourcing of nursing positions cut transcription costs by 38 percent and caused a large increase in efficiency in the first six months of implementation at three large United States hospitals in July of 2003.

In order to quantify the actual benefits offered by the civil service plan, the reported 5,764 hospitals in the nation are assumed to pay $71 million this year for the use of agencies or traveling nurses, and would also pay $81 million in sign on bonuses. With a total of $152 million in spending divided by the number of national hospitals, this would show an estimated $26,370.58 per hospital will be spent this year alone.

To further investigate how the proposal would affect the current healthcare system, the benefits enjoyed by the average hospital show a striking fact as well. From surveying several Knoxville area hospitals, it was found that the average community hospital has about 1000 employees, 28 percent of which are unskilled workers making approximately $14 per hour. This criterion can be used as a model. In this proposal, the average proposed wage for those graduating seniors participating in the program is $8.25 per hour and would result in hospitals already enjoying a savings of $5.75 per hour on unskilled labor. When you consider that there are 40 hours in a typical work week, at $5.75 savings per hour, each hospital is left with $230 saved per week per worker. When multiplying this savings by the number of weeks in the year, there is a savings of $11,960 per year per worker. So, in assuming that of 1000 employees there are 280 that are unskilled, there is a large savings of $3,432,520 per each 1000 employee hospital.

As previously mentioned, there are some unquantifiable benefits as well. For example, the saving in overtime pay is difficult to estimate because the number of nurses per hospital on average that would no longer be paid overtime is hard to approximate. This is in part due to the difference in overtime pay between hospitals; some hospitals pay as much as three times the regular pay for overtime work. Also, those that do not participate are ineligible for Medicare, although, typical exemptions such as disability would still exist. The fact that this benefit would not be enjoyed for such a long time makes it an unquantifiable benefit in the scope of this analysis (it being for a ten year period).

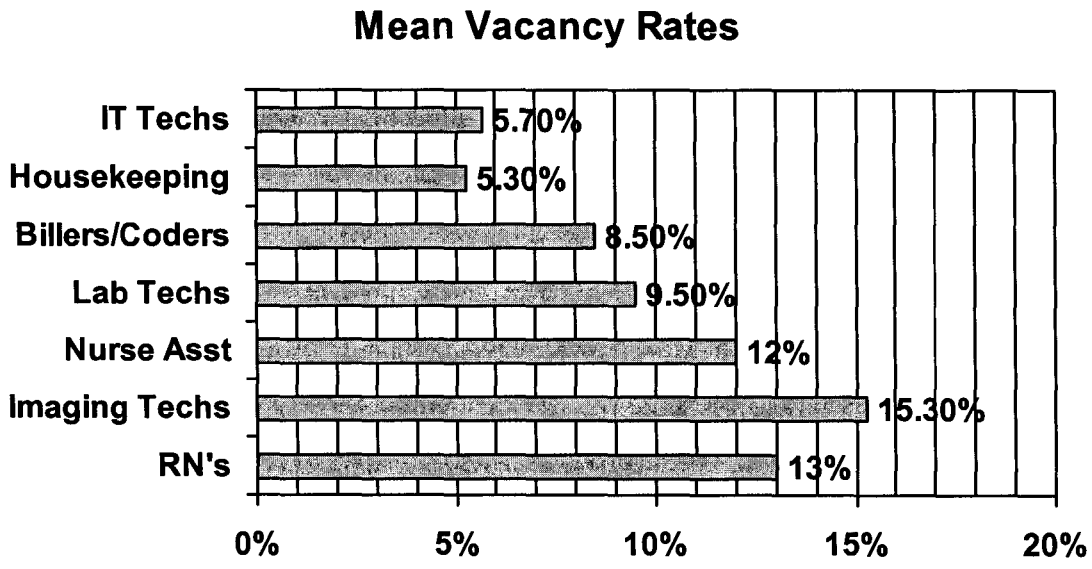
As with every long-term capital investment project, instituting a compulsory system of healthcare across the United States would have many costs to accompany its

benefits. Many of these costs can be measured and quantified while others may be estimated or considered totally unquantifiable. Any quantifiable costs have to be discounted in order to show current estimated values in order for there to be any meaningful analysis of the costs weighted against the benefits.

