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Foreword: New Directions in American Health Care: Innovations from Home and Abroad

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NEW DIRECTIONS IN AMERICAN HEALTH CARE: INNOVATIONS FROM HOME AND ABROAD

FOREWORD

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The articles in this issue stem from a health policy conference that occurred at Hofstra University in March 2010. An interdisciplinary focus defined the conference, "New Directions in American Health Care: Innovations from Home and Abroad."[1] The School of Law; the School of Education, Health and Human Services; the School of Medicine; the

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1. The conference was held on March 11-12, 2010. *See* Hofstra Univ., New Directions in American Health Care: Innovations from Home and Abroad (Mar. 11-12, 2010), http://www.hofstra.edu/pdf/Community/culctr/culctr_healthcare08_reg.pdf. We are grateful to the law firm of Garfunkel Wild, P.C.; EmblemHealth; Neurological Surgery, P.C.; the Center for Learning and Innovation at North Shore-LIJ Health System; and the Institute for Healthcare Equity at Nassau University Medical Center for their support and sponsorship of the conference. We are appreciative to Hofstra University and the Hofstra Cultural Center. We owe a special debt to Special Conference Adviser, Professor David Weiss, whose support was consistent and whose wisdom was invaluable; to the Conference Advisory Committee; and to Athelene Collins and Natalie Datlof of the Hofstra Cultural Center for the hard work that made the conference possible. We thank each of the schools that participated in the conference and their respective Deans (Nora Demleitner, Dean of the School of Law; Bernard Firestone, Dean of Hofstra College of Liberal Arts and Sciences; David Foulk, Dean of the School of Education, Health and Human Services; and Lawrence Smith, Dean of the School of Medicine). Finally, we are grateful to Toni Aiello, Reference Librarian, Hofstra University School of Law. Her intelligent, generous assistance before and during the conference made the event more learned than it would otherwise have been.

University's College of Liberal Arts and Sciences; and the University Cultural Center each played an important role in shaping the event.

Planned before the passage of the Patient Protection and Affordable Care Act ("ACA"),[2] we aimed, as co-directors of the event, to convene a group of scholars, advocates, practitioners, policy makers, and elected officials to consider how best to shape health care reform in the United States in light of the successful reform efforts in several states and in other countries. More specifically, we constructed the conference to facilitate discussion aimed at locating useful responses to shortcomings in the financing and delivery of health care in the United States, and at establishing a research agenda to study the causes and appropriate responses to the limitations in coverage and quality of health care in the United States.

The conference met each of the aims we set. It occurred in March 2010, about two weeks before President Obama signed the ACA.[3] Keynote speakers Peter Zweifel, a Swiss health economist and professor at the University of Zurich, and Vicente Navarro, Professor of Public Policy, Sociology and Policy Studies at Johns Hopkins University's Bloomberg School of Public Health, voiced contrasting visions of how best to reform the U.S. health care system. Dr. Zweifel presented the market-based Swiss system as a compelling model for an overhaul of the U.S. health care system. He focused on delineating advantages of individual, as compared to employer, choice among health coverage options. Dr. Navarro documented existing disparities in health and health care coverage across economic classes. He focused on the political and social determinants of health. Dr. Navarro argued cogently that American health policy largely serves the interests of the privileged social classes from which America's political and policy elites are overwhelmingly drawn.

Special conference guests included Deborah Bachrach, a health policy consultant and former New York State Medicaid director and deputy commissioner of health, who addressed the impact of federal health policy on the states; and former Vermont Governor Howard Dean[4] whose talk is included in this issue. Governor Dean, himself a

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). Portions of the 2010 health care reform were passed in a companion bill. *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

3. The bill was signed into law by President Obama on Tuesday, March 23, 2010. Sheryl Gay Stolberg & Robert Pear, *A Stroke of a Pen, Make That 20, and It's Official*, N.Y. TIMES, Mar. 24, 2010, at A19.

4. Howard Dean served as Governor of Vermont between 1991 and 2003. He was a candidate for the Democratic nomination of president in 2004 and served as Chair of the Democratic National Committee between 2005 and 2009.

physician, discussed a variety of economic, social, and political factors that have negatively affected the practice of medicine in the United States in the last half century.

Conference panels focused on, among other things, coverage innovation and the quality of care; the shape and future of the local health care workforce; the history of efforts to reform health care in the United States and the relevance of that history to contemporary socioeconomic changes; the particular health needs of an aging population and evidence-based solutions; innovative responses to socioeconomic disparities and, specifically, to disparities in health care; and models for reforming health care developed abroad and within several states. Interaction among panelists and between panelists and members of the audience was intense, committed, and informative. The essays in this issue reflect the breadth of concern, the seriousness of purpose, and the innovative spirit that shaped conference debate and discussion.

