

Book Review: Disentitlement? The Threats Facing Our Public Health Care Programs And A Rights-Based Response

Elizabeth A. Conradson Cleary
Marquette University Law School

Follow this and additional works at: <http://scholarship.law.marquette.edu/elders>



Part of the [Elder Law Commons](#)

Repository Citation

Conradson Cleary, Elizabeth A. (2004) "Book Review: Disentitlement? The Threats Facing Our Public Health Care Programs And A Rights-Based Response," *Marquette Elder's Advisor*: Vol. 6: Iss. 1, Article 9.
Available at: <http://scholarship.law.marquette.edu/elders/vol6/iss1/9>

This Article is brought to you for free and open access by the Journals at Marquette Law Scholarly Commons. It has been accepted for inclusion in Marquette Elder's Advisor by an authorized administrator of Marquette Law Scholarly Commons. For more information, please contact megan.obrien@marquette.edu.

REVIEW OF: DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH CARE PROGRAMS AND A RIGHTS-BASED RESPONSE, by Timothy Stoltzfus Jost. Oxford University Press (2003), 291 pages, \$45.00 (hard cover).

Reviewed by Elizabeth A. Conradson Cleary*

In his book, *Disentitlement? The Threats Facing Our Public Health Care Programs and a Rights-Based Response*,¹ Timothy Jost argues in opposition of a health-care system financed and driven in a private, individually-based market, asserting it does not and cannot assure access to affordable health care. Instead, he favors legal entitlements with the goal of achieving universal health-care coverage. While this seemingly counter-cultural, and perhaps unpopular, argument has been made before, Professor Jost offers a new perspective by focusing on the role that the law, legal rights, and courts play in developing and sustaining health systems.² Specifically, *Disentitlement* focuses on law as applied to comparative health system analysis, legal structures of health-care systems, the notion of entitlements, the hazardous move towards dismantling our current entitlement system, and understanding healthcare entitlements from a historical perspective.³ As Jost describes in his introduction, he has four stories to tell: the uniqueness of health care in comparison to other goods and services; the extensive and arduous history of the emergence of health-care entitlements; the continual opposition entitlements face from powerful economic and ideological interests; and the look of health-care entitlements in

* Elizabeth A. Conradson Cleary received her undergraduate degree in English at Creighton University in Omaha, Nebraska. She graduates from the Marquette University Law School in May 2005 and, upon completion of her dual degree in Health Law and Bioethics, she will graduate from the Medical College of Wisconsin in May 2006 with a Masters in Bioethics.

1. TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* (Oxford University Press 2003) [hereinafter *DISENTITLEMENT*].

2. *Id.* at vii-viii.

3. *Id.* at vii-ix.

other countries. Throughout his book, Jost focuses on the three American health-care entitlement programs—Medicare, Medicaid, and tax subsidies for employment-related health insurance.

PART I: THE UNIQUENESS OF HEALTH CARE

Following a thorough introductory chapter, Jost begins the first of his stories as he asserts the major contention of his book—the significance of and need for entitlements. Chapter two, "Why Entitlements Matter," opens with Jost distinguishing the "remarkably skewed" distribution of health-care costs.⁴ For example, "5% [of the population] are responsible for nearly 70% [of health-care costs]. By contrast, the least expensive 50% of the population accounts for only 3% of health-care expenditures."⁵ Naturally, insurance is a mechanism to help manage such gross risk distribution disparities. Such a model creates a form of health-care entitlements, due to its basis in an exchange relationship.

The chapter provides the foundation for his health-care entitlement argument as he unfolds the concepts of insurance, risk rating, risk pooling and ultimately, why individual health insurance does not work. Jost distinguishes health insurance from other types of insurance—rather than insuring a person's wealth, it instead insures a person's existing health.⁶ Additionally, health insurance premiums are based on immutable characteristics, such as "age, gender, health status, claims history and geographic location," characteristics that a person has little control over.⁷ Jost also notes key problems presented by private health insurance, such as affordability, biased selection, and high administrative costs⁸ of individual

4. *Id.* at 8.