The quantifiable costs include the loss of a class of students entering college. Due to the number of students who would participate in this program directly out of high school, there would inevitably be some decrease in the amount of students entering college. Because of the delay in entering secondary education, students will also be delayed one year on entering the workforce. Regardless whether students plan to complete college or go directly into the workforce from high school, this program would delay their entrance into their permanent careers and cost them the equivalent of one year's salary.

In addition to the delay for students entering college and the workforce, there is also the possibility of layoffs by healthcare providers of longtime workers due to the availability of new cheap labor. No company enjoys layoffs, so allowing current staff who may be replaced by unskilled workers to complete their training (as previously discussed) to become registered nurses could offset this problem. Currently in the United States, the nursing shortage is at an all-time high. Hospital staffs are requiring nurses to work massive amounts of overtime and thus, are paying them a 16% overtime rate. Healthcare providers are also being forced to decrease their quality of patient care due to the shortage. Nurse vacancy rates have climbed to over 13% in some areas of the Unites States. All of these statistics show that there would definitely be a demand for the possibly displaced workers lending one to believe that the displaced workers would not

actually be at a detriment, but rather receive a benefit from the program in the end; a better job paying better wages.



There is also a chance of an initial decrease in the quality of service to patients. As new, younger workers get acquainted with the rules, regulations, and procedures both in clerical work and in simple hospital tasks, patient care has the possibility to suffer. With this being stated, it should be pointed out that currently 34% of hospitals report an increase in patient complaints because of staff shortages and 59% of registered nurses report that it is difficult to provide adequate to patients due to the workforce shortage. In looking at this information, it is difficult to see how there could be much more of a decrease in quality or if such a decrease would even be noticeable. In theory, it could be possible that without the shortages, the quality of care could even increase, thus this cost (or benefit) remains rather unquantifiable.

In figuring the costs of delaying entry into the workforce for one year, it was assumed that the average salary six months after graduation in the United States is $37,191 (www.ouac.on.ac) and that there would be an average of 280 volunteers per 1,000 employee hospital, this would represent $10,413,480 in wages. Also assuming a project life cycle of 10 years, discount rates of 3% and 6% (Harberger Rates) would provide multipliers of 3.95 and 3.148 respectively. This multiplier, multiplied by the average tax rate of .282 (average of income tax, Medicare, and FICA) and also multiplied by the above wage calculation of $10,413,480 will provide values of $11,599,575 and $9,244,421 at discount rates of 3% and 6% respectively. Tax revenue was used in determining the cost of this project as this would be a project undertaken by the government and tax revenue is the monetary cost the *government* would incur if the proposed project were undertaken. This is, however, also assuming that Americans pay all their taxes while, in reality, tax payment rates fall well below the ideal 100% mark.

Once all the costs and benefits have been properly assessed, they had to be discounted properly as well. For the purpose of this proposal, it was determined that neither a flat consumption based discount rate nor an investment based discount rate would be accurate for discounting the costs and benefits. This is largely due to the fact that the money saved would be saved by hospitals in most cases and by the government in the long term. Hospitals do both consuming and investing and due to this fact a Harberger Rate was used in discounted the costs and benefits to present value. Harberger rates take into account the weight investment and consumption have in the economy and a weighted rate is produced that accounts for both actions. It was determined that his rate would better reflect the proper discount rate in the scenario for this proposal. For

discounting purposes, both a relatively high and low Harberger Rate was used in order to give an idea or range of what the benefits and costs could be valued at presently.

The high rate was at 6.17% and the low rate was 3.04% and when the costs and benefits were analyzed the following was found:

- Salary Savings: $3,432,520 per year per one thousand employee hospital
- Other Savings: $26,370.58 per year per one thousand employee hospital
- **Total Savings:** $3,458,890.58 per year per one thousand employee hospital
- **Discounted Savings (3%) 10 Years:** $29,504,336.65
- **Discounted Savings (6%) 10 Years:** $25,457,434,67

The associated costs were also totaled and discounted out as follows:

- **Total Costs (3%) 10 Years:** $11,599,575
- **Total Costs (6%) 10 Years:** $9,244,421

When the benefits and costs are weighed out, the resulting benefit-cost ratio results:

- **At 3% Discount Rate: 2.544**
- **At 6% Discount Rate: 2.754**

As one can see from the analysis, if this project was instituted it would definitely be a great benefit to the medical industry and help drastically where there are severe labor shortages currently.

