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Nancy E. Cropley

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THE AMERICAN “RIGHT” TO HEALTH CARE — AN IDEA WHOSE TIME HAS COME?

Nancy E. Cropley, R.N.*

I. INTRODUCTION

In 1949, Harry S Truman became the first American president to articulate a belief in an American “right” to health care. Eight years later, Congress mandated that right for a select group of citizens — veterans who had served in the armed services.¹ In 1958, the right was extended to the families of those serving on active duty in the military.² Quietly, and with virtually no opposition, the United States had embarked on its first experiment with socialized medicine. Extending the system to ordinary citizens, however, has engendered a long and costly battle, in human as well as economic terms.

The first legislation granting the right to health care to other groups of Americans was enacted in 1965. With the passage of the Medicare³ and Medicaid⁴ amendments to the Social Security Act, the oldest and the poorest among us became entitled to federally subsidized care. In 1972, Medicare coverage was extended to all Americans suffering from endstage renal disease and requiring dialysis or kidney transplant.⁵ More recently,

* Golden Gate University School of Law, Class of 1991.

1. Act of June 17, 1957, Pub. L. No. 85-56, 71 Stat. 110 (codified as amended at 38 U.S.C. § 601 (1982 & Supp. V 1987)).

2. Act of Sept. 21, 1958, Pub. L. No. 85-861, 72 Stat. 1447 (codified as amended at 10 U.S.C. § 1077 (1988)).

3. Health Insurance for the Aged and Disabled (Medicare Act), Pub. L. No. 89-97, 79 Stat. 291 (1965) (codified as amended at 42 U.S.C. § 1395 (1982 & Supp. V 1987)).

4. Grants to States for Medical Assistance Programs (Medicaid Act), Pub. L. No. 89-97, 79 Stat. 291 (1965) (codified as amended at 42 U.S.C. § 1396 (1982 & Supp. V 1987)).

5. Act of Oct. 30, 1972, Pub. L. No. 92-603, 86 Stat. 1371, 1473 (codified as amended at 42 U.S.C. § 426-1 (1982 & Supp. V 1987)).

some states have elected to extend Medicaid coverage to pregnant women and infants whose family incomes are above the poverty line.⁶ Meanwhile, the need for affordable care continues to far exceed the entitlements.

In recent years, several factors have combined to fuel a rising concern that the federal government is simply not doing enough to provide access to health care for all Americans. The most prominent of these factors are:

- The aging of the American population;
- The ever-increasing cost of the technological intervention that has become the hallmark of American medicine;
- The staggering financial impact of the AIDS epidemic;
- The growing number of workers whose employers do not offer health insurance; and
- The decrease in federal funding for health care.

A few states have attempted to fill the gap by creating programs to deliver health care to their citizens regardless of ability to pay.⁷

Yet even among the most stalwart apologists of the present system, the conviction is spreading that only the federal government can create a meaningful health care entitlement. When Senator Edward Kennedy and Representative Henry Waxman introduced their Basic Health Benefits for All Americans Act,⁸ the list of organizations endorsing the concept included the American Hospital Association and American Airlines.⁹ And the staid *New England Journal of Medicine* in 1989 published a

6. A provision of the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4101(a)(1), 101 Stat. 1330-140 to -141 (codified at 42 U.S.C. § 1396a (Supp. V 1987)), gave states the option of providing Medicaid coverage to pregnant women and children under one year of age who live in households with incomes up to 185% of the federal poverty level (the current poverty level is set at \$9690 per year for a family of three). As of January 1989, nine states had raised eligibility to this level, while an additional three had eligibility levels between 100% and 185% of the poverty level. Wagner, *Access for All People*, MODERN HEALTHCARE, July 28, 1989, at 26, 28 (citing statistics from the National Governors' Association).

7. See, e.g., Washington Health Care Access Act, *infra* notes 20-25 and accompanying text.

8. S. 768, 101st Cong., 1st Sess., 135 CONG. REC. S3765-73 (1989); H.R. 1846, 101st Cong., 1st Sess., 135 CONG. REC. E1180-81 (1989).

9. Over one hundred organizations, ranging from the Women's International League for Peace and Justice to the American Society of Internal Medicine, endorsed the concept. A complete listing of these groups can be found at 135 CONG. REC. 3775 (1989).

proposal by impeccably conservative economist Alain Enthoven¹⁰ calling for "nearly universal"¹¹ health care coverage financed by increased taxes.¹² National health insurance's hour may not be yet at hand, but some surprising people are winding the clock.

