

Adopting Universal Access in the United States

Bridget Armbruster
Student
University of Illinois
Champaign, IL

Faculty Advisor: Guy L. Snyder, MHA, RRT, PAHM, CFAAMA
Lecturer
University of Illinois, College of Applied Life Studies
Champaign, IL

The United States' healthcare system is tumbling in a downward trend. There are millions of Americans who are denied access to care every day. Healthcare costs are rising while services provided are being cut short. The United States' healthcare system is one of the only healthcare systems in the world that does not have universal access.

Universal access should be adopted in the United States because it will create a simple healthcare structure that will result in higher efficiency and effectiveness. In addition to providing care for all, universal access will create a more efficient system by reducing multiple payers, administrative waste, inappropriate care, competition among hospitals, and tertiary care.

One in every seven Americans has no healthcare. The other six find their healthcare costing more and more, while it's covering less and less. Healthcare reform in the United States is unavoidable. Universal access offers the most efficient and effective alternative. In 2001, \$1.4 trillion was spent on healthcare.¹ All this money was spent and still not everyone is covered. Some 43 million Americans are without healthcare and the numbers are only increasing. An additional 100,000 people a month will have no access to care unless they go to an emergency room. Of the 43 million Americans not receiving healthcare, 11 million of them are children.² America spends twice as much as other

developed nations on healthcare and still so many people do not have access to care.

Not only are there people without healthcare in the United States, but the quality of care and the amount of services provided in health plans are diminishing. Some Americans realize that healthcare in the United States is a problem. They may have trouble receiving adequate care, or may not be able to pay the medical bills of their loved ones, or may even be denied access to care. However, many Americans are afraid of living in a nation where there is national healthcare, commonly called universal access. Americans are scared by the thought of universal access and have doubts about its potential to be cost efficient and effective. They may fear government control over their health and the health of their families and be turned off by the thought of payment for healthcare through taxes. Although they do not necessarily see universal access as an option in the United States, this system has tremendous potential to be successful. Adopting universal access as the healthcare system is the best option for the United States because universal access can stem rising healthcare costs while providing healthcare for everyone. Universal access will reduce multiple payers, administrative waste, inappropriate treatment, competition among hospitals, and tertiary care.

Universal access will simplify the healthcare structure by reducing multiple payers. If multiple payers are reduced it will not only save money, but it will simplify and standardize the way healthcare is paid for. Physicians and healthcare administrators will no longer need to spend time filling out paperwork from thousands of different insurance companies. Angell, Himmelstien, Woolhandler, and Young acknowledge the high expenses that multiple payers add to the United States' healthcare expenditure in their article, "Proposal of the Physicians' Working Group for Single-Payer National Health

Insurance.”

Our multiplicity of insurers forces U.S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration...Only a true single payer system would realize large administrative savings.³

Universal access will reduce multiple payers which will result in saving administrative costs. When multiple payers are reduced through universal access there will be less paperwork for physicians and healthcare workers. Less paperwork will save money and time.

Multiple payers consist of a few national and state insurance programs but are mainly made up of private health insurance companies. The majority of these insurance companies in the United States do not have the interest of people as a major objective. Many times they are businesses with the goal of making a profit. In Light’s article, “Consuming More, Covering Less,” he explains the perspective of health insurance companies.

The health insurance industry has become a contest to see who can avoid higher risk individuals or insure them without paying out much in claims, creating a spiral of exclusion and discrimination as companies hone their practices finer and finer to exclude ever more people or health conditions.⁴

Even though people may have insurance, it is often hard for them to get the services they need because insurers do not want to cover prior health conditions, especially if they are high risk individuals.

Two terms, medical underwriting and the Inverse Coverage Law, explain how insurance companies deny access to needy people and avoid covering others. The term medical underwriting is used to describe how insurance companies find and determine potential risks in clients so that they can charge them more or avoid covering them.

Another important term that exists in a multiple payer system is the Inverse Coverage Law. It means that the more people need healthcare the less likely they are to receive it. So if someone is found to be a high risk individual because they are overweight, have diabetes, or lupus, then they are less likely to get the coverage they need. These terms show how the United States' healthcare is not rationed in terms of need.⁵ They also create a clearer understanding of why costs for services are increasing while the quality of the services is getting worse.