In addition to helping with the labor shortages, this reformation would help with other aforementioned problems in Medicare. Costs across the board would help curb the

rapidly inflating costs associated with healthcare. Citizens who do not participate in the program would not receive benefits in the future and this would decrease the costs of providing national healthcare down the road. With costs being cut, the cost of providing insurance could decrease and the economic implications discussed could be lessened. All in all, this proposal boasts a very strong benefit-cost ratio and would be a step in the right direction in reforming this nation's healthcare program for the better and giving it some hope of being solvent for a long time still to come.

Infant mortality, deaths per 1000 live births
www.irdes.fr/ecosante/OCDE/113010.html

	1960	1970	1980	1985	1990	1995	2000	2001	2002	2003
Australia	20.2	17.9	10.7	9.9	8.2	5.7	5.2	5.3	5	
Austria	37.5	25.9	14.3	11.2	7.8	5.4	4.8	4.8	4.1	
Belgium	31.2	21.1	12.1	9.8	8	6.1	4.8	4.5	4.9	
Canada	27.3	18.8	10.4	8	6.8	6	5.3	5.2		
Czech Republic	20	20.2	16.9	12.5	10.8	7.7	4.1	4	4.2	
Denmark	21.5	14.2	8.4	7.9	7.5	5.1	5.3	4.9	4.4	
Finland	21	13.2	7.6	6.3	5.6	3.9	3.8	3.2	3	
France	27.5	18.2	10	8.3	7.3	4.9	4.6	4.5	4.2	
Germany	35	22.5	12.4	9.1	7	5.3	4.4	4.3	4.3	
Greece	40.1	29.6	17.9	14.1	9.7	8.1	6.1	5.1	5.9	
Hungary	47.6	35.9	23.2	20.4	14.8	10.7	9.2	8.1	7.2	
Iceland	13	13.2	7.7	5.7	5.9	6.1	3	2.7	2.2	
Ireland	29.3	19.5	11.1	8.8	8.2	6.4	6.2	5.7	5.1	
Italy	43.9	29.6	14.6	10.5	8.2	6.2	4.5	4.7	4.7	
Japan	30.7	13.1	7.5	5.5	4.6	4.3	3.2	3.1	3	
Korea		45		13						
Luxembourg	31.5	24.9	11.5	9	7.3	5.5	5.1	5.9	5.1	
Mexico		79.3	50.9	41.1	36.1	27.5	23.3	22.4	21.4	20.1
Netherlands	17.9	12.7	8.6	8	7.1	5.5	5.1	5.4	5	
New Zealand	22.6	16.7	13	10.9	8.4	6.7	6.3			
Norway	18.9	12.7	8.1	8.5	7	4	3.8	3.9		
Poland	54.8	36.7	25.5	22	19.3	13.6	8.1	7.7	7.5	
Portugal	77.5	55.5	24.3	17.8	11	7.5	5.5	5	5	
Slovak Republic	28.6	25.7	20.9	16.3	12	11	8.6	6.2	7.6	
Spain	43.7	28.1	12.3	8.9	7.6	5.5	3.9	3.5	3.4	
Sweden	16.6	11	6.9	6.8	6	4.1	3.4	3.7	2.8	
Switzerland	21.1	15.1	9.1	6.9	6.8	5	4.9	5	4.5	
Turkey	189.5	145	117.5	88	57.6	45.6	41.9	40.6	39.4	38.3
United Kingdom	22.5	18.5	12.1	9.3	7.9	6.2	5.6	5.5	5.3	
United States	26	20	12.6	10.6	9.2	7.6	6.9	6.8		