II. THE CURRENT CRISIS

Throughout the late 1980s, the voices of the critics of the American health care system have become legion, often arising from startling sources. The president of the American Hospital Association began a 1989 speech to that body's annual convention with the words: "Let me start with a blunt summation: Something is wrong in American health care. . . . Our national health care expenditures total more than 11 percent of the Gross National Product. Yet there are gaps. No, there are gaping holes in health care coverage."¹³ And readers of the *Wall Street Journal* were bluntly informed by a Chrysler executive that the financial underpinnings of the American health care system are "broke, both literally and figuratively."¹⁴

Why this unprecedented call to action from these formerly staunch defenders of the free-enterprise system of health care delivery? Many are becoming convinced that the present system is simply no longer viable. Among the causes of this near collapse are:

- The aging of the American population; the eradication of many contagious diseases, combined with a declining birthrate and improved nutrition, has dramatically altered the age distribution in our society. It is estimated that by the year 2020, one American in five will be aged sixty-five or over. These elders, as a group, have more chronic health problems, more frequent need for hospitalization, and lower incomes than those under sixty-five.

10. Enthoven & Kronick, *A Consumer-Choice Health Plan for the 1990s* (pts. 1 & 2), 320 NEW ENG. J. MED. 29, 94 (1989).

11. *Id.* at 34, 95.

12. *Id.* at 32.

13. McCarthy, *Inside Track: McCarthy Outlines Standards for Health Reform*, HOSPITALS, Aug. 20, 1989, at 25, 25 (Carol McCarthy is president of the American Hospital Association).

14. Winslow, *National Health Plan Gains Unlikely Backer: Business*, WALL ST. J., Apr. 5, 1989, at B1, col. 3 (quoting Walter B. Maher, director of employee benefits for Chrysler).

- American medicine, like American society, is enamored of high technology. Computerized body scanning equipment, sophisticated laboratory procedures involving radiologic techniques, and electronic monitoring of body functions are mainstays of medical diagnosis in this country. These techniques are enormously expensive. Yet, in the words of officials of the federal Health Care Financing Agency, "the evidence substantiating the effectiveness of many such practices is frequently questionable and in many cases entirely lacking."¹⁵
- The AIDS epidemic has placed unprecedented strains on the system, and those strains are increasing daily; while the early victims of the epidemic were white middle-class males, most of whom were privately insured, the group among whom the disease is now spreading most rapidly is inner-city intravenous drug users, their sexual partners, and their children. The increased medical emphasis on early treatment of infected people is also raising alarm; one study has estimated the cost of early intervention for the estimated one million Americans now infected at a staggering five billion dollars a year.¹⁶
- Thirty-seven million Americans are uninsured; about one-third of this number are children.¹⁷ Of the adults, nearly two-thirds are employed full time, many in low-paying service jobs.¹⁸ These people have *no* insurance — no private insurance, no Medicare, no Medicaid. The numbers of these working poor have increased by about one million per year since 1980.¹⁹
- In an effort to curb runaway costs, the federal government has placed caps on the amount of money it will pay hospitals for care provided to Medicare recipients. Many hospitals have responded by raising costs to patients who have private insurance. This has created a vicious cycle in which insurance premiums are raised to meet the increased costs, leading to an increased number of uninsured.

15. Roper, Winkenwerder, Hackbarth, & Krakauer, *Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice*, 319 NEW ENG. J. MED. 1197, 1197 (1988).

16. Herscher, *Huge Costs Calculated for Early Treatment of AIDS*, San Francisco Chron., Sept. 15, 1989, at A1, col. 5.

17. McCarthy, *supra* note 13, at 25.

18. See Enthoven & Kronick, *supra* note 10, at 30, 36; 135 CONG. REC. S3764 (1989) (introduction by Senator Kennedy of the Basic Health Benefits for All Americans Act).

19. Kenkel, *States Move Toward Mandatory Health Care Coverage to Ensure That Working Poor Are Covered*, MODERN HEALTHCARE, July 28, 1989, at 36.