Governor Dean's presentation, "The Evolving Role of Physicians in a Reformed American Health Care System," delineated and considered a diverse set of factors that, in his view, have had unfortunate consequences for the practice of medicine in the United States. Among these factors are the fee-for-service system of payment, medical malpractice litigation, the scope and content of rules established by health insurance companies, and the organizational structure of hospitals.[5] More specifically, Governor Dean, who practiced internal medicine in Vermont for about a decade, concluded that fee-for-service medicine rewards, and thus almost inevitably encourages, responses among physicians that are often expensive and that do not necessarily maximally serve patients.[6] Similarly, medical decision-making has been shaped by a fear of being sued.[7] Governor Dean further pointed to the consequences of health insurance companies virtually always operating as large bureaucracies.[8] This has imposed a series of mindless obligations on health care providers, especially primary care doctors, which help almost no one and frustrate and dishearten physicians. Finally, Governor Dean explained that pressure from hospitals can limit the role of primary care doctors in caring for patients and patients' families in a specific set of contexts, such as end-of-life care.[9] We are

5. *See* Howard Dean, *The Evolving Role of Physicians in a Reformed American Health Care System*, 39 HOFSTRA L. REV. 9, 10-16 (2010).

6. *See id.* at 10-11.

7. *See id.* at 11.

8. *See id.* at 11-12.

9. *See id.* at 14-15.

grateful to Governor Dean for agreeing to include the text of his provocative and informative presentation among the essays in this issue.

The essay, "New Directions in American Health Care," offers a vision for a reformed American health care system from Lawrence G. Smith, M.D., Dean of the Hofstra North Shore-LIJ School of Medicine,[10] and Megan Anderson, Director of Clinical Program Initiatives at the North Shore-LIJ Health System. Smith and Anderson argue that our current system is characterized by "pockets of extraordinary excellence that often sit in a sea of mediocrity and wastefully high costs."[11] Typically, care is poorly coordinated across inpatient and outpatient settings. Patients consult with multiple specialists who do not communicate with each other. Logically, primary care physicians would play the role of care coordinators. Yet, medical students shun training for this position, recognizing that specialists reap financial rewards and status far in excess of primary care doctors. Rigid hierarchies among health care workers impede creation of an "effective team culture" that could foster "openness, collaboration, communication, and the ability to learn from mistakes."[12] Excessive resources are devoted to managing disease after individuals get sick, while prevention and health promotion receive short shrift. Smith and Anderson propose a multipronged program to address these shortcomings. Among other things, they propose expanding access to health care coverage, promoting the use of evidence-based treatment standards, creating electronic medical records that can be used seamlessly across treatment settings, and reforming provider payment modalities to foster coordinated, high-quality health care.[13] Medical education, Smith and Anderson stress, must also change. The current American norm for the education of physicians often yields graduates "more focused on personal income and physician autonomy than altruistic patient care."[14]

In "Health Reform and Health Equity: Sharing Responsibility for Health in the United States," Professor Erika Blacksher argues that health equality will only become possible once health is "treated as a shared responsibility."[15] Blacksher begins with the proposition, one

10. The Hofstra North Shore-LIJ School of Medicine will admit its first class of students in 2011. Press Release, Hofstra N. Shore-LIJ Sch. of Med., Hofstra, North Shore-LIJ Receive Medical School Approvals, Open Facility: New School of Medicine to Enroll First Class in Summer 2011 (June 8, 2010), http://medicine.hofstra.edu/about/news/pressreleases/060710_accreditation.html.

11. Lawrence G. Smith & Megan Anderson, *New Directions in American Health Care*, 39 HOFSTRA L. REV. 23, 23 (2010).

12. *Id.* at 36.

13. *Id.* at 30-32.

14. *Id.* at 37.

15. Erika Blacksher, *Health Reform and Health Equity: Sharing Responsibility for Health in*

which is supported by significant research, that achieving health equity will depend on an agenda that the United States seems unwilling to embrace—an agenda that would respond forcefully in reshaping the "'social determinants of health.'"[16] In comparing attitudes toward socioeconomic and health disparities in the United States with those in England and Canada, Blacksher pinpoints a worrisome difference. Both England and Canada officially identify "health inequalities as 'inequities' or 'disparities,' which connote their moral unacceptability, and justify government action on grounds of social justice and social responsibility."[17] In contrast, the United States has long stressed, and continues to stress, the significance of personal responsibility in determining health. Despite this, notes Blacksher, "[f]orces for a progressive health agenda" are not absent in the United States.[18] In this regard, she points to, among other developments, a 2008 report of the Robert Wood Johnson Foundation's ("RWJF") Commission to Build a Healthier America that argued in favor of focusing on the social determinants of health.[19] Work of the RWJF and the Pew Charitable Trusts calls attention to the implications for health of non-health sector policies, and recent initiatives in New York City that have banned trans-fats in restaurants, required restaurants to post calorie counts, and planted trees in low-income areas of the City in which asthma rates have been high.[20] Blacksher suggests that if similar developments are generalized within the U.S. population, the nation will then have embarked on a "truly comprehensive health equity agenda."[21]

Professor Larry I. Palmer (working with co-author Joshua P. Booth) shaped his conference talk on "ERISA Preemption Doctrine as Health Policy" into a stimulating and constructional account of federal courts' varied responses to ERISA preemption.[22] Section 514 of the ERISA statute[23] provides that it "'shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan.'"[24] In their article, Booth

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the United States, 39 HOFSTRA L. REV. 41, 42 (2010).