5. *Id.* (citing Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures Revisited*, 20 HEALTH AFFAIRS 9, 12 (Mar./Apr. 2001)).

6. DISENTITLEMENT, *supra* note 1, at 10. "Typically, a 60-year-old male pays more than three times the premium paid by a 25-year-old male for the same coverage." *Id.* at 11, (citing DEOBRAH J. CHOLLET & GREGORY R. NIEHAUS, RISK MANAGEMENT AND INSURANCE 43 (Irwin/McGraw-Hill 1999)).

7. DISENTITLEMENT, *supra* note 1, at 10.

8. "[The costs for health insurers to choose risks carefully] may equal as much as 40% of premiums for individual policies, and as little as 6% of premiums for the large group policies. None of the money spent on these costs, however, goes for health care." *Id.* at 14.

insurance.⁹ His solution to the "health insurance conundrum"? Entitlements.

Virtually all developed nations entitle their residents, as a matter of law, to basic health-care services.¹⁰ As Jost notes, entitlement programs are founded on the concept of social solidarity—"on the belief that all of us are vulnerable to disease and accident, and thus all should be insured against these perils."¹¹ Despite the fact that the United States has far more uninsured people than other developed countries, health insurance has been made widely available through our three health-care entitlement programs.¹² These programs have extended health coverage to the elderly, poor children, pregnant women, the long-term disabled, and eighty-five percent of the working population.¹³ However, Jost points out that significant coverage gaps still remain, including many of the near-elderly, young adults, and the working poor.¹⁴ *Disentitlement* was written prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,¹⁵ which will provide Medicare beneficiaries with a prescription drug benefit, beginning in 2006. Therefore, Jost's critique that Medicare coverage excludes prescription drugs has since been addressed, at least in part. However, Jost also critiques Medicare for its exclusion of long-term care.¹⁶

But Jost warns that such solidarity-based programs are in

9. *Id.* at 11-14. "Because of the high administrative costs attending individual insurance, and because biased selection makes individual insurance unaffordable to those who need it most, no country relies on individual health insurance sold in private markets to cover its entire populations." *Id.* at 14.

10. *Id.* at 14-15.

11. *Id.* at 15.

12. *Id.*

13. DISENTITLEMENT, *supra* note 1, at 15.

14. *Id.*

15. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, § 101, 117 Stat. 2066. See Drew E. Altman, *The New Medicare Prescription-Drug Legislation*, 350 NEW ENG. J. MED 1, 9 (Jan. 1, 2004). Touted to be the most important health care legislation passed by Congress since the enactment of Medicare and Medicaid in 1965, the Act has been met with mixed results. Liberals criticize the benefit as being too meager and believe that private health insurance plans will profit off the healthiest beneficiaries, ultimately undermining the traditional program by driving up the costs over time. On the other hand, conservatives are unhappy with the establishment of a big new entitlement program and feel that the legislation does not do enough to control future Medicare spending. Medicare beneficiaries will obtain their drug benefit from private health maintenance organizations.

16. DISENTITLEMENT, *supra* note 1, at 17.

jeopardy.¹⁷ In recent years, conservative policy proposals have threatened to bring about disenfranchisement by replacing the solidarity principle with markets.¹⁸ "In their ideal system, all would pay their own way (with the assistance of tax credits for the poor), and all would purchase as individuals in health insurance markets."¹⁹

PART II: THE HISTORY AND CHARACTER OF AMERICAN HEALTH-CARE ENTITLEMENT

Chapters three and four explore the second theme within *Disenfranchisement*—the extensive and arduous history surrounding the emergence of health-care entitlements. Specifically, in chapter three, Jost considers the nature of American health-care entitlements from a variety of legal perspectives. Upon examining the legal ramifications of entitlement status, Jost notes that "[a]lthough the U.S. Constitution does not guarantee [an entitlement to health care], such a fundamental human right to health care is widely recognized throughout the world, both in international human rights law and in the constitutions of many nations."²⁰ Article 25 of the Universal Declaration of Human Rights states: "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of . . . sickness, [and] disability."²¹ Additionally, the International Covenant on Economic, Social, and Cultural Rights (ICE-SCR) provides: "The State Parties . . . recognize the right to everyone to the enjoyment of the highest attainable standard of physical and mental health."²²

In response to the lack of any constitutionally protected health-care rights, Jost remarks how "the U.S. Constitution is the product of the late eighteenth century, not from the late twentieth century. It reflects a time when the primary concern of nation builders was to protect citizens from arbitrary and

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.* at 24.

