Liberal Benefits, Conservative Spending

by Stephanie Woolhandler, M.D., M.P.H., and David U. Himmelstein, M.D.

Few would dispute that our health care system is deeply troubled. Estimates are that 39 million Americans are completely uninsured, and millions more have inadequate coverage. After a brief lull, health care costs have resumed their exuberant growth. Health maintenance organizations (HMOs) have both failed to contain costs and fallen to the basement of public esteem, commercial pressure threatens medicine's best traditions, and healing has become a spectator sport, with physicians and patients performing before a growing audience of bureaucrats and reviewers.

Opinions on solving these problems are even more divided.We advocate national health insurance because we are convinced that any lesser measures will fail.

The Problem

In the 35 years since the implementation of Medicare and Medicaid, a welter of patchwork reforms has been tried. HMOs and diagnosis-related groups promised businesslike efficiency that would contain costs and free funds to expand coverage, but the resulting market competition has created a variety of new problems. Billions of dollars have been used to expand Medicaid and similar programs for children, and both Medicare and Medicaid have tried managed care. None of these initiatives has made a dent in the number of uninsured. Nor have they durably controlled costs or lessened the bureaucratization that is consuming the medical profession.

Patchwork reforms founder on a simple problem: expanding coverage always increases costs unless resources are diverted from elsewhere in the system. With the U.S. economy going sour, our health care costs are nearly double those of any other nation and large infusions of new money are unlikely.

Without this new money, patchwork reforms can only increase coverage by siphoning resources from existing clinical care. Advocates of managed care and market competition once argued that their strategy could reduce health care costs by trimming clinical fat. Unfortunately, this "diet" program was overseen by new layers of bureaucrats who were not only intrusive but also expensive and devoured virtually all of the clinical savings.

Resources are seeping inexorably from the bedside to the executive suite. Bureaucracy now consumes nearly 30 percent of our health care budget. The shortage of bedside nurses co-exists with a proliferation of RN utilization reviewers, and clinicians are being pressured to see more patients to increase institutional profit by their colleagues who have withdrawn from direct care and now work in administration. The latest policy nostrums—medical savings accounts and voucher schemes such as President Bush's "premium support" proposal for Medicare—would further amplify bureaucracy and limit care.

Medical savings accounts discourage preventive and primary care and fail to curb the high costs of care for the severe illnesses that account for most health spending. These plans also require insurers to start keeping track of all out-of-pocket spending while retaining their existing bureaucracy, and would slash the cross-subsidy from healthy enrollees to the sick.

Voucher programs are thinly veiled mechanisms to cut care. The vouchers offered are invariably too skimpy to allow people to purchase adequate coverage, forcing lower income individuals into substandard plans. Voucher schemes also posit that frail elders and other vulnerable patients will make wise purchasing decisions from a welter of confusing insurance options, and they boost insurance overhead by shifting people from group plans (Medicare or employer groups) into the individual insurance market where overhead consumes more than 35 percent of premiums.

To anyone with a history of cancer, voucher programs are a cruel joke. Vouchers would cover only a fraction of the exorbitant premiums insurance companies charge cancer survivors in the individual insurance market.

The Solution

The key to achieving significant health care savings is single-source payment. Canada and numerous other nations use this solution and it works. Canadian hospitals, which are mostly private, nonprofit institutions, do not bill for individual patients. They are paid a global annual budget to cover all costs, much as a fire department is funded in the U.S. Physicians, most of whom are in private practice, bill by checking a box on a simple insurance form. Fee schedules are negotiated annually between provincial medical associations and governments, but all patients have the same coverage, so patients with cancer and others who need expensive or long-term care need never fear exceeding their benefits.

Unfortunately, during the 1990s, Canada's health care funding was starved by governments responsive to pressure from the healthy and wealthy who did not want to subsidize care for the sick and poor. Canadian and U.S. health care spending was once comparable, but today Canada spends barely half what we do per capita. Even though shortages of expensive, high-technology care have