Attempting to deal with the mounting crisis, a few states have created their own programs to meet the health care needs of their citizens. In Washington, the Health Care Access Act of 1988²⁰ established a trust account to provide basic health care for uninsured Washingtonians.²¹ The Act will cover Washington families whose incomes are up to 200% of the federal poverty level.²² The funds will be paid to established managed care systems that contract with the state.²³ Co-payment will be required, but the amount charged those families with incomes less than 120% of the poverty level will be nominal. Major exceptions to the co-payment requirement are "proven prevention programs, such as prenatal care" The state will pay completely for these.²⁴ The Washington plan is now in the demonstration phase, covering five areas of the state chosen to insure "a population reasonably representative of the portion of the state's population that lacks such coverage"²⁵

In 1987, Oregon made national headlines by announcing that the state would no longer provide Medicaid funding for organ transplants. In July 1989, Governor Neil Goldschmidt signed into law a bill making rationing of state Medicaid funds mandatory.²⁶ The new law creates a Health Services Commission,²⁷ which will be responsible for drawing up a priority list of health services for Medicaid recipients.²⁸ The legislature will decide each year how far down the list the state can afford to go.²⁹ State senate president and co-author of the bill John Kitzhaber is an emergency room physician who contends that the controversial legislation represents a marked improvement over the present system, which "ration people while maintaining an increasingly rich benefit package for the shrinking number of people who remain eligible. And this represents rationing of the

20. Health Care Access Act of 1987, ch. 5, 1987 Wash. Laws 1st Ex. Sess. 5 (codified at WASH. REV. CODE § 70.47 (1989)).

21. WASH. REV. CODE § 70.47.030 (1989).

22. *Id.* § 70.47.020(4).

23. *Id.* § 70.47.060(7).

24. *Id.* § 70.47.060(4)(c).

25. *Id.* § 70.47.060(6).

26. Act effective July 1, 1989, ch. 836, 1989 Or. Laws 836 (codified at OR. REV. STAT. §§ 414.025, .036, .042 (1990)).

27. *Id.* § 4(1).

28. *Id.* § 4a(3).

29. *Id.* § 4a(5).

very worst kind — rationing that reflects no social policy, which has no ethical or clinical basis, which is being done silently, implicitly, and by default.’ ”³⁰

In companion legislation, Oregon established an incentive plan to encourage private employers to provide health insurance to their workers.³¹ The law sets a 1994 deadline for full implementation of the employment based coverage, and offers employers tax credits for benefit costs.³² The credit is equal to fifty percent of the premium paid by the employer, or twenty-five dollars per month per covered employee, whichever is less.³³ Both the rationing plan and the employment based provisions became effective July 31, 1989. If both function as intended, almost all Oregon citizens will be covered by some form of insurance within five years.³⁴

In an equally dramatic but less heralded move, Mississippi in 1989 closed three state charity hospitals in order to divert their annual funding of six million dollars to the state's Medicaid program.³⁵ State health planners estimate that the diversion will result in an additional thirty million dollars in federal Medicaid funds, which the state hospital association president called probably the largest single expansion in appropriations since Medicaid has been in existence.³⁶ In October 1988, Mississippi raised Medicaid income eligibility for pregnant women and infants to 185% of the federal poverty level. A July 1989, expansion of eligibility for children under age five living in homes with incomes at or below the poverty level was expected to add twenty thousand children to the rolls.³⁷

30. Salzman, *Oregon Prescribes a Cure for National Health Need*, L.A. TIMES, Sep. 3, 1989, § 5 (Opinion), at 3, col. 1.

31. Act approved June 19, 1989, ch. 381, 1989 Or. Laws 381 (codified at OR. REV. STAT. §§ 315.096, 317.113, 653.725, .765, .775 (1990)).

32. *Id.* § 8(1).

33. *Id.* § 8(2).

34. Salzman, *supra* note 30.

35. Wagner, *supra* note 6, at 27, 32.

36. *Id.* at 32, 34.

37. *Id.* at 34.