21. *Id.* at 24-25.

22. DISENFRANCHISEMENT, *supra* note 1, at 25, quoting Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICE-SCR) (1966).

oppressive government."²³ At the time, protection of health and welfare were of local concerns.²⁴ The remainder of the chapter looks at Medicare, Medicaid, and federal tax subsidies as statutory entitlements, the federal court's protections of these entitlements,²⁵ functional meanings of entitlements for providers and beneficiaries,²⁶ entitlements as a budget function, and political entitlements.

Chapter four explores the history and character of health-care entitlements in this country. Regarding the negative connotations Americans have towards entitlements, Jost notes: "Americans have always put a high value on self-reliant individualism. Dependence on the community or state, it is widely believed, is shameful; an admission of personal and moral failure."²⁷ Jost traces the "emergence of welfare and social insurance programs up through the New Deal and discuss[es] federal health-care programs that preceded the Medicare and Medicaid programs, including tax subsidies for employment-based health insurance."²⁸ This section focuses on the origins of entitlements, the rise of entitlements, the emergence of social insurance in Europe,²⁹ the American response and entitlements under the New Deal, public insurance in the United States,³⁰ and the birth of tax-subsidized employment-related health insurance.

Focusing mainly on their entitlement characteristics, Jost examines the important debate surrounding the Social Security amendments of 1965 that created these entitlement programs.

23. *Id.* at 25.

24. *Id.* (citing Wendy Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267, 293 (Winter, 1992)).

25. DISENTITLEMENT, *supra* note 1, at 38. Ultimately, "the lack of a constitutional right to health care means that the courts cannot generally call into question the decisions that the legislature makes with respect to health care." However, American courts "do take responsibility for interpreting legislation and thus will hear challenges against the acts of administrative agencies in applying entitlement law." *Id.*

26. *See id.* at 39-44. Functional meanings include eligibility, benefit coverage, provider participation, and provider payment.

27. *Id.* at 65.

28. *Id.* at 66.

29. *See id.* at 71. "The notion of social solidarity as a basis for public health insurance has always enjoyed a much firmer foundation in Europe than in the United States, across political boundaries."

30. "At the outset of the twenty-first century, health insurance costs are again on the increase, and the number of those insured through their place of employment is again dropping. But employment-related health insurance remains our primary source of insurance coverage." *Id.* at 80.

Specifically, Jost concentrates on the birth of public assistance health-care programs and the efforts to create universal social health insurance in the United States.³¹

Additionally, Jost considers Medicare and Medicaid's development as entitlement programs in the decades following their creations, including the evolution of rights to employment-related insurance benefits under ERISA. In particular, this section addresses statutory entitlements in the Medicare and Medicaid legislation, access to judicial review under Medicare³² and Medicaid, and beneficiary rights under ERISA. This chapter provides the framework for the following four chapters in which Jost explores recent and proposed changes that would restrict these entitlements.³³

31. "The rabid anticommunism of the late 1940s and early 1950s put on hold any further attempts to expand government funding of health-care services. . . . Nevertheless, pressure for national health insurance was quietly building among organized labor and the elderly." DISENTITLEMENT, *supra* note 1, at 83.

32. At the inception of the legislation:

The limitations imposed by the Medicare statute on administrative and judicial review soon began to impose hardships on Medicare beneficiaries and providers who were denied either services or payment under Part B, without recourse to review beyond the carrier, or who were required to endure long and often costly delays while exhausting Part A remedies. *Id.* at 89.