Total expenditure on health
% GDP
www.irdes.fr/ecosante/OCDE/411010.html

	1960	1970	1980	1985	1990	1991	1992	1993	1994	1995
Australia	4.1		7	7.4	7.8	8	8.1	8.2	8.2	8.2
Austria	4.3	5.3	7.6	6.6	7.1	7.1	7.5	7.9	7.9	8.2
Belgium		4	6.4	7.2	7.4	7.8	8	8.1	7.9	8.7
Canada	5.4	7	7.1	8.2	9	9.7	10	9.9	9.5	9.2
Czech Republic					5	5.2	5.4	7.2	7.3	7.3
Denmark			9.1	8.7	8.5	8.4	8.5	8.8	8.5	8.2
Finland	3.8	5.6	6.4	7.2	7.8	9	9.1	8.3	7.7	7.5
France	3.8	5.4	7.1	8.2	8.6	8.8	9	9.4	9.4	9.5
Germany		6.2	8.7	9	8.5		9.9	9.9	10.2	10.6
Greece		6.1	6.6		7.4	7.2	7.9	8.8	9.7	9.6
Hungary						7.1	7.7	7.7	8.3	7.5
Iceland	3	4.7	6.2	7.3	8	8.2	8.3	8.4	8.3	8.4
Ireland	3.7	5.1	8.4	7.6	6.1	6.5	7.1	7	7	6.8
Italy					8	8.3	8.4	8.1	7.8	7.4
Japan	3	4.5	6.5	6.7	5.9	6	6.2	6.5	6.7	6.8
Korea				4	4.4	4.1	4.4	4.4	4.4	4.4
Luxembourg		3.6	5.9	5.9	6.1	5.9	6.2	6.2	6.1	6.4
Mexico					4.8	5.2	5.6	5.8	5.8	5.6
Netherlands			7.5	7.4	8	8.2	8.4	8.6	8.4	8.4
New Zealand		5.1	5.9	5.2	6.9	7.4	7.5	7.2	7.2	7.2
Norway	2.9	4.4	7	6.6	7.7	8.1	8.2	8	7.9	7.9
Poland					4.9	6.1	6.2	5.9	5.6	5.6
Portugal		2.6	5.6	6	6.2	6.8	7	7.3	7.3	8.2
Slovak Republic										
Spain	1.5	3.6	5.4	5.5	6.7	6.9	7.2	7.5	7.4	7.6
Sweden		6.9	9.1	8.7	8.4	8.2	8.3	8.6	8.2	8.1
Switzerland	4.9	5.4	7.3	7.7	8.3	8.9	9.3	9.4	9.5	9.7
Turkey		2.4	3.3	2.2	3.6	3.8	3.8	3.7	3.6	3.4
United Kingdom	3.9	4.5	5.6	5.9	6	6.5	6.9	6.9	7	7
United States	5	6.9	8.7	10	11.9	12.6	13	13.3	13.2	13.3

Total expenditure on health
% GDP
www.irdes.fr/ecosante/OCDE/411010.htm

	1996	1997	1998	1999	2000	2001	2002
Australia	8.4	8.5	8.6	8.8	9	9.1	
Austria	8.3	7.6	7.7	7.8	7.7	7.6	7.7
Belgium	8.9	8.6	8.6	8.7	8.8	9	9.1
Canada	9	8.9	9.2	9	8.9	9.4	9.6
Czech Republic	7.1	7.1	7.1	7.1	7.1	7.3	7.4
Denmark	8.3	8.2	8.4	8.5	8.4	8.6	8.8
Finland	7.6	7.3	6.9	6.9	6.7	7	7.3
France	9.5	9.4	9.3	9.3	9.3	9.4	9.7
Germany	10.9	10.7	10.6	10.6	10.6	10.8	10.9
Greece	9.6	9.4	9.4	9.6	9.7	9.4	9.5
Hungary	7.2	7	7.3	7.4	7.1	7.4	7.8
Iceland	8.4	8.1	8.6	9.4	9.2	9.2	9.9
Ireland	6.6	6.4	6.2	6.3	6.4	6.9	7.3
Italy	7.5	7.7	7.7	7.8	8.1	8.3	8.5
Japan	7	6.9	7.2	7.4	7.6	7.8	
Korea	4.6	4.7	4.8	5	5.1	5.9	
Luxembourg	6.4	5.9	5.8	6.2	5.5	5.9	6.2
Mexico	5.1	5.3	5.4	5.6	5.6	6	6.1
Netherlands	8.3	8.2	8.1	8.2	8.2	8.5	9.1
New Zealand	7.2	7.4	7.9	7.8	7.9	8	8.5
Norway	7.9	7.8	8.5	8.5	7.7	8.1	8.7
Poland	6	5.7	6	5.9	5.7	6	6.1
Portugal	8.4	8.5	8.4	8.7	9.2	9.3	9.3
Slovak Republic		5.8	5.7	5.8	5.5	5.6	5.7
Spain	7.6	7.5	7.5	7.5	7.5	7.5	7.6
Sweden	8.4	8.2	8.3	8.4	8.4	8.8	9.2
Switzerland	10.1	10.2	10.3	10.5	10.4	10.9	11.2
Turkey	3.9	4.2	4.8	6.4	6.6		
United Kingdom	7	6.8	6.9	7.2	7.3	7.5	7.7
United States	13.2	13	13	13	13.1	13.9	14.6