III. FUTURE TRENDS

Two proposals attracting national attention may portend the ways in which the American right to health care will be extended in the nineties. The Basic Health Benefits for All Americans Act³⁸ was introduced by Senator Edward Kennedy (Democrat, Massachusetts) and Representative Henry Waxman (Democrat, California) on April 12, 1989. "Consumer-choice," originally unveiled by Stanford's Alain Enthoven in the 1970s, reappeared in a revised version in January 1989 issues of the *New England Journal of Medicine*.³⁹

A. THE KENNEDY-WAXMAN APPROACH

The Basic Health Benefits for All Americans Act is designed to meet the needs of two groups of Americans: those employed for seventeen and one half hours per week or more, and all other uninsured citizens.⁴⁰ The Act would extend coverage to workers by requiring that all employers of twenty-six or more people offer a basic benefit package to employees and their families.⁴¹ The mandatory package would include prenatal care, well-baby care for children up to one year old, screening and diagnostic procedures, inpatient hospital charges (including some psychiatric hospitalizations), and the services of physicians and nurse practitioners.⁴² Premiums would be paid completely by the employer for workers earning less than 125% of the federal minimum wage;⁴³ those earning more could be required to pay up to twenty percent of the monthly actuarial rate determined by the employer.⁴⁴

"Certified regional insurers" would be credentialed through the Department of Health and Human Services;⁴⁵ these insurers

38. See *supra* note 8.

39. Enthoven & Kronick, *supra* note 10.

40. Basic Health Benefits for All Americans Act, *supra* note 8, §§ 201(a), (b), 303(3)(A).

41. *Id.* § 303(4)(D).

42. *Id.* §§ 312(a)(1)-(5), 303(11).

43. *Id.* § 314(b)(2).

44. *Id.* § 314(b)(1). The monthly actuarial rate is defined as the actual cost of the benefits plus administrative costs and an appropriate amount for a contingency margin. These figures apply only to the basic package; nothing in the Act would require employers to offer a more comprehensive package. *Id.* at §§ 301(b), 311(b)(1).

45. *Id.* § 322.

would agree to accept all employees of an employer seeking coverage, with no "pre-existing conditions" exceptions.⁴⁶ Managed care systems such as health maintenance organizations (HMOs) would be eligible for certification, as would traditional underwriters.⁴⁷ The Act provides for federal subsidization of compliance costs for small businesses⁴⁸ and imposes substantial fines on non-complying employers.⁴⁹ It does not, however, create a disincentive for employers who reduce employees' working hours in order to avoid the mandate.

The non-employment based provisions of the Act⁵⁰ provide for incremental coverage over a ten year period for all Americans not covered through employment. One year from the date on which the Act becomes effective, all families and individuals with incomes at or below the federal poverty line would be added to Medicaid.⁵¹ Five years later, Medicaid coverage would extend to those with incomes up to 185% of the poverty level.⁵² Finally, all others would be covered by Medicaid at the beginning of the tenth year after the Act's effective date.⁵³ A graduated co-payment or deductible would be collected from those above the poverty line.⁵⁴ Coverage would be essentially the same as for the employment based package; a major exception is that preventive health care for children up to age twenty-one would be provided under the public plan.⁵⁵

B. CONSUMER-CHOICE⁵⁶

The 1989 version of this proposal, co-authored by former Nixon adviser Alain Enthoven and his research assistant Richard Kronick, stirred major controversy in the medical world when it was published in January of that year. The authors direct their plan to two goals: providing protection from health

46. *Id.* § 313(b). The pre-existing condition exemption now allows insurers to decline to cover any medical condition already in existence at the time the policy is issued.

47. *Id.* §§ 322(b)(6), 323(b)(1)-(2).

48. *Id.* § 341.

49. *Id.* § 332.

50. *Id.* § 401.

51. *Id.* §§ 901(a)(1), (b)(1).

52. *Id.* §§ 901(a)(2), (b)(2).

53. *Id.* § 901(a)(3).

54. *Id.* § 903.

55. *Id.* § 902.

56. See Enthoven & Kronick, *supra* note 10.

care expenses for all Americans, and promoting the economical financing and delivery of health care.⁵⁷ Achieving these goals, they say, would create “nearly universal” health care coverage in the United States.⁵⁸

Consumer-choice relies heavily on direct taxes. The authors advocate legislation that would require employers to cover all full-time employees and their families, and to pay an eight percent payroll tax on the first \$22,500 in earnings of each uncovered worker.⁵⁹ The payroll tax is intended to discourage employers from reducing workers’ hours in order to avoid coverage. Self-employed persons, early retirees, and all others not covered by full-time employment would pay an eight percent income tax surcharge based on adjusted gross income.⁶⁰ A third source of revenue under this plan would come from a change in the current tax regulations which allow employees to count employer paid benefits as non-taxable income; under consumer-choice, a worker who chose to participate in a more comprehensive package would be taxed on the difference between the value of the package and the value of mandatory coverage.⁶¹ All these taxes would be funneled through the federal Health Care Financing Agency to statewide “public sponsors” (similar in concept to Kennedy-Waxman’s “regional insurers” but covering only one state instead of a wide region), which would receive approximately seventy percent of their funds from the federal government; the remaining thirty percent would come from the states.⁶²