Over the past few decades, since the creation of Medicaid, the Supreme Court has effectively campaigned to "limit and channel review of Medicare decisions." *Id.* at 91. See generally *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) (permitting providers to omit the purely formal step of contesting the validity of Medicare regulations at the first, intermediary level of review, as long as the providers properly raised the regulatory issue when it obtained agency review subsequently at the Provider Reimbursement Review Board (PRRB) level); *Mich. Acad. of Family Physicians v. Blue Cross & Blue Shield of Mich.*, 476 U.S. 667 (1986) (holding that federal courts had jurisdiction to review the 'method' under which Part B benefits were determined, even while acknowledging the statute's absolute preclusion of jurisdiction to review Part B benefits determinations themselves.), but see *Shalala v. Illinois Council on Long-Term Care*, 529 U.S. 1 (2000) (effectively abandoning *Michigan Academy*, limiting its application to situations where administrative review was totally precluded by statute); *Heckler v. Cmty Health*, 466 U.S. 602 (1984) (holding that 1) claims were essentially claims for payment of benefits as to which administrative remedies had to be exhausted, 2) exhaustion of administrative remedies would not be futile, and 3) decision of the Secretary that the surgery was not reasonable and necessary and means chosen by the Secretary to effectuate that decision were discretionary decisions not subject to review by mandamus.); *Schweicker v. McClure*, 456 U.S. 188 (1982) (finding that the provisions of Medicare limiting Part B appeals to hearing officers chosen by the carriers did not violate the Due Process Clause); *U. S. v. Erika*, 456 U.S. 201 (1982) (rejecting Court of Claims jurisdiction in Part B cases); *Weinberger v. Salfi*, 422 U.S. 749 (1975) (rejecting general "federal question" jurisdiction in Social Security Act cases). Jost surmises: "[e]ven though the Medicare entitlement is facially absolute, therefore, it is in fact primarily an entitlement to an administrative process, with judicial review only available in extraordinary cases." DISENTITLEMENT, *supra* note 1, at 91.

33. DISENTITLEMENT, *supra* note 1, at 66-67.

PART III: THE THREATS THAT AMERICAN HEALTH-CARE ENTITLEMENTS FACE

Chapters five through eight address *Disentitlement's* third theme—the continual opposition entitlements face by powerful economic and ideological interests. Jost initiates his investigation with chapter five, in which he surveys experiments with privatization in the forms of Medicare and Medicaid managed care. Topics within this chapter include: the history of Medicare managed care (and the analysis of their successes and failures); a balance sheet of Medicare plus choice; the outlook for Medicare managed care; Medicaid managed care; a history of Medicaid managed care; and an evaluation of Medicaid managed care.³⁴ Jost concludes that these programs, however, have not been as beneficial as one would expect:

Although these [managed care] programs have certain achievements, particularly in the Medicaid program, on the whole they have not saved money and have a mixed record on improving accessibility and quality. The Medicare and Medicaid managed-care experience, therefore, gives us more reason to be cautious than to be enthusiastic about privatization and individualization of public health-care entitlements.³⁵

In chapter six, entitled "Medicare 'Reform': Disentitlement through Privatization," Jost asserts that privatization would not be good for Medicare:

The greatest threat to contemporary American health-care entitlements . . . is the movement advocating the privatization of Medicare. This movement threatens to privatize both the delivery of Medicare services (through voucher or premium support proposals) and the financing of Medicare (through proposals to create individual investment accounts). Either form of privatization would endanger Medicare as a universal social insurance program for the elderly and disabled.³⁶

34. *Id.* at 111-29.

35. *Id.* at 111.

36. *Id.* at 138.