continued on page 22

Less Freedom, Less Care

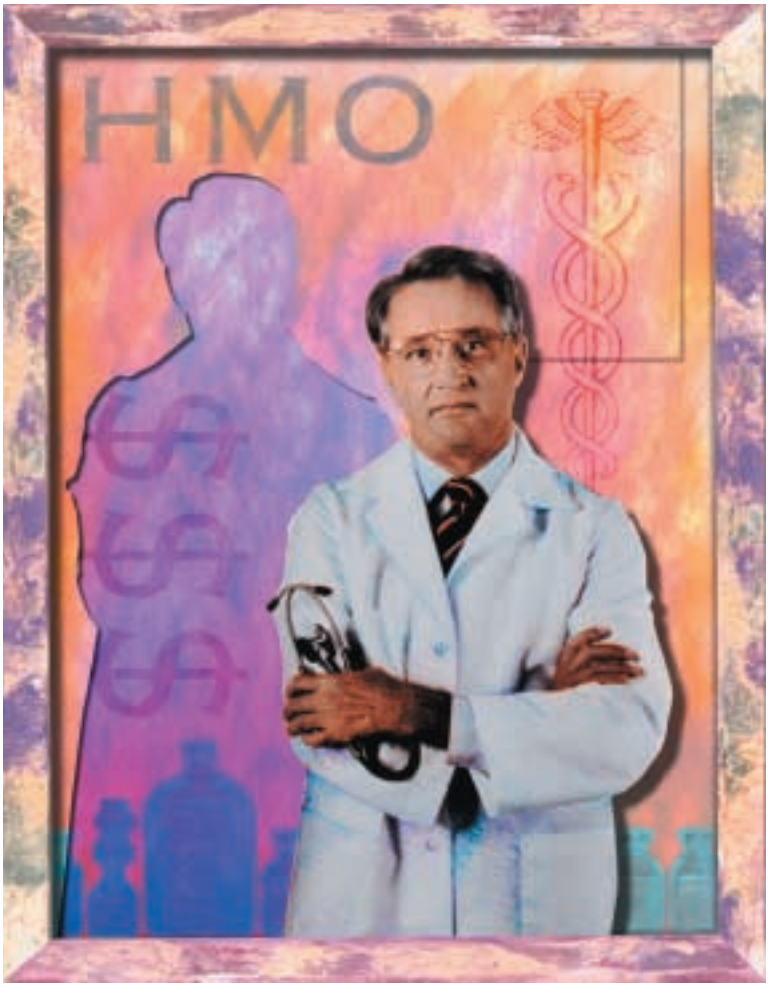
by John C. Goodman, Ph.D.

National health insurance in other countries has been a failure, not a success. Over the past decade, almost every developed country with a national health care system has introduced market-oriented reforms, often looking to the United States for guidance.

Virtually every country with national health insurance has proclaimed health care to be a basic human right. Yet far from guaranteeing that right, their systems routinely impose health care rationing that delays or denies needed care. For example, in England, more than 1 million people are waiting to be admitted to hospitals at any one time. In New Zealand, the number of people on waiting lists for surgery and other treatments is more than 90,000, and in Canada, more than 878,000 are waiting for treatment of all types.

In Canada, the average patient waits more than seven weeks to see a specialist after a GP's referral and another nine weeks until surgery. In Britain, some patients wait more than a year. Patients who wait are often waiting in pain, and many are risking their lives. One investigation found that delays in treating colon cancer are so long in Britain that 20 percent of the cases considered curable at time of diagnosis had become incurable by the time of treatment.

Not only do residents of other countries not have a right to health care, they may have fewer rights than foreigners have. While more than 1 million British patients waited for care, 10,000 private-pay patients—about half of whom were foreigners—received preferential treatment in Britain's top government hospitals in 2001. While American patients traveling to Canada can pay cash and jump to the head of the queue for heart surgery at Ontario hospitals, it would be illegal for Canadians to do so.



ILLUSTRATION/EYEWIRE

On the surface, the number of people waiting may seem small relative to the total population (from 0.5 percent in Canada to 2.5 percent in New Zealand); however, considering that only about 16 percent of the population enters a hospital each year in developed countries, these numbers are actually quite high. In New Zealand, for example, almost one person is waiting for every five who receive treatment.

One reason people are waiting for care is a conscious decision by the government to limit health care resources and a lack of specialists to deliver treatment. In the United States, almost nine out of every 10 physicians are specialists. In Canada and New Zealand, this number is close to half, but drops to a third in Australia.

Less Equipment, Fewer Drugs

Compared to the United States, patients in other countries also have difficulty obtaining access to advanced diagnostic equipment. The United States has four times the number of CT scanners and five times the number of MRI scanners per capita as Britain, and three times as many CT scanners and nine times as many MRI units as Canada.