16. *Id.* at 44, 46.

17. *Id.* at 46.

18. *Id.* at 55.

19. *See generally* ROBERT WOOD JOHNSON FOUND., OVERCOMING OBSTACLES TO HEALTH (2008) (identifying the inequities in the U.S. health care system).

20. *See* Blacksher, *supra* note 15, at 56-57.

21. *Id.* at 58.

22. Joshua P. Booth & Larry I. Palmer, *ERISA Preemption Doctrine as Health Policy*, 39 HOFSTRA L. REV. 59 (2010).

23. Employee Retirement Income Security Act (ERISA), Pub. L. 93-406, 88 Stat. 829 (1974) (codified as amended in 29 U.S.C. §§ 1001–1461 (2006)).

24. Booth & Palmer, *supra* note 22, at 60 (quoting ERISA § 514, codified at 29 U.S.C. § 1144).

and Palmer insightfully address one of the most perplexing conundrums in health law—the apparently inconsistent consequences of Section 514 for state regulation of health policy.[25] Using an institutional approach, the authors note the reluctance of the U.S. Supreme Court, in cases involving questions about the scope of ERISA's preemption, to interfere with the integrity of "general health care" statutes.[26] Specifically, they report:

> If [a] statute merely focuses on a single side of the equation, employer contributions, courts are more likely to find that the statute is incompatible with the ERISA experiment. If, on the other hand, the statute creates a scheme involving a role for both private actors and the state, the courts are likely to uphold the statute.[27]

Thus, Booth and Palmer characterize ERISA, at least in part, as an effort to shape "the roles of the government and private employers in providing health care."[28] They conclude that—in light of the myriad of policy issues that implicitly or explicitly informs courts' decisions about the reach of ERISA preemption—the ACA will almost certainly have a "major effect on ERISA preemption doctrine."[29]

Finally, conference co-director Professor Rachel Kreier and keynote speaker Professor Peter Zweifel co-authored "Health Insurance in Switzerland: A Closer Look at a System Often Offered as a Model for the United States."[30] Their article provides a detailed overview of the Swiss health care system as established by the 1994 Revised Health Insurance Law, while comparing and contrasting its characteristics with the provisions of the ACA. As economists, they highlight the role that economic ideas have played in shaping the Swiss approach, which relies on individual choice among competing not-for-profit health insurers.[31] The Swiss system is characterized by a robust insistence on solidarity among Swiss citizens, whether they are rich or poor, healthy or sick, young or old.[32] An individual mandate to purchase insurance, community rating, and guaranteed issue is the most important tool to ensure solidarity between the healthy and sick, and across generations.[33]

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25. *See id.* at 60-61.
26. *See id.* at 80.
27. *Id.* at 83.
28. *Id.* at 85.
29. *Id.* at 87.
30. Rachel Kreier & Peter Zweifel, *Health Insurance in Switzerland: A Closer Look at a System Often Offered as a Model for the United States*, 39 HOFSTRA L. REV. 89 (2010).
31. *See id.* at 92-94.
32. *Id.* at 97.
33. *Id.* at 92-94.

An extensive system of subsidies for those of modest means promotes solidarity across income groups. Kreier and Zweifel explore the performance of the Swiss system in terms of health outcomes, equity, and cost. The Swiss generally have excellent health outcomes, and a high-quality health care system.[34] The Swiss also achieve an impressive degree of equity in outcomes compared to other wealthy democracies. More surprisingly, although the Swiss system was until recently the second most expensive system in the world (after the United States), Kreier and Zweifel report that the Swiss have had substantial success in controlling the escalation of costs.[35]

In addition to papers delivered at the conference, this issue contains an exciting article by Elizabeth Weeks Leonard. In "Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform," Professor Leonard explains state efforts to nullify the ACA as an instance of "rhetorical federalism."[36] She defines that term as the "highly public, highly vocal invocation of states-rights arguments to frame objections to comprehensive, sea-changing federal policies."[37] Leonard identifies a "salutary effect" of rhetorical federalism on "health care decisionmaking and federal-state relations."[38] She concludes that because it appears to place substantive and political arguments to the side, the debate about health care reform engendered within the context of rhetorical federalism encourages the public to focus on and attend to "fundamental values and policies" that led to and that may flow from the federal health reform law.[39]

These papers, individually and as a set, reflect the innovative energy that characterized the conference panels and post-panel debates. We hope and believe that the synergy that developed as conference participants, working from the perspectives of many different professions and disciplines (including, among others, law, medicine, nursing policy analysis, advocacy, and philosophy), responded to each other's concerns, analyses, and proposals, will continue to inform debate as the nation actualizes, and perhaps reshapes, the ACA. The essays collected in this symposium issue of the Law Review further that process.

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34. *Id.* at 101-02.

35. *See id.* at 100-01.

36. Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111, 112, 161-62 (2010).

37. *Id.* at 112.

38. *Id.* at 113.

39. *Id.* at 167.

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