Jost points out that the arguments in favor of privatization stem from the 'disastrous' future of Medicare.³⁷ "First, the babyboom generation . . . will be reaching age 65 beginning in 2011, swelling the ranks of those receiving Medicare for the following half century."³⁸ From this fact, Medicare enrollment is expected to rise from the current 15% of the population to 20% in 2025 and 25% in 2073.³⁹ Second, due to lowered fertility rates, which have dropped in decades following the baby boom, there will be fewer workers available to finance Medicare as the baby boomers move into retirement.⁴⁰ The third problem is that individuals are living longer.⁴¹

Despite the naysayers' worries about the financial future of Medicare, Jost contends "[t]he bottom line . . . is that Medicare, as federal program, can no more go bankrupt than can the Defense Department or, for that matter, the Congress. The trust fund is primarily an accounting artifact."⁴² Regardless, the ominous bankruptcy argument has "often served as a popular rallying cry for those who would like to shrink the program or to privatize it."⁴³

The remainder of the chapter speaks to problems with the

37. *Id.*

38. *Id.* (citing David McKusick, *Demographic Issues in Medicare Reform*, 18 HEALTH AFFAIRS 194 (Jan./Feb. 1999)).

39. DISENTITLEMENT, *supra* note 1, at 138-39 (citing McKusick, *supra* note 38, at 196).

40. DISENTITLEMENT, *supra* note 1, at 139. The fertility rates have dropped "from 3.6 children per couple in the late 1950s to about 1.8 in 1976 and to 2.0 today." *Id.* at 139, n.5.

41. *Id.* at 139. "Between 1960 and 1999, the life expectancy of persons who reach age 65 increased by 3.4 years. In 1999 there were 4.2 million Americans aged 85 and older, compared to only 929 thousand in 1960." *Id.* (citing NATIONAL CENTER FOR HEALTH STATISTICS (NCHS), HEALTH, UNITED STATES, 2001 (NCHS 2001) table 163, p. 127). Jost also addresses the argument that Medicare costs may increase due to beneficiaries requiring more services as they age:

In fact, however, although expenditures in the last two years of life increase with age of death, this increase is primarily due to the cost of nursing-home care for the very old, which is only covered by Medicare to a very limited extent. Medicare expenditures during the last two years of life decline from \$37,000 for persons who die at age 75 to \$21,000 for those who die at age 95." DISENTITLEMENT, *supra* note 1, at 139 (citing Brenda C. Spillman & James Lubitz, *The Effect of Longevity on Spending for Acute and Long-Term Care*, 342 NEW ENG. J. OF MED. 1409, 1412).

Despite the dispelled correlation between Medicare expenditures and aging beneficiaries, Jost reminds us that: "But the simple fact that Medicare beneficiaries remain on the rolls longer will drive up costs, even if their care does not become more expensive with age." DISENTITLEMENT, *supra* note 1, at 139.

42. *Id.* at 140.

43. *Id.*

current Medicare program,⁴⁴ how Medicare might be modernized,⁴⁵ and whether "reform" is really necessary. Regardless of the approach to possible Medicare reform, Jost suggests cautious behavior is necessary and to follow the ancient medical nostrum, *primum non nocere* (first do no harm).⁴⁶ To illustrate this message, Jost writes of a recent time of financial prosperity—the federal surplus of 2000. While one of the agreed upon ideas of both President Clinton and Congress was to use part of the surplus to help the Medicare and Social Security programs, unfortunately, "the intoxication of actually having money to start paying down debts was too much for the politicians to bear; huge tax cuts followed, as well as an unexpected war, and before long, the surplus was gone."⁴⁷ Ultimately, Jost draws the important lesson: Expect the unexpected.⁴⁸ In his words, "[t]o make dramatic changes in the program based simply on pure speculation about what the world will look like in three-quarters of a century would be the most foolish thing we could do."⁴⁹

Chapter seven evaluates Medicaid and its disenitlement through devaluation. Jost traces the history of devolution from the beginnings of the program to 1965-1994, a time of expansive federal control, to the following years, when the tide shifted towards greater state discretion,⁵⁰ and, as a result, further devolution.⁵¹ Jost assess Medicaid's devolution and concludes that if it only includes the poor, it will always have problems; a

44. The author cites a lack of outpatient drug coverage (a problem which will be addressed starting in 2006, due to the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *see* discussion *infra* p. 183), poor coverage for long-term care, high and irrationally targeted cost sharing, poor coordination of care, and slow-moving approach to new medical technologies. *Id.* at 141-43.

45. Jost looks at possible suggestions, such as a defined contribution program, competitive contracting, and proposals for private Medicare financing.