Patients in single-payer systems often lack access to lifesaving prescription drugs that many

continued on page 23

resulted, Canada's health outcomes remain better than ours: their life expectancy is two years longer and most quality comparisons indicate that Canadians enjoy care equivalent to that received by insured Americans. For instance, Canadian death rates are lower than those in the U.S. for both cardiovascular disease and cancer, especially among younger individuals with potentially curable malignancies. A system structured like Canada's but with double the funding could provide high-quality care without the waits or shortages that Canadians have experienced.

The Model

The national health insurance that we propose would create a single, tax-funded, comprehensive insurer in each state, federally mandated but locally controlled. Everyone would be fully insured for all medically necessary services, and private insurance duplicating the national health insurance coverage would be proscribed (as is currently the case with Medicare). The current Byzantine insurance bureaucracy, with its tangle of regulations and wasteful duplication, would be dismantled. Instead, the national health insurance trust fund would dispense all payments, and central administrative costs would be limited by law to less than 3 percent of total health care spending.

PHOTOGRAPH/COMSTOCK

Each hospital and nursing home would negotiate an annual global budget with the national health insurance based on past expenditures, projected changes in costs and use, and proposed new and innovative programs. Many hospital administrative tasks would disappear. There would be no hospital bills to keep track of, no eligibility determinations to make, and no need to attribute costs and charges to individual patients.

Clinics and group practices could elect to be paid fee-for-service or receive global budgets similar to hospitals. While HMOs that merely contract with providers for care would be eliminated, those that actually employ physicians and own clinical facilities could receive global budgets, fee-for-service payments, or capitation payments (with the proviso that such payments could not be diverted to profits or exorbitant executive compensation).

As in Canada, physicians could elect to be paid on a fee-for-service basis or receive salaries from hospitals, clinics, or HMOs.

Properly structured, the administrative savings national health insurance could create would pay for the expanded coverage.

Funding

While national health insurance would require new taxes, these would be fully offset by a decrease in insurance premiums and out-of-pocket costs. The additional tax burden would be smaller than anticipated, since nearly 60 percent of health care spending is already tax supported (vs. roughly 70 percent in Canada). Besides Medicare, Medicaid, and other public programs, our governments fund tax subsidies for private insurance that exceed $100 billion per year, and local, state, and federal agencies that purchase private coverage for government workers account for 22.5 percent of total employer health care spending (Woolhandler and Himmelstein, unpublished analysis of Current Population Survey data from the U.S. Census Bureau, 2001).

We suggest that the national health insurance program be demonstrated in one or two states before it is nationally adopted. Funding might initially mimic existing patterns to minimize economic disruption, but all payments would be funneled through the national health insurance trust fund that would receive the monies that currently go to Medicare, Medicaid, and employee health benefit subsidies. Employers would pay a tax equivalent to what they now spend for group insurance policies. In the long run, a shift to a more progressive financial base funded by income tax would provide a fairer and more efficient revenue stream.

The Difficulties

The national health insurance we propose faces important political and practical obstacles. The virtual elimination of private health insurance will evoke stiff opposition from insurance firms and investor-owned hospitals. Drug firms will fear that a national health insurance program would curtail their profits. In addition, the financial viability of the proposed system is critically dependent on achieving and maintaining administrative simplicity. Vigilance and statutory limits would be needed to curb the tendency of bureaucracy to reproduce and amplify itself. Canada controls costs by enforcing overall budgetary limits. Canada also implements a macromanagement approach that contrasts sharply with our micromanagement approach, with its case-by-case scrutiny of billions of individual expenditures.

Conclusions

National health insurance could solve the cost versus access conflict by slashing bureaucratic waste and reorienting the way we pay for health care. National health insurance could also restore the physician-patient relationship and free physicians from the bonds of managed care and overwhelming paperwork, while still giving patients a free choice of physicians and hospitals.

How many more failed patchwork reforms must we try? How many more patients must be deprived of care because they cannot afford it, and how many trillions of dollars must we squander on a malignant bureaucracy before we adopt the only viable solution?

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Americans take for granted. For example, less than one-third of British patients who suffer a heart attack receive beta-blockers (used by 75 percent of patients in the United States), despite the fact that post-heart attack use of these drugs reduces death by 20 percent.