Another problem with multiple payer systems is that insurance companies offer incentives to providers to under serve their patients. Many times insurance companies use incentives so that physicians run fewer tests and perform fewer surgeries. For example, if a physician performed five surgical procedures instead of ten, the physician might receive a bonus around the holidays. The catch is that they will only get the bonus if they do not go over those five surgical procedures.⁶ If insurance companies use incentives as a way for physicians to control costs, they may take people's lives and deny needy people access to care. In "One Physicians Confession: An interview with Linda Peeno, M.D.," Dr. Peeno describes making decisions about her patients' care.

I am here today primarily to make a public confession. As a physician, I denied a man a necessary operation that would have saved his life, and thus caused his death. No person or group has held me accountable for this, because, in fact, what I did was I saved a company a half a million dollars for this.⁷

United States insurance companies give incentives to physicians ultimately because they do not want their companies to suffer; they want to survive and make a profit. Universal access will reduce multiple payers which will reduce overhead healthcare costs and incentives for physicians to under serve, while ensuring that everyone has access to care.

The United States needs to adopt universal access in order to stop high administrative costs. In the United States, 30% of the total healthcare expenditure is spent on administration.⁸ Administrative costs can be related to billing, filing, or anything that has to do with running a hospital or healthcare organization. From 1983-1987, administrative costs rose 37% and continue to rise.⁹ Himmelstein and Woolhandler found that \$309 billion of the total healthcare expenditure went towards administration spending in 1999.¹⁰

The reason why administration costs are so high in the United States is because one of the largest expenses for a hospital is salaries.¹¹ Administrative salaries account for 22% of hospital salary expenses.¹² Administrative costs are also wasted when United States' hospitals are not properly used. In "The Ten Commandments of Health Care," Lamm explains the situation with the oversupply of hospitals.

There are 200,000 excess hospital beds in the United states. That's equivalent to at least 1,000 hospitals out there that we don't need, that we've overbuilt.¹³

There is an overabundance of hospitals and hospital beds in some areas of the country while other rural areas are short of hospitals. If there was a switch to universal access then administrators and health managers could assess the need for hospitals around the nation and conserve costs.

By switching to universal access, health researchers believe that the United States could save half of the money that is spent on administration. From Himmelstein and Woolhandler's research, the savings from administrative waste would be around \$155 billion.¹⁴ The amount saved from administration waste can be transferred into other areas of healthcare. For instance, the money saved in administration can then be used to cover

many of the 43 million Americans without insurance. Reducing administrative waste is an easy solution to contain costs in the United States. It is described by Bodenheimer and Grumbach as a painless cost control method because it does not ration important care, it just reduces some of the unnecessary administrative spending.¹⁵ The United States needs to switch the current healthcare system to universal access so administrative costs will stop rising.

Universal access in the United States will reduce inappropriate care. Right now the United States performs many healthcare procedures that are unnecessary and add to the United States' total healthcare expenditure. Professor O'Rourke and Professor Iammarino explain in "Future of Healthcare Reform in the USA: Lessons from Abroad" how Rand Corporation carried out a study to determine the appropriateness of treatment being done in the United States. The panel that assessed the level of appropriateness of treatments was made up of physicians who came from an abundance of specialties. They looked at three different procedures: carotid endarterectomy, coronary angiography, and upper gastrointestinal endoscope. The results from the study were:

They concluded that two thirds of these procedures were done for inappropriate or questionable reasons. They also found that almost 10% of the patients who underwent the procedure died or suffered a stroke as a direct result.¹⁶

The three procedures that were examined are not the only inappropriate treatment procedures taking place in the United States. For example, the Rand Corporation also discovered that 44% of 386 coronary bypass surgeries were inappropriate.¹⁷

Physicians in the United States are more likely, than other countries, to perform unnecessary procedures because healthcare is looked at as a commodity in the United States. People who have money and can afford insurance have healthcare. Those who can

not afford it are just out of luck. Having elective procedures in the United States is almost like purchasing something at the store (5). Physicians may have a hard time saying no to a patient who is ready to pay whatever is necessary to have bypass surgery. Patients, along with their families and loved ones, put pressure on physicians and feel that if they can pay and want a procedure done then they should have it.

In the United Kingdom they have universal access. They have a national budget and they are able to work with in a lower budget. There was a comparison of British physicians to American physicians. “The British physicians were more than twice as likely to judge care inappropriate than their American counterparts.”¹⁸ Some Americans may feel that British physicians are making poor decisions if they say no to an elective procedure or that they are being cheap. However, British physicians and American physicians are both well qualified.