46. DISENTITLEMENT, *supra* note 1, at 154.

47. *Id.*

48. *Id.*

49. *Id.*

50. Jost references that the sources for greater state discretion stem from waivers of federal statutory requirements, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the Balanced Budget Act (BBA) of 1997 (providing the option of Medicaid managed care to become universally available to the states), and the State Children's Health Insurance Program (SCHIP) (SCHIP was explicitly created as a nonentitlement program. Jost quotes the SCHIP statute as saying: "Nothing in this subchapter shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan." DISENTITLEMENT, *supra* note 1, at 170.).

51. *Id.* at 162-72.

comprehensive program is necessary:

Our experience with Medicaid . . . has demonstrated that a program for the poor will always be politically vulnerable, underfunded, and generally inadequate. No other developed country covers only its poor with its health-care entitlement programs (through some provide extra benefits, such as the waiver of cost-sharing requirements to the poor). Only if the poor are included in a comprehensive program for the general population will they receive adequate and dignified health care.⁵²

Chapter eight looks at tax credits for health insurance and asks if this is a disentanglement of America's workers. In particular, Jost makes a critique of employment-based health insurance tax subsidies; examines why this type of health insurance persists and what the most significant problem with employment-related insurance is;⁵³ and discusses the individual tax credit solution.

Jost believes that "[b]ecause this system encourages group solidarity at the employer level, it deals reasonably effectively with the problems of biased selection that bedevil individual health insurance markets."⁵⁴ Despite the systems' many faults, "it has extended insurance to 172 million Americans, far more than have been reached by the individual insurance market, and even more than are covered by public insurance."⁵⁵

However, our current employment-based health insurance system still faces many problems, such as inequity in distribution of benefits, job lock, and dampening effects on wage growth.⁵⁶ Jost compares most countries' progressive financing of health insurance to the regressive nature of U.S. health insurance

52. *Id.* at 178.

53. "[T]he greatest limitation of the employment-related insurance tax preference entitlement is that it does not afford Americans a right to health insurance by virtue of their citizenship or residency in the United States, but rather provides an entitlement to a tax subsidy (the value of which varies depending on the extent of the insured's tax exposure), which only benefits employees who (1) work for employers that offer health insurance benefits and (2) choose to accept those benefits (and to pay the employee's share of health insurance premiums)." *Id.* at 189.

54. *Id.* at 197.

55. *Id.*

56. DISENTITLEMENT, *supra* note 1, at 197.

financing situation:⁵⁷

In most countries, financing of health insurance is progressive, not regressive as in the United States. Yet the proposals currently being debated for devolution and individualization head in the wrong direction. They would only modestly expand coverage at best, would do little for the sick and elderly uninsured (those most in need of coverage) and might well destroy a system that currently works reasonably well. What we need, rather, is a program that will build on, not tear down, what we already have.⁵⁸

PART IV: HEALTH-CARE ENTITLEMENTS IN OTHER COUNTRIES

Just next turns to examples of countries that have designed such systems: the British National Health Service (NHS) and the German social health insurance system. Chapters nine and ten concentrate on his fourth story—what health-care systems look like in other countries. Britain's NHS serves as a national health service model, while Germany's program represents a social insurance model. The key difference between the two is the source of spending. National programs, like Britain's, are primarily funded from general tax revenues,⁵⁹ while social insurance systems are primarily funded through payroll taxes from employers and employees.⁶⁰ Each country uses some general-revenue funds.

In reference to the British system in chapter nine, the hallmarks of the model are "payment for health-care services from general taxes and direct government provision of health care."⁶¹ Jost provides brief history of the program, an overview of its organizational structure,⁶² the nature of NHS

57. *Id.*

58. *Id.* at 197-98.

59. *Id.* at 204.

60. *Id.* at 238.

61. *Id.* at 204.

