

Universal Health Care

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The last attempt to formulate a national plan for universal health care ended 11 years ago with the collapse of the Clinton Plan for “health care reform.” Since then, there have been incremental initiatives toward greater health care coverage, notably HIPAA and SCHIP, but as laboratories for developing universal health care, the states have not been able to marshal the necessary political and economic resources. This may now be changing. According to the National Conference of State Legislatures, at least 18 states currently have introduced legislation regarding universal health care: California, Colorado, Connecticut, Florida, Hawaii, Kansas, Illinois, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, and Vermont.

Maine.

Maine’s Dirigo Health plan has gotten considerable attention since it was signed into law in 2003. It is a voluntary, market-based plan, intended to achieve universal coverage in the state by 2009. It was designed to provide small businesses and employees with an option for coverage. But as a voluntary plan, it will fall far short of universal coverage, for it uses private marketplace health insurance, with premiums subsidized by the state on a sliding scale based on family income. Maine contracts with Anthem Blue Cross and Blue Shield of Maine and competes with existing health plans to offer health coverage to employees who work at least 20 hours per week. Employers must offer coverage to dependents and families. Employers cover at least 60 percent of the cost of the workers' premiums, and employees must then pay the remainder of the cost. The state now provides coverage for families earning up to 300 percent of the federal poverty level. Maine has about 138,000 uninsured citizens to cover. Officials have yet to resolve several funding issues, including how to redirect anticipated savings for insurers.

Vermont.

On April 21, the Vermont House passed and sent to the Senate a bill to create a single-payer system under which all Vermonters would gain coverage for all health services determined to be “essential” by the state government. It would create a health care delivery system that is “equitable, universal, well-coordinated, patient-centered, cohesive, unified, comprehensive, continuous, sufficient, fair, sustainable, and accountable,” establish cost containment targets, and enforce them through global budgets for hospitals and caps on physician reimbursement rates. The state would impose “play or pay” taxes on both employer payrolls and employee paychecks at businesses that don't offer health insurance. State health planning would be brought back in the form of an “integrated, community-based system” overseen by regional community health boards composed of citizens. The cost to the state would be about \$2 billion per year, but it could save Vermonters more than \$118 million a year over current medical insurance costs and cover every Vermonter in the process, according to a study by the Lewin Group.(1) Of course, if enacted, the funding available to the state legislators will help them decide what services are “essential.” The legislation does not address how to integrate Medicare, Medicaid and other

public health insurance programs into the state's universal health care. On June 22, Gov. Jim Douglas (R) vetoed it. His administration is working on a new proposal, and the state legislature has created a 10-member panel to explore reform options.

California.

Remember the old saw about California, "Whatever is going to happen, will happen first in California?" That most populous of our states has been leading the way in many national trends for a long time now, so one wonders if it could now be a harbinger of the beginning of the first true universal health care system for the nation. California has been considering a much more radical approach, one that would use a single-payer to achieve true universal health insurance. State Senator Sheila Kuehl (D-Santa Monica) is sponsoring legislation, dubbed the California Health Insurance Reliability Act (SB 840) that would provide medical, dental, vision, hospitalization, and prescription drug benefits for all Californians. It would replace private insurance plans and also extend coverage to approximately 7 million Californians who have no health insurance. The program would be funded by a system of means-based premiums, and all uninsured residents would have to buy coverage or enroll in a sponsored program. A Lewin Group study ("The Health Care for All Californians Act: Cost and Economic Impacts Analysis," January 19, 2005) found that a single-payer system could cut health care expenses in California by \$25 billion per year, and save California \$343.6 billion in health care costs over the next 10 years, mainly by cutting administration and using bulk purchases of drugs and medical equipment.