The United Kingdom spends \$1,000 per capita and 100% of their population has healthcare.¹⁹ The United States spends more than four times what the United Kingdom spends: \$4,500 per capita, and only 85% of people have access to some care.²⁰ Two ways to measure the health status of a nation is to look at infant mortality rates and the elderly population. The United Kingdom’s infant mortality rate is slightly lower than the United States and the United Kingdom also has a higher percentage of elderly people in their population. Universal access in the United Kingdom seems to be beneficial. They are able to provide efficient and effective care while working on a much lower budget than the United States.

Other ways that the United States wastes money on unnecessary procedures is through “flat-of-the-curve medicine.” This occurs when medical procedures increase cost

but do not make health status any better.²¹ One example of a flat-of-the-curve medicine described by Lamm is an artificial heart because it is very expensive but benefits only a few people. In Understanding Health Policy: A Clinical Approach, Bodenheimer and Grumbach explain a procedure that would be categorized by Lamm as a flat-of-the-curve medicine.

...almost one in four births in the United States occurs by cesarean delivery, a rate nearly twice that of most other Western industrialized nations. Many studies have suggested that the high rates of cesarean section in the U.S. add to the costs of care without improving overall neonatal or maternal birth outcomes.²²

This is inappropriate because cesarean deliveries are not needed at the rate they are being done. They increase United States' healthcare costs but do not effect the health status.

If the United States worked on a national budget and made reducing the number of inappropriate procedures a priority then the United States would save money and, sometimes, save lives too. Health researchers estimate that \$50 billion can be saved just be reducing inappropriate care.²³

Universal access in the United States will reduce competition among hospitals. Currently, hospitals all over the country compete for business. They spend money on marketing strategies, advertising campaigns, and compete to get well-qualified physicians to work for them. In the United States' multiple payer system the hospitals must compete in order to survive.

One way hospitals compete is by having top of the line technology. This is a huge drain on healthcare finances because many neighboring hospitals have identical technology. Rosenbaum describes, in his article "America's Economic Outlaw: The U.S. Health Care System," what some hospital's motives are for acquiring such high

technology.

Hospitals and clinics compete to have the latest equipment, often as a matter of prestige and to attract better staffs of doctors. The oversupply increases prices charge for each use of the machine.²⁴

From Rosenbaum's example, some hospitals have high technology as a way to attract highly regarded physicians. This means that some hospitals are not focusing on the interest of patients when purchasing new equipment.

If the United States decided to have universal access, then the nation could work together to care for its people instead of competing against one another. In the United States hospitals are constantly competing to attract the best physicians, have the latest technology, and make the hospital's appearance appealing both inside and out. This competition is vital to a hospital's success, however, it is wasting healthcare dollars. If the United States adopted universal access then hospitals could begin working together and share resources to provide the best care for everyone. For instance, instead of neighboring hospitals having the same advanced technology, they could share the technology. In addition to hospitals cooperating with one another, costs used to compete in marketing and purchasing advanced technology would be saved. The United States should adopt universal access like other developed countries and make caring for their people top priority over purchasing new equipment.

Lastly, universal access will reduce tertiary care in the United States and place emphasis on prevention. In the United States the healthcare system should really be called a medical system. This is because, as Oswald explains, in her article, "Access to What? Health Care for Whom?" it follows a medical model.

Patients get attention only when they are sick, rather than learning how to keep themselves from getting sick when they are well. The system focuses on patients' deficiencies and pathologies, not their resources.²⁵

Oswald goes on to say that medical model of healthcare is disease oriented, provider and physician centered, and focused on the individual patient rather than the community at large.

The upstream/downstream model compares the effectiveness of prevention, secondary care and tertiary care. Imagine the population as people falling into a stream of water and being swept down into the current. There are three possible ways to save the drowning people. The first option would be to drag the people out of the water after they have fallen into the stream. This is tertiary care. The second option is to grab the people as they are falling in the water (secondary care). And the last option is to create a barrier so that the people do not fall in the stream or to teach them how to swim so they can survive on their own (prevention).²⁶

The best option in the upstream/downstream model is prevention and the worst option is tertiary care. Prevention requires less time, energy, money and people because once you teach the people how to swim then they can swim on their own and they will not drown. Tertiary care, the worst option, is to pull the drowning people out of the water. By the time the people are pulled out they may be dead or have serious injuries. They will require more energy and expenses. They will also continue to fall into the stream. So a lot of time, energy and money will be needed to keep them alive. The second option, secondary care, is much better than the first but not nearly as successful as the first option.²⁷