62. Notably, "[t]he British [NHS] is one of the largest employers in the world, with around one million employees" DISENTITLEMENT, *supra* note 1, at 206. Also, "unlike the United States or Germany, specialists are found almost exclusively within hospitals. [General practitioners] in the community serve a gatekeeper function, seeing patients initially and referring them to hospitals for outpatient specialists consultations, or perhaps

entitlements,⁶³ and the advantages⁶⁴ of the model, as well as its disadvantages and problems.⁶⁵

Jost emphasizes that perhaps the most important lesson that can be gleaned from the British experience is the importance of legal health-care entitlements: "[t]he fact that a British citizen cannot successfully sue the NHS for denied services goes far to explain why services are often not available."⁶⁶ In addition, the NHS experience also shows the hazard of depending on single-source funding. Jost instead suggests that a publicly funded health service should come from several sources, such as both general revenues and dedicated taxes, "or from both national and regional governments."⁶⁷

The positive lessons Jost takes from the British system are that, as opposed to the privatizers' fearful, doomsday scenarios, it is possible to effectively control health-care costs in a public system. Additionally, public health-care systems make equitable health-care access significantly more available and can facilitate primary and coordinated care.⁶⁸ Lastly, this program allows professionals the freedom to use their own judgment when serving patients.⁶⁹ Jost concludes that "[a]lthough the British NHS system is flawed, in sum, we should still attend to it in considering the redesign of our own badly flawed system."⁷⁰

Chapter ten explores the German public health-care system—the oldest (and perhaps most successful) public health-

for inpatient admission, as needed." *Id.* at 207.

63. "The NHS was founded on a vision of providing a comprehensive, publicly funded services, free at point-of-service delivery." *Id.* at 208. Jost continues by quoting the National Health Service (NHS) Act:

Every man and woman and child can rely on getting all the advice and treatment and care which they need in matters of personal health; that what they get shall be the best . . . ; that their getting these shall not depend on whether they can pay for them or any other factor irrelevant to the real need The service must be "comprehensive" in two sense—first, that it is available to all people and second, that it covers all necessary forms of health care. *Id.*

64. Namely, equitable access to health care, effective cost control, emphasis on primary care, clinical freedom, and central coordination and direction. *DISENTITLEMENT*, *supra* note 1, at 208.

65. In particular, lack of resources, prevalence of wait lists, lack of access to technology, and continuous reorganization. *Id.* at 222-27.

66. *Id.* at 227.

67. *Id.*

68. *Id.*

69. *Id.*

70. *DISENTITLEMENT*, *supra* note 1, at 227.

care financing system in the world.⁷¹ Jost finds this system a useful study model, because it makes available "universal access to sophisticated and up-to-date health care with minimal rationing of services" and though it is relatively expensive, according to international standards, it still costs less than our own system.⁷² Jost claims that the German system can help our consideration of entitlements in the following four respects:

1. The model of social insurance, created in Germany and followed in the design of our own Medicare system, has proved adept at developing both a psychological expectation of and cultural commitment to health-care entitlements, which, in turn, have led to a high level of societal commitment to the sharing of health-care risk.

2. The German approach of affording statutory—indeed, constitutional—guarantees of health care on the one hand but operationalizing them through quasi-public, self-governing, corporatist insurance and provider institutions on the other hand, creates a system in which political, professional, and market forces all play a part. At its best, this system draws on professional expertise, democratic governance, and legal oversight to offer a reasonably effective, responsible, and accountable system of health-care provision and coverage.

3. The German system of negotiated, fixed sectoral budgets affords a greater capacity for exerting fiscal discipline than the U.S.'s open-ended budgetary entitlements, but at the same time it provides greater flexibility than the more constrained British National Health Services.

4. The German social court system, as it operates in the context of the health-care system, provides a useful model of how courts can protect entitlements while still observing budget controls.⁷³

71. *Id.* at 235 "Initiated by Otto von Bismarck in 1883, the German social health insurance system served as the model for public health insurance systems throughout the world through the middle of the twentieth century, and it continues to exemplify one of the primary approaches to public health-care financing." *Id.*

72. *Id.*

73. *Id.* at 235-36.