Under this plan, the state's residents would pay for their health care through their taxes instead of paying insurance premiums, and health insurance would no longer be sold in the state. That alone would excise an enormous cost from the state's health care burden. As for hospitals and other providers, they would once again be paid under fee-for-service, an arrangement they should like better than being subject to so many administratively differing health plans. And the efficiency of having just one system with greatly reduced administrative costs (planning replaces marketing) and tremendous purchasing power over pharmaceuticals, medical devices, supplies, and equipment, would result in an affordable system covering everyone. Of course, its ability to truly cover everyone, and its ability to expend its resources on prevention and public health rather than on the profit motive, is what inspires those of us who still have the public interest at heart, and see health care as a right. In this view, it is fitting that individual means should be translated into the public purchasing power that can work for the public good, but that good will only be realized if legislators' oversight of all the program's parameters provides for continued commitment to those principles under which the program was originally established.

There have been parallels between California and the nation in this for at least sixty years. At about the time that President Truman was proposing to establish a national health care system, an idea shot-down by the AMA, AHA, and Sen. Taft of Ohio among others, then Republican Governor (and later Chief Justice of the U.S. Supreme Court) Earl Warren was proposing it in California.

Perennial Problems: One Solution.

The fundamental problem in the states is that they contain within them the same competing interests that doomed the Clinton plan, and so a greater countervailing force from outside the states is needed. In a nation where business prosperity is paramount and competition is respected and feared, the decisive push to do something may be found in what it will take for businesses and states to prosper today.

General Motors and the other automakers are a case in point for the inability of business to continue to bear the burden of health insurance benefits and compete in a multi-national marketplace. Wal-Mart, and other low-wage employers that fail to provide full health insurance to many of their employees, have raised issues of unfair competition by, in effect, shifting their costs to the states through the states' safety net programs. At the same time, the states are so short of revenue to continue funding Medicaid and other programs in their budgets that they are looking to tax their businesses for increased revenue. In addition, the states are facing rapidly rising costs for the health benefits they continue to provide to their own former employees in retirement.

While advancing these ideas, it must also be admitted that government-run programs are always subject to all the pitfalls of politics and the wastefulness of bureaucracies. We must be willing to countenance replacing marketplace competition with political policymaking. We must believe in our ability to achieve equity in health care through good public process. As Americans, we must reeducate ourselves to participate as well informed citizens in a national debate over health care budgeting and rationing. The degree of social justice present in a national health care system is largely a question of how progressive the tax system is that supports it. Like all government, this too must be government by the people, for the people. That means that it will work only so long as the people's eternal vigilance provides the accountability to make government service a moral imperative. And in an era when "public" has been denigrated and "private" oversold, and taxes abhorred in favor of paying even more out of individual motivation and discretion, it will be easy for conservatives and the private sector to instill fear in voters just as they did with the Clinton Plan in 1994, and also with still another single-payer legislative initiative that failed in California at the same time.

Can there be any solution to this short of a federal takeover of the financing of health care? With its own rapidly growing costs for an expanded Medicare program and well over half the costs of Medicaid, how else but by realizing the administrative efficiencies of a single-payer health care system can the federal government accomplish it? By consolidating federal, state, and private health insurance programs under one administration, the savings could be more than sufficient to fund a true universal health care program.(2)

Computing Cost Savings / Affordability

The National Coalition on Health Care (NCHC) has studied various scenarios for providing universal health care, and has analyzed four of them intensively:

1. Employer mandate supplemented by individual mandates where necessary.
2. Expansion of existing programs that currently provide coverage to defined populations.
3. Development of a new program modeled after the Federal Employees Health Benefit

Program (FEHBP).

4. A universal, publicly financed, single-payer program.

All four approaches to universal health care would result in overall cost savings nationally out of the same efficiencies California wishes to realize. The NCHC employed Professor Kenneth Thorpe of Emory University to compute the savings that would be projected to accrue from operationalizing each plan. Thorpe projected that the cost savings in each plan's tenth year (2015) would range from \$125 billion to \$182 billion. He also made projections for the total change in spending (i.e., the cumulative savings) for each in comparison with the nation's present "system" for the years 2006 through 2015, and came up with the following figures:

1. \$320 billion reduction.
2. \$320 billion reduction.
3. \$370 billion reduction.
4. \$1136 billion (\$1.136 trillion) reduction.