Ninety-nine percent of the United States' total healthcare expenditure is spent on

tertiary care.²⁸ Researchers, health educators and physicians know that primary care will produce better long term results in the United States' health status. Professor O'Rourke and Professor Iammarino describe the United States healthcare system as a medical/sick care non-system. They feel that the United States' healthcare effort should work more with all healthy people to prevent them from becoming sick, rather than giving only some of them treatment when they are already sick.²⁹

The extent of the United States' focus on tertiary care is reflected in the ratio of general practitioners, who provide primary care and treat illnesses, to specialists, who treat illnesses. Only 35% of physicians are general practitioners, the other 65% are specialists. In other developed countries these figures are the opposite.³⁰ There should be more general practitioners because they can educate patients about preventive measures and how to take care of themselves. Specialists are also needed but at a lower level.

Adopting universal access as the healthcare system in the United States will place greater importance on prevention and primary care rather than tertiary care. Money would be saved with universal access because there would not be as many costly specialists and, hopefully, over time the health status of the United States would improve with the focus increasing on prevention and primary care. If the health status improves then there would be less need for expensive procedures. For instance, going back to the upstream/downstream illustration, if educators began to teach people how to swim then eventually not as many will drown. Universal access has potential to effect the health status of Americans as the shift goes from tertiary care to prevention.

If the United States decides to have universal access then there is an option of making payments through taxes. This method of funding universal access really alarms

people and scares them away from the idea of universal access. Americans do not realize how much money they already spend on health programs like WIC (Women, Infants, and Children) and Medicare through taxes. Woolhandler and Himmelstein explain the amount of healthcare that is paid through taxes in their article, “Paying for National Insurance- And Not Getting It: Taxes pay for a larger share of U.S. healthcare than most Americans think they do.”

The threat of steep tax hikes has torpedoed the debate over national health insurance. Yet according to our calculations, the current tax-financed share of health spending is far higher than most people think: 59.8%...U.S. tax-financed health spending is now the highest in the world.³¹

In essence, 60% of the total healthcare expenditure is paid through taxes. This amounts to \$724 billion or \$2,604 per capita³² of the total \$4,500 that the United States spends per capita. Switzerland has the second most expensive healthcare system and they spend \$2,500 per capita.³³ This is less than what Americans spend just on their taxes alone. If Americans knew how much already comes from their taxes then they should realize that they already spend more in taxes than what other developed countries pay in total for healthcare where all citizens have access.

Angell, M.D., brings up an important point about the payment of healthcare. She is aware that Americans are afraid of universal access because they fear their taxes will escalate. However, she believes that if there was funding through taxes for universal access then it would not be much more than what Americans already pay. In the article, “Are We in a Health Care Crisis?,” she reminds people that:

And yet we pay for healthcare now. We pay for it out of our paychecks, out of cost of goods and services, out of deductibles, co-payments, out of pocket for much of what we get now. It would be much more efficient and cheaper to pay

for it out of taxes.³⁴

Angell, M.D., believes that payment through taxes will be more efficient and is not likely to cost anymore than what people already spend now on healthcare. Plus everyone will be able to have access to care. Funding universal access through taxes should not be feared. It is a more efficient and effective way to pay for care.

Healthcare management in the United States would change if universal access was chosen for healthcare reform. Universal access will create a more simple healthcare system by having a clear national healthcare plan. With a national plan there will be a reduction of multiple payers, administrative waste, inappropriate care, competition among hospitals and tertiary care. This will make the management of healthcare for the United States more efficient and effective. Healthcare managers will have a crucial role in paving the way for universal access in the United States. With one national plan healthcare managers can outline standards for hospitals and healthcare professionals to follow. They also can work together to set standards for procedures and paperwork. Another aspect of healthcare management that will adjust is education and training. Perhaps, schools will study about different ways that other countries manage universal access in the hopes of continually improving healthcare.

Overall, healthcare management would benefit from a more common organizational structure with universal access. The nation's hospitals and other health facilities would share the same mission and goals for healthcare. There could be a national committee of healthcare managers who reside over different regions to assure that the national goals are being met and, with the help of healthcare financiers, make sure that the national budget is going as planned.

The United States needs healthcare reform. Healthcare costs are escalating while access and services provided are becoming less and less. In Anderson and Poullier's article, "Health Spending, Access, and Outcome: Trends in Industrialized countries," they reveal a few of the prominent, negative aspects of the United States' healthcare.

