

## States and Health Care Reform: Solutions or Illusions?

In recent years, Oregon was first on the road of good intentions. More recently, it was followed by Tennessee, Minnesota, Maine, Vermont, Massachusetts, California..., with Maine being the first with universal health insurance as its objective (Dirigo Health Reform Act, 2003). Shouldn't it be clear by now where the road leads? Can states really expect to go it alone, or are they perpetrating illusions?

The greatest value to health care delivery would be achieved through a single-payer<sup>1</sup> health care system, the only way of attaining both universal coverage and built-in cost control, for its administration would be a function of public policy. And that would enable it to employ its power of reimbursement to create a health care system to match, one that could promote wellness through public health and primary care. But such a program is both politically infeasible and impossible for a state without federal support. Federal funding through Medicare, Medicaid, SCHIP, and other federally-controlled programs would have to be made available.

States need to rely on employer-provided health insurance to subsidize their plans, so they are forced to see this as part of their solution instead of the problem it is. At best, it is a two-edged sword in that the state then assumes responsibility for completing a service package more adequate than that included in private insurance. And should a state wish to require that employers cover their employees with adequate health insurance, under ERISA, the state may require a federal waiver to do so. Almost everything else a state does to ensure its citizens have insurance tends to undermine the need for, and the willingness of, employers to continue bearing the burden of providing it. And it is hard for states to avoid employing administratively complicated means tests, graduated premiums, copays, deductibles, uncovered expenses, and other such cost-saving devices that soon become barriers to care, effectively preventing them from achieving universality. All these ploys do is to obscure the fundamental principle that no private insurance instrument can do anything to make health care more affordable in the aggregate. On the contrary, by adding 20 percent or more in overhead in the form of marketing, processing enrollments, and collecting premiums, they make costs even more unaffordable.

**Access to universal health care will never be achieved until we realize that private insurance and employer-provided coverage are the Trojan horses of the American health care non-system.**

States have no control over medical cost inflation, being unable to set prices, limit utilization, or reverse the inexorable demographics of aging. The inflation in costs is due to service factors beyond state control, primarily the erosion of primary care, and the waste fueled by the profit motive – the administrative inefficiencies of private insurance companies, the expense of high-tech modalities, and ever higher prices. The price of private insurance too rises much faster than inflation<sup>2</sup> and state tax rates, so every year that passes widens the gap between the costs of state-funded universal health insurance and the ability of a state to cover the costs. And no allowance is made for the effects of all the state's players "modeling the system," resulting in higher costs than originally projected. States are required to have balanced budgets, so they soon reach a point where their plans become economically or politically unsustainable, or ineffective in solving their original problems. And to the extent that a state were successful, it would attract as new residents those people most costly for it to cover.

None of this should be seen as critical of states' efforts to better extend a safety net over their medically uninsured, and that is in fact about all they can achieve through their attempts at "universal health coverage." How many such political experiments does it take before we will perceive these tragedies as farce?

From following state politics, one would never think there could be a science of health policy. Wouldn't you think that states would know by now that they haven't the means to support a program to ensure adequate health care for all of their citizens? And that the principal reason why they can't is because they won't ... limit the profits of their insurers and other profit centers in their health care industry?<sup>3</sup> Why do most state programs *add to* the profits of providers, providers who benefit from the waste represented in that fragmentation of effort? Doesn't this bring us to consideration of the politics of states, and of the nation?

### **Political Options, Social Consequences**

An imbalance between rich and poor is the oldest and most fatal ailment of all republics.

-- Plutarch

Plutarch was quite literally correct. Life expectancy is greatest in those nations that display the lowest income inequality gradients – Japan and the Scandinavian countries – while nations like the U.S. and the U.K. with higher gradients have lower life expectancies. And here in the U.S., the states with the least income disparities – Utah, Iowa, New Hampshire – have the best population health, while those with the greatest disparities – Louisiana, Mississippi, New York – have the worst.

The very painful fact that explains the states' dilemma is that we have allowed the polarization of our population by income to grow to the extent that it precludes a means of achieving universality in affordability. To achieve this now utopian goal, we would either have to impose highly graduated premiums according to income, or return to the highly progressive income taxes we had a half-century ago. And this, the most equitable solution for our society as a whole, is the least politically feasible of all. The moral here isn't just about health care, it fits the whole society. True health care reform will require us to once again see taxes as "what we pay for a civilized society." (Oliver Wendell Holmes, Jr.)