Enthoven’s mandated coverage is similar to the Kennedy-Waxman bill’s. Consumer-choice, however, goes much further in altering the traditional American medical system; the plan heavily favors managed care services such as HMOs. Consumers who chose to use a fee-for-service physician would do so at their own expense.⁶³ The authors candidly admit that, while nothing in the

57. *Id.* at 29, 31.

58. *Id.* at 34, 95.

59. *Id.* at 32.

60. *Id.*

61. *Id.* at 33, 36.

62. *Id.* at 31, 34.

63. *Id.* at 31. A similar system is already being implemented by two large West Coast employers. During March 1990, both Pacific Telesis (72,000 employees) and Wells Fargo Bank announced major changes in their employee health benefits plans. Both new

language of the proposal would limit the physician's right to private practice, "in the long run, the most successful organizations would probably be large, prepaid group practices"⁶⁴

Enthoven and Kronick view their proposal as a "plausible starting point for incremental reform"⁶⁵ of the American health care system, concluding:

In view of our historic preferences for limited government and decentralization, our reliance on incentives in the private sector, and our at least partial success with relatively efficiently organized systems of health care, it seems reasonable to give comprehensive reform of incentives a serious try before something more alien and drastic is considered.⁶⁶

IV. ENSURING ACCESS IN THE NINETIES

While the need for substantial changes in the American health care system is widely acknowledged, there is no agreement on how these changes should be realized. A viable plan to provide access to health care for all Americans must address the concerns of all the groups necessary to effect such a change. These groups include consumers, employers, the insurance industry, organized medicine, and the federal bureaucracy. A plan capable of winning the support of all of them must encompass six major attributes:⁶⁷

1. *Universality* — all consumers must be guaranteed access to a basic benefits package and a comprehensive system of health care.

2. *Comprehensive coverage* — access must be assured to a full range of preventive, inpatient, longterm, and home health care.

plans provide for complete coverage through a single HMO; employees who choose to use their own doctors or non-HMO hospital may do so by paying 20-30% of the charges. Russell, *Pac Bell Revamps Employee Health Plan to Contain Costs*, San Francisco Chron., Mar. 22, 1990, at C1, col. 5.

64. Enthoven & Kronick, *supra* note 10, at 96.

65. *Id.* at 97.

66. *Id.* at 101.

67. Six point list suggested by and adapted from HEALTH ACCESS, THE CALIFORNIA DREAM, THE CALIFORNIA NIGHTMARE 57 (1988).

3. *Cost sharing* — the costs and risks of financing coverage must be broadly based on ability to pay.

4. *Cost effectiveness* — proven mechanisms for containing health care costs without reducing access to basic services must be utilized, and new strategies developed.

5. *Allocation of health resources based on reasoned public policy*⁶⁸ — this may be the most difficult change of all to implement. American medicine and the American public are accustomed to a financing system which spends the most money on procedures which are least likely to be successful; heart transplants are a good example.

6. *Accountability to the consumer* — any reform must ensure that the health care system becomes more responsive to the needs and concerns of the consumer.

Each of the previously discussed proposals meets some of the six criteria. All seek to assure universality, and all include some elements of cost sharing and cost effectiveness. Only the Oregon approach has attempted to deal with the difficult public policy questions of resource allocation. Finally, none of them addresses access to longterm care in nursing homes or at home, and none deals directly with accountability to the consumer.

A universal access plan for the nineties will incorporate the best of each of these proposals into new strategies designed to guarantee that the six criteria are met. Universality will be achieved through a combination of employment based and public insurance. Employers who currently provide coverage for their workers will see a reduction in cost as all employers are required to offer health insurance benefits and hospitals no longer have the need to “pass through” the costs of care for the uninsured. At least in the start-up phase, small employers will need the kind of subsidies envisioned by the Kennedy-Waxman

68. Economists frequently make a distinction between the words “ration” and “allocate”: generally, rationing is used to refer to the administrative distribution of scarce goods, while allocation is used to denote a market-driven system (e.g., a consumer who does not have the purchase price of a new Porsche will not be “allocated” one). Common English, however, uses the terms interchangeably, and they are so used in this Comment.

bill.⁶⁹ Preserving the “no pre-existing conditions exception”⁷⁰ provision of that bill will also further universality.