Life expectancy, Males and Females at birth (Years)
www.irdes.fr/ecosante/OCDE/111000.html

	1990		1995	
	Females at birth	Males at birth	Females at birth	Males at birth
Australia	80.1	73.9	80.8	75
Austria	78.8	72.2	79.9	73.3
Belgium	79.4	72.7	80.2	73.4
Canada	80.8	74.4	81.1	75.1
Czech Republic	75.4	67.6	76.6	69.7
Denmark	77.7	72	77.8	72.7
Finland	78.9	70.9	80.2	72.8
France	80.9	72.8	81.8	73.9
Germany	78.4	72	79.7	73.3
Greece	79.5	74.6	80.3	75
Hungary	73.7	65.1	74.5	65.3
Iceland	80.5	75.4	80	75.9
Ireland	77.6	72.1	78.4	72.9
Italy	80.1	73.6	81.3	74.9
Japan	81.9	75.9	82.9	76.4
Korea			77.4	69.6
Luxembourg	78.5	72.3	80.2	73
Mexico	74.1	68.3	75.3	70
Netherlands	80.9	73.8	80.4	74.6
New Zealand	78.3	72.4	79.5	74.2
Norway	79.8	73.4	80.8	74.8
Poland	76.3	66.7	76.4	67.6
Portugal	77.4	70.4	78.7	71.6
Slovak Republic	75.4	66.6	76.3	68.4
Spain	80.3	73.3	81.5	74.3
Sweden	80.4	74.8	81.4	76.2
Switzerland	80.7	74	81.7	75.3
Turkey	68.7	64.2	69.4	64.9
United Kingdom	78.5	72.9	79.2	74
United States	78.8	71.8	78.9	72.5

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Life expectancy, Males and Females at birth (Years)
www.irdes.fr/ecosante/OCDE/111000.htm

	2000		2001	
	Females at birth	**Males at birth**	**Females at birth**	**Males at birth**
Australia	82	76.6	82.4	77
Austria	81.1	75.1	81.5	75.6
Belgium	80.8	74.6	81.1	74.9
Canada	82	76.7	82.2	77.1
Czech Republic	78.4	71.7	78.5	72.1
Denmark	79.3	74.5	79.3	74.7
Finland	81	74.2	81.5	74.6
France	82.7	75.3	82.9	75.5
Germany	81	75	81.3	75.6
Greece	80.6	75.5	80.7	75.4
Hungary	75.9	67.4	76.4	68.1
Iceland	81.4	78	82.2	78.3
Ireland	79.1	73.9	79.7	74.7
Italy	82.5	76.6	82.8	76.7
Japan	84.6	77.7	84.9	78.1
Korea			80	72.8
Luxembourg	81.1	74.8	80.7	75.2
Mexico	76.5	71.6	76.8	71.9
Netherlands	80.5	75.5	80.7	76.8
New Zealand	80.9	76	80.9	76
Norway	81.4	76	81.5	76.2
Poland	77.9	69.7	78.3	70.2
Portugal	80	73.2	80.3	73.5
Slovak Republic	77.4	69.2	77.7	69.6
Spain	82.5	75.7	82.9	76.6
Sweden	82	77.4	82.1	77.6
Switzerland	82.6	76.9	83	77.4
Turkey	70.4	65.8	70.6	66
United Kingdom	80.2	75.5	80.4	75.7
United States	79.5	74.1	79.8	74.4

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