These net savings accrue even after taking into account the increases in federal spending needed to secure universal coverage. The report (3) summarizes the impact of these plans on national health care spending as follows:

System-wide health care reform, along the lines that the Coalition's specifications envision, would produce substantial reductions in national health care spending — reductions that would begin soon after reforms were phased in and that would increase over time.

As projected by the Centers for Medicare and Medicaid Services (CMS), national health care spending would be expected to rise under current law — that is, in the absence of major health care reform — from nearly \$2.1 trillion in 2006 to more than \$3.8 trillion in 2015. That means that the proportion of our gross domestic product devoted to health care spending would jump from about 15.6 percent now to 19 percent in 2015 — an increase of 3.4 percentage points. (p.12)

Public Health vs. the Profit Motive

Some of us see all four of these approaches as incremental too, for they address the financing of health care, but do nothing to rationalize its delivery. To do that, further steps are needed to remove the remaining profit motive from the delivery system and restructure its priorities toward prevention and public health. Only then might we as citizens and taxpayers receive full value for what we spend on health, a measure in which we ranked 72nd among all nations in the World Health Report 2000.(4)

Universal Health Care can be more than just efficient in its use of public resources. It can serve the greatest good by taking two more radical steps.

- * Adopting a public health model for its goals and priorities.
- * Eliminating the profit motive from health care.

Making public health a national priority means empowering communities to support the best

possible health status for everyone in them. This gives us a set of imperatives sorely missing from today's health care: To provide health education as a fundamental part of everyone's right to public education so that they may become promoters of their own wellness; to foster health promotion, primary care, and disease prevention; and to enable all community members to understand and participate in public forums on health policy.

The principles of compassion, fairness, and social justice that define public health are incompatible with the profit motive in health care. Rather, the resources taken out of the community to fund health care should be returned as benefits to the community. Thus we can see the second step as implicit in the first.

Of course, what we are proposing here is what is appropriately labeled "socialized medicine," and the connotations of the term presage its fate in our nation. In the only example available to us out of American experience, it would be like expanding the Veteran's Administration health care system (a true system!) to cover everyone, and making all health care providers salaried employees of the U.S. Public Health Service, resulting in a system like that of the U.K. The government ownership of the health care delivery system would be more "socialization" than would be palatable to a people wedded to ideals of opportunity through entrepreneurship and through unlimited personal spending for one's own health care. Therefore, progressive policy advocates use Medicare as a model instead, proposing to stretch its reach to cover all ages, thereby preserving the beloved private practice model, and resulting in a national system like that of Canada.

Will California lead the way in revealing to us that "Health Care Is a Right" and that it requires us to finally develop a national health care delivery system? And if so, how radical a system? History teaches us that countries have systems reflecting their own established values and precedents. The democratic process in which political and business interests are already entrenched is surely one of ours. Opposition to radical economic, political, and social change is overwhelming, and so change is evolutionary, not revolutionary. We may yet wind up extending Medicare incrementally to ever younger ages, but let us always do so with a vision of these ideals present in mind and heart. The answers to such questions are yet to come, but I believe that they must come through a campaign that has the quality that William James described as "the moral equivalent of war."

References

- (1) "Analysis of the Costs and Impact of Universal Health Care Coverage Under a Single Payer Model for the State of Vermont," The Lewin Group, Inc., August 28, 2001. Full text of the study is available on-line at: <http://www.dsw.state.vt.us/districts/ovha/AnalysisoftheCosts.pdf>.
- (2) Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med* 2003; 349:768-775.
- (3) For Thorpe's report, go to <http://www.nchc.org/materials/studies/Thorpe%20booklet.pdf>.
- (4) For a useful summary of the World Health Report 2000 and its insights for the US health care non-system, see "With Liberty and Justice for All?"