Both public and private insurers must be required to cover longterm care and home care services. Both plans must also provide for childhood immunizations, prenatal care, well-baby care and preventive dental care for children. The goal of comprehensive coverage will be advanced through these requirements.

Financing coverage may be most easily accomplished through a system of direct taxes like that proposed by Enthoven. (“Easily” is used here in the procedural sense; winning political support for increased taxes may of course prove very difficult.) In order to act as an incentive to the employer, the cost of the tax must be higher than the average cost to the employer of providing coverage. Mandating employer coverage of employees and their dependants will reduce the number of uninsured by about two-thirds.⁷¹ Those remaining uninsured can be gradually phased into Medicaid, à la Kennedy-Waxman.

The use of regional or statewide insurers certified by the federal government will provide an effective cost-containment mechanism by encouraging competition among insurers for the more than twenty-two million new policy holders.⁷² This mechanism could be made even more cost effective if the federal government made coverage by a certified insurer a condition of its contracts with private industry. Ideally, certification preference would be given to health maintenance organizations; pragmatically, however, such a requirement would mobilize the opposition of the powerful insurance lobby. Similarly, Enthoven’s suggestion of mandated coverage only for services provided by HMOs would be sure to invoke the resistance of organized medicine.

An allocation process modeled after that adopted in Oregon could ensure decisions based on agreed upon priorities. Before

69. See *supra* note 48.

70. See *supra* note 46.

71. Enthoven & Kronick, *supra* note 10, at 30, 36 (citing estimates provided by the Congressional Budget Office).

72. *Id.*

voting each year on the allocation of available resources, Congress would seek maximum input from the public. One way to accomplish this would be through the familiar Congressional questionnaire mailed to constituents. Public hearings in the Congressional districts could also be utilized.

Finally, a system must be put into place to ensure ultimate accountability to the consumer. One author has suggested "a technology of patient experience" consisting of

a common, patient-understood language of health outcomes; a national database containing information and analysis on clinical, financial, and health outcomes that estimates as best we can the relation between medical interventions and health outcomes, as well as the relation between health outcomes and money; and an opportunity for each decision-maker to have access to the analyses that are relevant to the choices they must make.⁷³

Some essentials of such a technology are already in place. The federal Health Care Financing Agency (HCFA) has established a monitoring system which provides annual statistics on raw mortality rates, age-adjusted mortality rates, and total hospital admissions; hospital admissions according to age, race, and sex; and mortality and morbidity rates associated with various conditions.⁷⁴ While this database currently covers only Medicare recipients, it could easily be expanded to include Medicaid and, eventually, all health care recipients.⁷⁵ HCFA also currently collects patient-specific data provided on a voluntary basis from about half the states.⁷⁶ Making the submission of this data mandatory and integrating it with the hospital-based information would be a substantial start to a readily available source of comparative data for the decision-making consumer.

73. Ellwood, *Shattuck Lecture — Outcomes Management: A Technology of Patient Experience*, 318 NEW ENG. J. MED. 1549, 1551 (1988).

74. Roper, Winkenwerder, Hackbarth, & Krakauer, *supra* note 15, at 1198.

75. The basic framework for such a comprehensive database may lie in the National Program for the Assessment of Patient Outcomes, designed by the National Center for Health Services Research and Health Care Technology Assessment (NCHSR). The NCHSR program is intended to focus on the population under age sixty-five (eliminating most Medicare statistics) and on the medical needs of women and children. *Id.* at 1200.

76. *Id.* at 1198.

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Women, as health care consumers and as primary caregivers within the hospital setting as well as in the home, must take an active role in the development of a national health access plan. We must insist that our voices be heard at every stage of the process, and that any plan adopted meets our needs. The author hopes this Comment will stimulate discussion and debate on this topic among women across all political, class, race, and economic lines, and will contribute to a consensus among all American women that access to health care must become a priority issue for the nineties.