Jost explores the above aspects of the German system and examines how they are operationalized in the following contexts: "making coverage decisions with respect to new or unconventional medical treatments and payment for physician's services."⁷⁴ Lastly, Jost notes the emerging problems with the German system.⁷⁵ Jost surmises that the German system, nonetheless, remains an excellent model:

Despite its problems, however, Germany . . . still has much to offer as a model for designing health-care entitlements. In fact, Germany has succeeded in providing technologically advanced health-care services to all its residents at a relatively reasonable cost, and has done so under the reasonably exercised oversight of legal institutions that have supported the goal of cost control while respecting the rights of insureds and providers.⁷⁶

PART V: LESSONS

The final chapter, "Toward an Entitlement-Based Health-Care System," describes the different categories of entitlements, followed by conclusions regarding various choices within these categories and their resulting practical implications.⁷⁷ Jost categorizes health-care entitlements in terms of the conceptual basis of the rights asserted, the legal enforceability of those rights, the populations that they protect, and the extent to which they require the participation of others in addition to the government to be effectuated.⁷⁸

Following this examination is the cream of the book—the take-home lessons for the United States. Building on the broad and thorough analysis of health-care entitlements, Jost makes two key points. The first is that a private market in individual

74. *See id.* at 236, 236-55.

75. These problems include: the limitation of its financing mechanism, the less regressive contribution approach than private insurance-based systems, problems within the wage-based contributions (i.e.: high level of premiums, the tendency that the program is funded by those with lower incomes and without much help from the wealthiest of society, and participants' contributions that are based solely on their wages), and increasing costs. *See generally id.* at 255-57.

76. DISENTITLEMENT, *supra* note 1, at 257.

77. *Id.* at 265.

78. *Id.*

health insurance does not and cannot assure universal access to health insurance.⁷⁹ Insurance for health care is unique. If a need for insurance is based on health instead of wealth, the most vulnerable—the elderly and the chronically ill—are less likely to afford coverage. Administrative costs associated with free market regulation become useless in terms of providing health care. Compared to group-based alternatives, the administrative costs associated with regulating individual health insurance makes the price unnecessarily high.

The second key point Jost makes is based on the conceptual basis for legal entitlements, which plays a crucial role in the long-term viability of health-care financing and delivery systems.⁸⁰ Additionally, social insurance entitlements are the most politically sustainable. In relation to how to finance a health-care system, “[t]he best system might be one based on a hypothecated tax that is based on income generally and is not subject to any caps.”⁸¹ Other important finance lessons include: “we must learn from other nations in that completely open-ended budgets for health-care entitlement programs are not sustainable. We must accept limits, and then develop legal institutions that can reasonably allocate resources within those limits.”⁸²

With respect to the enforceability of rights, Jost argues that “the best approach is likely to be to afford an entitlement to a process—preferably a process that involves health-care experts, representatives of the public, and persons who are legally trained.”⁸³

One of the most vital lessons that *Disentitlement* extracts is that the insurance model creates the most sustainable form of health-care entitlements, due to its exchange relationship. The insured pays a premium, contribution, or payroll tax and, in exchange, receives health-care coverage when needed. In addition to allowing for pooling of risk, this exchange relationship creates political and legal entitlements.

Disentitlement provides readers with a thoroughly comprehensive overview of the nature and importance of health-care entitlements. As tempting as the seemingly logical

79. *Id.* at 270.

80. *Id.*

81. *Id.* at 271.

82. DISENTITLEMENT, *supra* note 1, at 276.

83. *Id.* at 272.

arguments for market-based health-care system may be,⁸⁴ Jost repeatedly demonstrates how "competition in unregulated markets for health-care financing focuses on avoiding risks, thus diminishing access. It has also proved largely ineffective in controlling costs."⁸⁵

While Jost does not pretend to provide a complete blueprint for a reconstructed health-care system, he does assert his premise that "it is vital to consider the role of legal rights."⁸⁶ Legal entitlements are necessary to ensure universal access to health insurance and health care. When the day comes for true health care reform, this lesson should not be forgotten.

84. The notion that "competition promotes choice, quality, and innovation and brings down cost, in turn extending access." *Id.* at 278.

85. *Id.*

86. *Id.* at 277.