The United States has the lowest percentage of the population with government-assured health insurance. It also has the fewest hospital days per capita, the highest hospital expenditures per day, and substantially higher physician incomes than the other OECD countries. On the available outcome measures, the United States is generally on the bottom half, and its relative ranking has been declining since 1960.³⁵

Since 1960, the United States' healthcare rankings have been tumbling in a downward trend. It seems that strategies employed to contain costs or to improve the quality of care over the last 40 years have not been effective or efficient.

Universal access will create a fairer healthcare system. Instead of healthcare being treated as a commodity it could be treated as a human right. Everyone, no matter their age, ethnicity, income level, or whether or not they have a disease could have access to care. People would no longer need to worry about money when it comes to their health or the health of their loved one. People would feel secure about their healthcare as an elder. And hospitals would no longer need to see people's insurance cards before they help them. The United States should adopt universal access because it will help simplify the healthcare system, stem rising healthcare costs, and provide access for everyone.

Adopting universal access will create positive health outcomes for the United States.

¹ Aaron Catlin, et al. "Trends in U.S. Health Care Spending 2001," Health Affairs 22, no. 1 (2003): 1.

² Nicholas Iammarino and Thomas W. O'Rourke, "Future of Healthcare Reform in the USA: Lessons from Abroad," Expert Review Pharmacoeconomics Outcomes Research 2, no. 3 (2002): 279, 286.

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- ³ Marcia Angell, David U. Himmelstein, Steffie Woolhandler, and Quentin Young, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Journal of the American Medical Association 290 (2003): 820.
- ⁴ Donald W. Light, "Excluding More, Covering Less- The Health Insurance Industry in the U.S.," PAC Bulletin 22, no. 1 (1992): 8.
- ⁵ Light, 3.
- ⁶ Marcia Angell, in an interview by Fred Silverman and Michele Demark Epstein. Healthcare Crisis: Who's at Risk. Public Broadcasting system: 1.
- ⁷ Linda Peeno in an Interview by Bob Cardey and Ian Brown, One Physician's Confession: An interview with Linda Peeno, M.D., Canadian Broadcast Company. 12 January 1997: 1.
- ⁸ Marcia Angell, David U. Himmelstein, Steffie Woolhandler, and Quentin Young, 809.
- ⁹ Nicholas Iammarino and Thomas O'Rourke, 282.
- ¹⁰ "Paying for National Health Insurance- And Not getting It," Health Affairs 21, no. 4 (2002): 94.
- ¹¹ Andrew E. Cameron and William O. Cleverly, Essentials of Health Care Finances, 5th ed. (Gaithersburg: MY: Aspen Publishers, 2002): 214.
- ¹² Nicholas Iammarino and Thomas O'Rourke, 282.
- ¹³ Richard D. Lamm, "Ten Commandments of Health Care," The Nation's Health, 5th ed., Boston: Jones and Bartlett Publishers, 1990: 129.
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- ¹⁵ Thomas S. Bodenheimer and Kevin Grumbach, Understanding Health Policy: A Clinical Approach, 3rd ed. (Chicago: McGraw-Hill, 2002): 78.
- ¹⁶ Nicholas Iammarino and Thomas O'Rourke, 282.
- ¹⁷ Nicholas Iammarino and Thomas O'Rourke, 282.
- ¹⁸ Nicholas Iammarino and Thomas O'Rourke, 282.
- ¹⁹ Marcia Angell, 1.
- ²⁰ Number of Americans Without Health Insurance Rose in 2002, Increases Would Have been Much Larger if Medicaid and SCHIP Enrollment Gains Had Not Offset the Loss of Private Health Insurance," Center on Budget and Policy Priorities, 8 October 2003, <<http://www.cbpp.org/9-30-03health.htm>> (29 November 2003): 1.

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- 25 Nancy Oswald, "Access to What? Health Care for Whom?" Health/PAC Bulletin, spring 1992: 29.
- 26 Thomas O'Rourke, "Reflections on Directions in Health Education: Implication for Policy and Practice," Health Education 20, no. 6 (1989): 8.
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- 28 Thomas O'Rourke, "Health Care Reform- Insights for Health Educators," American Journal of health Education 33, no. 5 (2002): 298.
- 29 Nicholas Iammarino and Thomas O'Rourke, 286-287.
- 30 Nicholas Iammarino and Thomas O'Rourke, 287.
- 31 David U. Himmelstein and Steffie Woolhandler, 88.
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- 33 Marcia Angell, 1.
- 34 Marcia Angell, 3.
- 35 Gerard F. Anderson and Jean-Pierre Poullier, "Health Spending: Access, and Outcomes: Trends in Industrialized Countries," Health Affairs 18, no. 3 (1999):1.

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