According to the World Health Organization (WHO), as many as 25,000 people in Britain die of cancer each year because they cannot obtain the latest cancer treatments. As a result of not receiving the care they need, people with curable diseases, such as breast or prostate cancer, often do not survive. In the United States, only one in four patients diagnosed with breast cancer dies of the disease, compared to one in three in Germany and France, and almost one in two in New Zealand. In the United States, only one of every five patients with prostate cancer dies of the disease, compared to one in four in Canada, one in two in France, and over half in Britain.

Less Efficient Services

Unable to obtain the free health care they have been promised, patients in other countries often turn to the private sector. In Britain, 7 million people have private insurance for services the government theoretically provides for free. Ironically, the NHS is the largest provider of private care in the country. In New Zealand, more than one-third of the population has private health insurance to cover services that are supposed to be provided free-of-charge by the state. Canadians spend $1 billion a year in the United States for health care. This figure includes revenues from seven Canadian provinces that send their breast and prostate cancer patients to the U.S. for radiation therapy. In Australia, about one-third of the population has private health insurance, and private-sector spending accounts for almost one-third of all health care spending.

Critics of U.S. health care often maintain that the systems of other countries are more efficient, yet all the evidence points the other way. While more than 1 million people wait for medical treatment in Britain, close to 16 percent of hospital beds are empty on any given day. An additional 15 to 16 percent of British hospital beds are filled with patients who should be in nursing homes, geriatric wards, or at home, closing almost one-third of the nation's hospital beds to acute-care patients.

If hospitals operating under global budgets were truly more efficient, American hospital administrators would be traveling to those countries to learn about their management practices. In fact, the travel is in the opposite direction. Although U.S. hospitals certainly have room for improvement, they already are far more efficient than their international counterparts.

While countries with national health insurance routinely skimp on services for the seriously ill, they often provide too many services for patients with minor ailments. For example, there are more than 18 million ambulance rides in Britain every year, or about one ride for every three people in the country. Eighty percent of the rides are for such non-emergency purposes as outpatient care and pharmacy visits and amount to little more than free taxi service. The NHS provides free day care services in Britain to more than 260,000, home care or home help services to 578,000, home alterations for 375,000, and occupational therapy for 300,000.

The British preference for "caring" over "curing" is a direct result of the political nature of national health insurance. In a typical U.S. private health care plan, 41 percent of health care dollars are spent on the sickest 2 percent of the population. In a political system, politicians cannot afford to spend 41 percent of the budget on 2 percent of the voters, many of whom are probably too sick to vote anyway. The temptation is always to take from the few who are sick and spend the money instead on the population at large.

Despite the promise of equal care for all, inequalities pervade every government-run health care system. In Britain, people from poor urban areas live shorter lives and die more frequently from common, treatable illnesses than their wealthier neighbors. In Canada, vast inequalities also exist. Residents of Vancouver receive almost three times more specialist services per person than residents of the Peace River region. Among the 29 health regions of British Columbia, there is a ratio of 5 to 1 difference in per capita services of internists, and a ratio of 31 to 1 difference in the services of psychiatrists.

National health care systems have not failed because of minor glitches or easily correctable problems. Their critical defects flow inexorably from the fact that they are government run.

Solution: Making Markets Work in Health Care

Because 95 percent of hospital revenues come from third-party payers, the treatment prices hospitals charge patients are not market-driven but artificial prices designed to maximize revenue against third-party reimbursement formulas. While the federal government has encouraged an institutionalized, bureaucratized market by subsidizing third-party payment, evidence suggests that the market would be radically different if patients were spending their own funds.

Competitive markets encourage efficiency because consumers in competitive markets have the opportunity to choose their service providers. When consumers are drawn to low-cost providers, providers search for low-cost methods of delivering services.

Medical Savings Accounts (MSAs) are probably the single best step towards a market-based solution to the health care crisis. Several states have taken steps to enact or endorse some version of MSAs (also called Medical IRAs and Medisave Accounts). These tax-free, interest-bearing personal accounts permit people to set money aside for small health care expenditures while purchasing catastrophic health insurance for major medical expenses. Colorado, Arizona, Idaho, Illinois, Michigan, Mississippi, and Missouri have passed bills exempting MSAs from state taxes, and MSA legislation is also being considered in other states.

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