It isn't just that the perception of inequality has adverse health consequences, poverty also prevents its victims from participating more fully in what their communities have to offer. New York Times columnist Nicholas Kristof, writing about what he saw in post-Katrina New Orleans, provides this commentary:

What we've seen over and over is that even if there is a free clinic, the poor family may depend on a single mother who doesn't have a car or driver's license and so can't get there. Or she can't afford the gas. Or her car doesn't have insurance. Or she doesn't understand how serious the symptoms are. Or she is working at a low-level job where she can't just ask for time off to take a child to the clinic. Or she doesn't speak English. Or she's illegal and is worried that INS agents may look at the

clinic's records. Or she's got three other small children and can't leave two at home while she takes her sick child on a series of bus rides to the clinic. Or...the possibilities are endless. The point is that making medical care accessible to the poor requires much more than making it free.<sup>4</sup>

And the larger point is one that needs to be appreciated by the electorate and the candidates: Health care reform to achieve universal health care will be of limited benefit to those most in need of it unless we address those upstream factors that are uniquely the province of good governance. Poverty is one, for it is exclusionary. The most effective way of overcoming the syndromes of poverty is through the liberating empowerment of good education, but poverty is also the major impediment to its success.

So what is the outlook for true health care reform? I find it in a highly provocative statistic: There are 172 countries that conduct elections. The U.S. is 139th in the percentage of eligible citizens who vote. If we were truly serious about improving public health, first among its "Ten Essential Services" would be Encouraging People to Participate in the Political Process.

It seems that the only positive outcome of all of this might be to inform and motivate the electorate to seek nationally the solution that their states have tried, and failed, to achieve. And that will have to start with the realization that we have long gotten used to looking at this and other major social problems with blinders on. Among our blind spots are

- Giving disproportionate weight to individual freedoms over communitarian needs;
- Translating love of freedoms into "market competition" as the answer to all needs without appreciating the need for government to set rules and standards making those "markets" responsible for producing public goods;
- Thinking that being poor is a moral failure for which the individual alone is responsible;
- Believing that our taxes are inordinately high (They are lower in relation to GDP than any other nation in the OECD<sup>5</sup>), and seeing income redistribution as *inequitable*;
- Seeing government, and especially its spending, as the problem. (This is *half right*. We are the government, but our ignorance is the problem.)
- Failing to so much as understand the very concept of "public health," and valuing medical cures instead of the temperate lifestyles that would improve quality of life and largely obviate need for them.
- Making all these things into ideological/political struggles among special interests instead of seeing them for what they are – an imperative to all of us to practice greater compassion and *civitas*.

But what has to be the most embarrassing of all national blind spots is our parochial view of health care itself, one that blinds us to our status as a third-world nation in terms of health care outcomes. Embarrassing us not only to the rest of the world, but to ourselves for achieving so little true benefit for what we spend. Worst of all, it blinds us to the lessons available in the many examples of more efficient health systems of the world's nations, and in the efforts of the World Health Organization to promote public health, lessons that ought to guide us toward improvement.<sup>6</sup> Instead,

our nation's most outstanding feature is being the world's only industrialized nation that does not have health care as a right of citizenship, and resists doing anything about it, instead attacking its advocates as villains. All this serves to do is to obscure the fact that designing a health care system that efficiently provides the means to improve the health status of all citizens is not especially complex. What is inordinately complex are the forces battling any fundamental change to the status quo, forces behind a national battle intended to exhaust far more effort than needed for an effective solution.

These days it can be depressing to acknowledge that we live in a democracy, for as has often been noted, in a democracy, people get the government they deserve. Before we can expect to develop a health care system that works in our interest, we will need to develop a democratic process and a government that does. **The best way, really the only way, to improve public health is to improve the public in it.**

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<sup>1</sup> A more radically egalitarian set of values along with even greater efficiency could be achieved through a no-payer system – one owned and operated by the government as in the U.K. and the Scandinavian countries. If health care is seen to be a *right*, then its provision is an *entitlement*.

<sup>2</sup> In 1987, health insurance cost 7.7% of median family income. By 2004, even with the intervening cost-dampening effects of managed care, that figure had risen to 18%.

<sup>3</sup> Eliot Spitzer's promise to do nothing less than this as New York's new governor distinguishes him from the politics-as-usual approach in other states. See my "Health Care Reform in New York: Looking Forward and Looking Back," in *Health Planning TODAY*, 1<sup>st</sup> Quarter 2007.

<sup>4</sup> Nicholas D. Kristof, "Wretched of the Earth," *The New York Review of Books*, 54, 9 (May 31, 2007). <http://www.nybooks.com/articles/20230>.

<sup>5</sup> *BMJ*, doi:10.1136/bmj.39042.375544.BE (published 23 November 2006).

<sup>6</sup> It seems obvious that we have closed minds about American health care, a condition that has been ascribed to American education as well: "The most successful tyranny is not the one that uses force to assure uniformity but the one that removes the awareness of other possibilities, that makes it seem inconceivable that other ways are viable, that removes the sense that there is an outside." Allan Bloom, *The Closing of the American Mind* (Simon & Schuster, 1987), p. 249. This book's radically unorthodox take on higher education opened it and our culture to scrutiny, much as the documentary *Sicko* is now doing for health care.

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